

EXPLORING FAMILY INVOLVEMENT IN COMPREHENSIVE SCHOOL HEALTH

by

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Submitted in partial fulfilment of the requirements  
for the degree of Master of Arts

at

Dalhousie University  
Halifax, Nova Scotia  
August 2014

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## DEDICATION

I would like to dedicate this to my Mom, who was an involved parent – regardless of my appreciation for it at the time. Thanks Mom!

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## **ABSTRACT**

A health promoting school plans and acts towards providing a healthy school environment through healthy initiatives and engaging with stakeholders in health, education, government, community, families, students and staff within a comprehensive framework known as comprehensive school health. Students attending such a school have increased academic success, better diet quality and increased physical activity levels. The involvement of families is a valuable aspect of comprehensive school health; with greater involvement the potential is there to improve its success.

This research used interpretive phenomenology within a constructivist paradigm. Semi-structured interviews were conducted with eight individuals caring for a child in Grade 4, 5, or 6 in a Nova Scotia elementary school. These interviews were analyzed to gain a deeper understanding of family involvement. It was found that involvement was varied, the school community was an important facilitator, and that school leadership had an important role in fostering family involvement.



## **LIST OF ABBREVIATIONS USED**

CASH – Canadian Association for School Health

CLASS – Children’s Lifestyle And School Performance Study

CSH – Comprehensive School Health

HPS – Health Promoting School(s)

JCSH – Pan-Canadian Joint Consortium for School Health

NSHPS – Nova Scotia Health Promoting School

PHAC – Public Health Agency of Canada

SEM – Social Ecological Model

WHO – World Health Organization

## ACKNOWLEDGEMENTS

I would like to start by acknowledging my supervisor, Dr. Sara Kirk who has provided the guidance and support for me to grow and learn as a researcher and overall a better understanding of collaborative practices in health promotion. I would also like to thank my supervisory committee members Dr. Cindy Shearer, Dr. Misty Rossiter, and “soon-to-be-Dr.” Barb Hamilton-Hinch for their on-going support throughout this process.

I would also like to thank my classmates and colleagues for their support whether it was reading pieces of my thesis, talking concepts through, or helping me to relax with some down time. And to my friends and family for always checking in to see how I was doing and reminding me of how good it will all feel when all is said and done.

Lastly, a special thank you to my husband, Nevawn, who has loved and supported me every step of the way doing whatever was needed so that I could focus on achieving this goal. I love you!

## CHAPTER 1 INTRODUCTION

### 1.1 Statement of Problem

For a number of years, rates of overweight and obesity in Canada have risen dramatically in the adult population as well as the child and youth populations (Public Health Agency of Canada (PHAC), 2009). The Government of Nova Scotia reports that one in three children and youth are overweight or obese (Province of Nova Scotia, 2012). This is a concern as it not only increases the risk of obesity in adulthood, but also increases the likelihood of these children and youth developing chronic diseases such as type two diabetes and heart disease (PHAC, 2009), which will put a strain on the Nova Scotia healthcare system. Research has already shown that obese children have 21% higher healthcare costs than their “normal” weight peers (Kuhle, et al., 2011). Given the prevalence of obesity among youth in Nova Scotia, prevention efforts have focused on the education system, and more specifically the school setting as a means to address this public health issue.

Health and education are linked in a number of ways. Most notably, education is one of the social determinants of health (Mikkonen & Raphael, 2010; PHAC, 2012b). Individuals with higher education levels tend to be healthier than their less educated peers (Mikkonen & Raphael). Health is also linked with education in that children with better diet quality and who are active have better educational outcomes (Florence, Asbridge, & Veugelers, 2008; Canadian Teachers’ Federation, 2010).

Comprehensive school health initiatives, where health is embedded within the ethos of a school, have been linked to better health and educational outcomes in children and youth (International Union for Health Promotion and Education, 2010). In Nova Scotia,

researchers found that in schools where a more comprehensive approach to school health was undertaken, students had increased success with standardized tests, better diet quality, and increased physical activity (Florence, et al., 2008; Veugelers & Fitzgerald, 2005).

Comprehensive school health is defined in a number of ways by organizations across Canada and globally. The Pan-Canadian Joint Consortium for School Health (JCSH) identifies comprehensive school health through a framework of four pillars – teaching and learning, social and physical environment, healthy school policy, and partnerships and services (JCSH, 2012). Teaching and learning refers to the school’s curriculum and resources that support students to gain the knowledge and skills required to lead healthy lives. The social environment is the extent to which the schools’ setting supports positive relationships between students, staff, and the surrounding community; promoting emotional and mental well-being. The physical environment is the state of repair, cleanliness and care for the physical amenities in the school community such as the buildings and green spaces. Healthy school policies are those that promote a safe and caring school environment for all. The partnerships and services pillar refers to the relationships between the school and students’ families, the greater school community, and community organizations that can offer services to support the well-being of students and school staff (JCSH, 2012).

The JCSH pillars are based on the Ottawa Charter for Health Promotion (PHAC, 2012a) that includes actions for health promotion such as supportive environments, healthy public policy, strengthening community actions, and development of personal health skills. Similar to JCSH, the Canadian Association for School Health (CASH)

(2012) identifies four strategies for the implementation of comprehensive school health: instruction, preventive health services, social support, and healthy physical environment. Deschesnes, Martin, and Hill (2003) identify four conditions needed for the implementation of comprehensive school health: negotiated planning and coordination of support; collaborative action between school, family and community, political and financial support, and evaluation.

In other jurisdictions, comprehensive school health is synonymous with health promoting schools – the terms are often used interchangeably. The World Health Organization (WHO) describes a health promoting school as one that plans and takes action toward providing a healthy learning, living, and working environment for all through the implementation of comprehensive health initiatives and engaging a variety of partners including health and education professionals, government, community members, parents, students and staff (WHO, 2012). This definition encompasses the JCSH (2012) framework as well as Deschesnes et al. (2003), and the Canadian Association for School Health (CASH) (2012). No matter the terminology or framework used, each definition involves a coordinated approach to health that moves beyond classroom-based models to more integrated health promotion that focuses on student behaviours and attitudes, and their physical and social environments.

Collaborative engagement or involvement is entrenched in the description of comprehensive school health and health promoting schools (CASH, 2012; Deschesnes et al., 2003; JSCH, 2012, PHAC, 2008; WHO, 2012). This includes parents/guardians, families, and/or caregivers as they can be reached directly through the students by schools. Families will be used to refer to these groupings and any care provided for the

child. Families can engage in comprehensive school health in many ways and have the opportunity to provide the support needed by schools to reinforce healthy messages in the home. Involvement can entail hands on activities such as through the implementation of health promotion programs (e.g. volunteering with the school's breakfast or lunch program) or advocating for healthy change within the school environment (e.g. advocating to the school board for more crossing guards in the school area).

In 2003, the Children's Lifestyle And School-performance Study found that in a group of schools that used a more comprehensive approach to school health, the students also demonstrated increased academic success, better diet quality, and increased physical activity levels, even after adjusting for known confounders such as parental education and income levels (Florence, et al., 2008; Veugelers & Fitzgerald, 2005). Following this study, in 2005 the Health Promoting Schools Nova Scotia (HPSNS) or health promoting schools (HPS) program was introduced in the province as a comprehensive school health strategy (McIsaac, Sim, Penney, Kirk, & Veugelers, 2012).

More recently, a program called Schools Plus has been initiated in a number of schools across the province. This program was developed in response to a government appointed inquiry report that recommended a specific strategy be developed for children and youth at risk. This strategy would bring together a number of local and provincial partners from a variety of backgrounds – health, education, community services, and justice – for its implementation (Province of Nova Scotia, 2006). Schools Plus was an initiative derived from a larger strategy to target the school environment. The main tenets of the Schools Plus program are to develop a variety of programs and services at school sites that also extend beyond school hours, create awareness within the school

community, develop collaborative partnerships, increase youth engagement, and increase the involvement of families in the school and community (Province of Nova Scotia, 2006).

While both of these Nova Scotia comprehensive school health programs have identified family involvement as a component for successful implementation, for the purpose of this research the focus will be on HPSNS. This focus will align with previous and current HPS research adding an understanding of family perceptions and attitudes. This will provide the information needed in order to gain, or increase, support and participation for the program.

Research in the area of family involvement has been mainly concerned with the academic aspect of education, i.e. teaching, learning or grade attainment. This research has shown that family involvement has significant academic benefits for students (Eccles & Harold, 1993; Herman & Yeh, 1983). These benefits include increased academic successes, as well as supporting schools in advocacy projects, providing additional resources, and reinforcing school messages in the home. Eccles & Harold (1993) further identified parent (and family) characteristics that play a role in how parents decide on their involvement that includes their individual attitudes, beliefs, perceptions and assumptions. Similarly, Hoover-Dempsey et al. (2005) identified role construction, efficacy, interpretation of invitations to participate, and skills and knowledge as influencing factors for parental involvement. This information has been very helpful in relation to the academic side of education and could help with comprehensive school health. However, little is known about family involvement in comprehensive school health initiatives in the Nova Scotia context.

Information gained from this research can provide a deeper understanding of the family perception and involvement with comprehensive school health in Nova Scotia. Findings from this research can have theoretical and practical implications for school and school board officials, others directly involved with comprehensive school health (i.e. school health teams, Schools Plus Advisory Committees, sport animators), interested government partners, and the research community.

## **1.2 Purpose of the Research**

The purpose of this study is to understand the perceptions and attitudes of families toward involvement in comprehensive school health and the factors that shape their involvement. The focus of the research is on family involvement in comprehensive school health programs in Nova Scotia. Primarily, it will emphasize health promoting schools within elementary schools in Nova Scotia with Schools Plus as a secondary focus to ensure inclusiveness of comprehensive school health in Nova Scotia. Schools Plus is not included in the main focus as it is only in a small number of schools across the province and the population to be interviewed may not have experience with the program.

## **1.3 Research Questions**

Using a qualitative research design, this study was guided by the following research questions:

1. What do families understand about comprehensive school health in their schools?
2. What do families see as their role in comprehensive school health?
3. Why are families involved, or not, in comprehensive school health?
4. What are the main influences of, or barriers to, involvement?



#### **1.4 Study Design**

Adults caring for at least one child enrolled in a Nova Scotia elementary school, specifically Grade 4, Grade 5, or Grade 6, were invited to participate. Using an interpretive phenomenological approach, participants were engaged in individual semi-structured interviews. An interview guide provided a framework of the topic area to be discussed with specific questions related to the research, however the interviewer was able to modify the order of questions and ask follow-up questions at her discretion, as required to further explore topics. Interviews were analyzed using a thematic analysis approach using a ladder of participation (Arnstein, 1969) and social ecological model (Cotrell, Girvan, & McKenzie, 2009) framework to guide the analysis.

## CHAPTER 2 LITERATURE REVIEW

### 2.1 Health Promoting Schools

A health promoting school is one that plans and takes specific action to provide a healthy learning and working environment for students, staff and teachers through the implementation of healthy policies, initiatives or programs (Province of Nova Scotia, 2009; PHAC, 2008; JCSH, 2012; WHO, 2012). The health promoting schools initiative has been adopted into the Nova Scotia context for many years. While occurring in pockets around the province, this concept was formalized into a provincial initiative and began in 2005 (McIsaac, et al., 2012). This was a result of reports from a provincial research project that showed positive linkages between comprehensive school health approaches, and the health and learning of students. This project was the Children's Lifestyle And School-performance Study (CLASS) conducted in 2003.

In the CLASS study, researchers found a small number of schools in one area of Nova Scotia that had adopted a comprehensive approach to health in their schools and this translated into positive outcomes for the health and learning of the students in those schools (Florence, et al., 2008; Veugelers & Fitzgerald, 2005). Specifically, children had better diet quality, increased physical activity levels, decreased amounts of screen time, and were less likely to be overweight and obese (Veugelers & Fitzgerald). In addition, CLASS found that students who had the best diet quality were 30% less likely to be unsuccessful with their Grade 6 Elementary Literacy Assessment (Florence, et al.). It is important to note that this was prior to the formalized initiative funded by the province.

The information gained from CLASS in 2003 provided key insight into the connection between the school environment and its impact on the health of children. This

research provided the evidence needed to positively influence decision makers in the province as seen with the initiation of the HPSNS (Health Promoting School Nova Scotia) initiative. A small number of evaluations have been carried out for specific programs within regional school boards, but little has been done qualitatively to look into the components of health promoting schools as a way to strengthen the initiative.

Using comprehensive school health as a framework, one of the components of health promoting schools is the partnerships or collaboration with the greater school community (WHO, 2012). This school community involves everyone from those in the school – students, teachers, administrators, and staff – to those outside the school – local businesses, health professionals, government, and last but not least parents and families (Province of Nova Scotia, 2009; PHAC, 2008; WHO, 2012). Booth and Samdal (1997) state that inclusiveness is a fundamental principle to be followed for health promoting school (HPS) implementation. This means fully involving parents and the wider local community in the development and implementation of HPS initiatives in the school. By involving families and community, they too can benefit from HPS initiatives with increased health knowledge and skills, as well as gaining assurance that they are part of the local school community and their ideas and participation matter (WHO, 2000).

## **2.2 Partnerships and Participation**

It is essential to understand partnerships and participation from the broader perspective of citizen participation. Arnstein (1969) developed a model of participation in the form of a ladder (Figure 1) arguing that citizen participation is related to citizen power. The author suggests that the lowest rung represented the least level of participation, and as the ladder is climbed, the level of true participation increases along

with the power of those involved. Arnstein stated that the power in participation is related to the effect with which citizens are involved in “determining how information is shared, goals and policies are set, ... programs are operated” (p. 216).

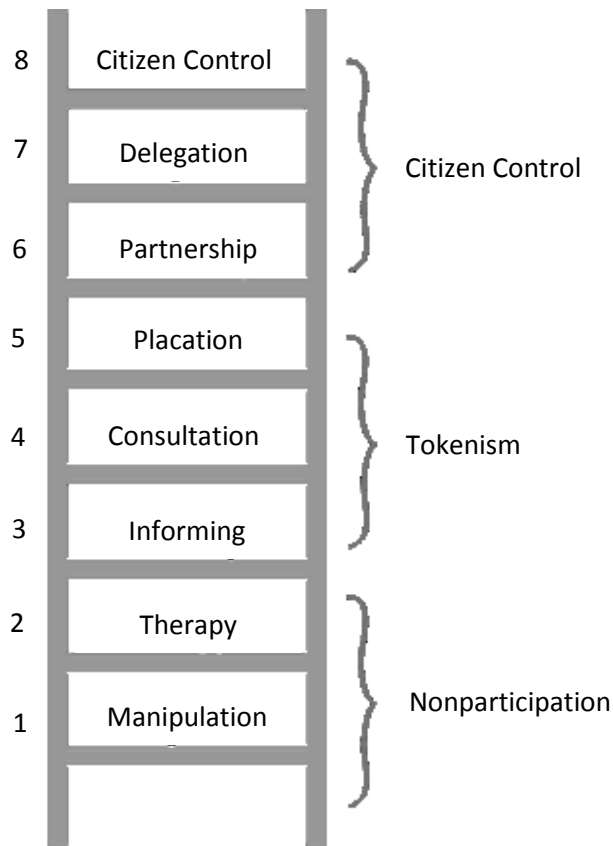


Figure 1 Arnstein's Ladder of Citizen Participation. (Arnstein, 1969)

The ladder is presented with eight rungs divided into three categories of participation, beginning at the bottom level with manipulation and therapy that make up the non-participation category depicted in Figure 1. At this low level of involvement, (non-) participants are engaged by those of power through education or changing ideals to align with that of the powered group (Arnstein, 1969). The second category, degrees of tokenism include the ladder rungs of informing, consultation and placation where the participants are beginning to have a voice but that voice may not necessarily be taken into

account for the decision making process (Arnstein, 1969; Minkler & Pies, 2005). The final category, degrees of citizen power include true forms of participation, or engagement – partnership, delegated power, and citizen control (Arnstein, 1969; Ife & Tesoriero, 2006; Minkler & Pies, 2005).

While Arnstein (1969) offered this model as levels of participation she noted limitations particularly with regards to whether there is a clear progression up the ladder rungs to achieve true participation or if there is a compounding effect (Connor, 1988). These limitations were explored by Connor (1988) whose aim was to build on Arnstien's work by creating a more systematic model and approach to participation.

Connor's (1988) ladder contains seven rungs: education, information feedback, consultation, joint planning, mediation, litigation, and resolution/prevention. He presented each as a connected relationship in that each rung builds to the next and can at times occur simultaneously to meet the needs of those involved or to be reflective of the situation. For example education, information feedback, and consultation can happen within the same community meeting. Connor (1988) argued that those who seek involvement require the education – that is they need to be informed – and have an understanding of the issue. As people become educated on the topic they then move into the second stage of engaging in feedback procedures. Through the information feedback process, citizens are providing their thoughts and views on the information presented and may also address gaps or issues that may arise. The next step is consultation, where Connor (1988) views the people providing information on how to move forward and what actions are required to move the agenda forward. He differentiates this from the information feedback rung in that at this stage the solutions are being identified to

address the feedback provided in the earlier phase. Connor places these three components together at the level of the general public where they are in more of an advisory role providing information for the next steps.

The next three stages, Connor (1988) places into a category of leaders where there is more control and involvement in decision-making processes. In joint planning, those involved are partners in the process having an equal role. Mediation and litigation refer more to settling disputes in the joint planning process where power is equal, negotiation is certain and alternative solutions cannot be determined. A specialized facilitator often conducts mediation whereas litigation is a more legalized method of coming to agreement. Connor notes that when it comes to litigation it is important to realize the reality that animosity may have been created and will need to be subdued prior to moving into the next and last phase of resolution/prevention. It is here that all parties have agreed and resolved the issues with those feeling a sense of equality in arriving to the solution.

The work presented by Arnstein (1969) and Connor (1988) help us to understand that participation is variable along a continuum, vertical or horizontal – from merely being involved to being fully engaged. Their work leads to an understanding that true engagement, cannot be attained until there is an equal distribution of power in moving agendas forward. Minkler and Pies (2005) state that community involvement needs to be genuine and cannot occur simply because it has been mandated or something that is ‘supposed’ to happen. This is at the forefront of community development where the “goal is to build capacity for an entire system and all of its participants to operate as a community” (Walter, 2005, p. 66).

### **2.3 Community**

Exploring participation and engagement requires an understanding of community as the research is set within the school community. There are geographical communities and functional communities that have a common sense of identity outside of their location such as a church community or a school community (Ife & Tesoriero, 2006). Ife and Tesoriero explain that finding a single definition of community is challenging and describe five key characteristics: human scale, identity and belonging, shared set of obligations, *Gemeinschaft*, and culture.

Human scale is one characteristic identified referring to the level of interaction members have with each other (Ife & Tesoriero, 2006). Members can control this interaction and people are able to get to know one another as needed – this lends itself to smaller groupings, as larger groups would not allow for everyone to know everyone. Identity and belonging is where people feel that they are wanted, accepted and valued by the other members in that community (Ife & Tesoriero). There is also a sense of responsibility to the community that one feels they belong to. Having a shared set of obligations is another characteristic of community (Ife & Tesoriero). This includes rights and responsibilities where there is a set of expectations that each member will contribute to the community in some form or function. Another characteristic is from Tönnies' description of human interaction (as cited by Ife & Tesoriero, 2006) – *Gemeinschaft*. This refers to the notion of human interaction occurring with a small number of individuals whom they are familiar with and know well, rather than a large group of relatively unknown members. Finally culture is a characteristic of community (Ife & Tesoriero). It is a set of unique characteristics associated with the community that create

a shared set of values and beliefs, customs and traditions, where members are active producers of that culture.

## **2.4 Defining Involvement**

Having explored levels of participation through the work of Arnstein (1969) and Connor (1988), it is critical to this research to explore the literature relating to the form of family involvement in schools – determining what function families have played and the importance of their involvement. Most of the literature about parental or family involvement in children’s schooling describes involvement as supporting the academics – marks, reading, writing, mathematics, etc. Herman and Yeh (1983) studied the effects of parent involvement in schools and found that when parents volunteered their time, there was a direct benefit to student achievement as schools were able to reallocate resources to improving instruction. Epstein (1995) stated that families have a role to strengthen children’s views on school importance, homework, and activities that build student skills and feelings of success. Eccles and Harold (1993) found that family involvement was critical in the success of a child at all grades. These observations are further supported by DePlanty, Coulter-Kern and Duchane (2007), who report that parents must have an active role in the academic lives of their children in order for these children to achieve success. They added that families provide the necessary support – shelter, food, and clothing – for children to perform well in school.

Benefits outside of student success have also been documented. Epstein (1995) noted that family involvement can “improve school programs and school climate, provide family services and support, increase parents’ skills and leadership, connect families with others... and help teachers with their work” (p. 701). Similarly, Herman and Yeh (1983)



found that parental perceptions of their influence on the school increased as well as their rapport with the school when there was involvement.

Defining forms of family involvement is fundamental to understanding how to invite family participation. With an understanding of the form of involvement, it will be easier to articulate how involvement in education can relate to involvement in health promoting schools. Throughout the literature there are several definitions for parental involvement in education, however together these definitions can be put into two main categories: home-related and school-related. Home-related involvement is concerned with the parent and child interaction, and school-related involvement is about the interaction between the family and the school. This refined definition will help to keep things simple and concise, but acknowledges the fact that parental involvement is multifaceted (Epstein, 1995; Grolnick, Benjet, Kurowski & Apostoleris, 1997; Lightfoot, 2004; Waanders, Mendez & Downer, 2007).

Waanders et al. (2007) findings support this simpler categorization but include a dimension not presented with the previous authors – the parent-teacher relationship which adds to the complexity of defining involvement. It can be argued that the parent-teacher relationship can be included in the school-related involvement as it is defined as the interaction between the family and the school to which the teacher is affiliated.

Another definition of parental involvement in education is from Grolnick et al. (1997) who defined three forms of parent involvement: behaviour, cognitive-intellectual, and personal. Behaviour refers to the participation of parents in activities at school (school-related) or in the home (home-related); cognitive-intellectual refers to exposing children to intellectually stimulating activities (home-related); and personal refers to the

awareness of school activities (home-related and school-related) (Grolnick et al., 1997). Each of these forms can be put into one or both of the aforementioned involvement categories. While their definition emphasized the complexity, the home-/school-related definition can still apply for this research.

Epstein (1995) presents six types of involvement: parenting – creating a supportive home environment for learning (home-related), communication – between schools and families (school-related), volunteering – giving of time or skills (school-related), learning at home (home-related), decision making (school-related) and collaborating with community (home- and school-related). While this is the more complex of the definitions, it can be simplified into the two practical categories as noted in parentheses above.

While the definitions presented by Grolnick et al. (1997) and Epstein (1995) have emphasized the complexity of parental involvement, the home-/school-related definitions can still be applied. The term involvement will be used from this point forward to refer to both home-related and school-related forms of involvement, unless otherwise stated. Any initiative undertaken to involve families must take into consideration that there are many forms of participation and the function of that participation can vary. It is also important to understand that involvement has multiple influences.

## **2.5 Involvement Influences**

Acknowledging the widespread benefits of family involvement, several authors have examined the influences upon involvement. Grolnick et al. (1997) identified three areas of influence for family involvement. The first influence is the characteristics of the parent and child, which is a more individual level factor, where individual attitudes,

beliefs and values come into play. The next influence is the family context, which includes the social and economic context for families. Lastly, the authors discuss the influence of teacher behaviour and attitudes toward family involvement, which is more of the organization level.

DePlanty et al. (2007) who looked at perceptions of family involvement, had similar findings in that the school played a significant role in the influence of involvement. Teachers who believed that parents did not want to be involved did not put forth the effort to garner involvement, however when the opposite was true, teachers had more contact with parents and parents were more involved.

Family characteristics were also viewed as a strong influence (Eccles & Harold, 1993; Waanders et al., 2007). Social resources or support, marital status, efficacy, beliefs about the role of parents in education, employment, and ethnic identity were several characteristics identified. Eccles and Harold (1993) provide strategies to involve parents in spite of the familial differences which include offering parents more meaningful roles in school authority such as committee membership, keeping clear and open communication, and providing opportunities to support education both in the home and in the school. It is also interesting to note that a handbook has been developed to assist with the involvement of families and communities that provides specifics on building, strengthening, maintaining and evaluating these partnerships (Epstein, 2005).

## **2.6 Social Ecological Model**

Within health promotion and psychology there are many theories and models used to explain behaviour. One such model is the social ecological model, originally the ecological systems theory (Bronfenbrenner, 1977). Bronfenbrenner's model posits that

there are levels of factors ranging from micro (individual), meso (interpersonal), exo (organizational), and macro (community and intercultural) and that each of these levels interact to construct a person's behaviour. Numerous scholars have built upon Bronfenbrenner and the levels labelled as individual, interpersonal, organizational, community, and public policy as shown in figure 2 (Cotrell, Girvan, & McKenzie, 2009; Langille, & Rodgers, 2010; Gregson et al., 2001).

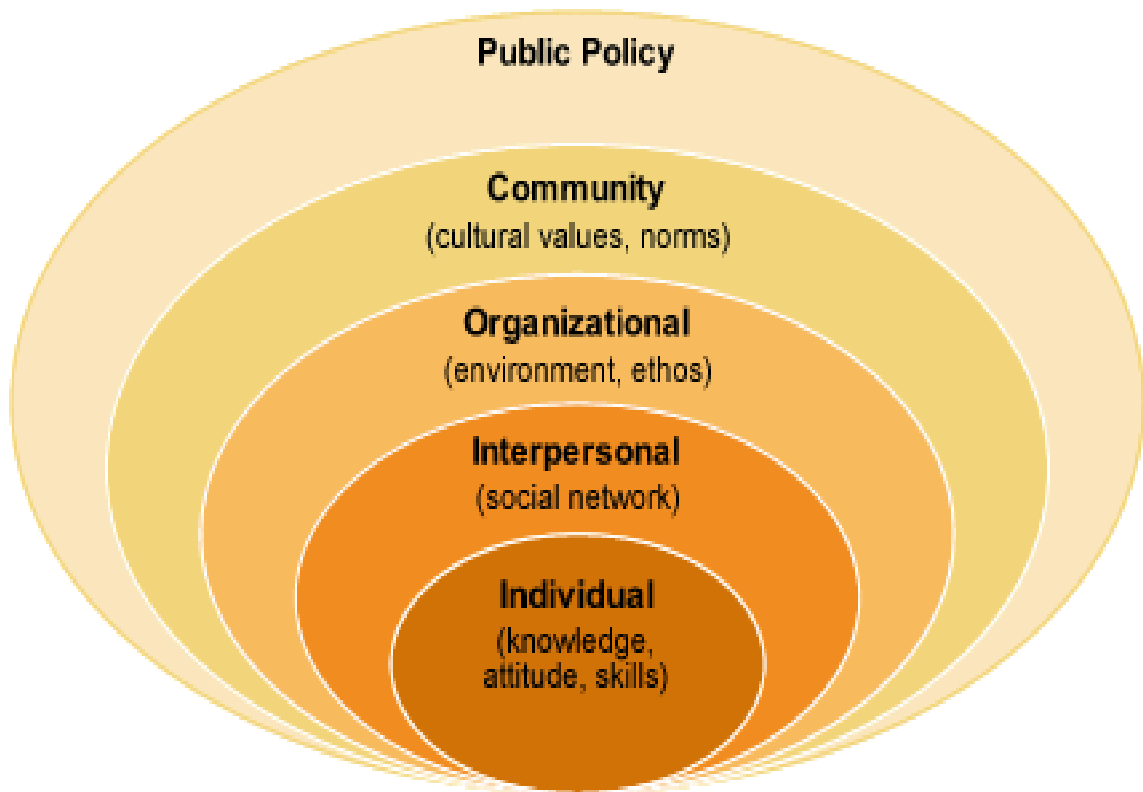


Figure 2 Bronfenbrenner's (1977) Social Ecological Model and levels defined. (Office of Behavioral & Social Sciences Research, n.d.)

These ecological models have been useful to explain behaviour and guide interventions, while recognizing the multiple layers of influence on human behaviour (Cotrell et al., 2009; McLeroy et al., 1988; Sallis, Owen, & Fisher, 2008; Stokols, 1996). Some have used this model to explain behaviours related to comprehensive school health

(Comer & Hayes, 1991; Langille, & Rodgers, 2010; Gregson et al., 2001). Therefore it is safe to say that the use of the social ecological model to align with previous research in the subject area and relevant as the study explores behaviour of families with respect to comprehensive school health.

The social ecological model recognizes multiple levels of influence from the individual's social environment and the interaction between each environment (Cotrell, et al., 2009; Stokols, 1996). As described in detail below, the levels of the model include the individual – their knowledge, skills, attitudes; the interpersonal – family and friends; the organizational – institutions such as school; the community – the relationships between organizations; and public policy – regulations and laws that govern a person's life (Cotrell et al., 2009; Gregson et al., 2001).

#### 2.6.1 Individual level

At the inner most level is the individual. This level focuses on behaviour through cognitive and psychological factors that include a person's knowledge, attitude, belief, and personality (Cotrell et al., 2009; Gregson et al., 2001). At this level, the thought processes and cognitive decision making are taken into account and includes perceived barriers or benefits to their action, as well as their cues to action (Cotrell et al.; Gregson, et al.)

#### 2.6.2 Interpersonal level

The interpersonal level includes social interactions with peers, friends, or family and the influence these groups have on a personal behaviour (Cottrell et al., 2009; Gregson et al., 2001). Through observational learning, individuals are learning how to behave in settings and are also receiving reinforcement for behaviours that fall within the

group norms. For example, parents whose peers believe parents have a role in the classroom, can influence how that parent thinks about becoming involved with the school.

### 2.6.3 Organizational level

This level includes the influences that occur from actions, policy and procedures within an organization or institution but have far reaching effects (Cotrell et al., 2009; Gregson et al., 2001). Organizations, or institutions, included in this level would be schools, businesses, and churches (Gregson et al.; Langille & Rodgers, 2010). Policy or procedure examples could be ones that govern the behaviour of the people from no smoking policies to parents having to ask for permission to enter the school where doors are locked.

### 2.6.4 Community level

At the community level behaviour is shaped through the social norms and networks that exist for groups, partnerships, and organizations (Cotrell et al., 2009; Gregson et al., 2001; Langille & Rodgers, 2010). Relationships within the groups are examined through social, physical and structural factors and then their influence on the organizational, interpersonal, and individual levels.

### 2.6.5 Public policy level

At this macro level, the model looks at the influence of larger societal policies and regulations (Cotrell et al., 2009; Gregson et al., 2001; Langille & Rodgers, 2010) at the municipal, provincial or federal level. These policies can regulate or support behaviours at each of the levels below it. At the same time, it is important to recognize that these

policies stem from many community level norms or relationships, positively or negatively.

## **2.7 Summary**

The literature indicates that parent or family involvement is fundamental for HPS or comprehensive school health (Booth & Samdal, 1997; Buddhirakkul, Suchaxaya, Srisuphan, & Chanprasit, 2007; Garcia-Dominic et al., 2010; Gugglberger & Dür, 2010; JCSH, 2012; WHO, 2000). Additionally, many have sought to describe and document the form and function of family involvement in education – how and why families are involved. Further in the literature, models exist that have been used to describe involvement – Arnstien’s (1969) ladder of participation – as well as the complexity of behavioural influences through the social ecological model (Cotrell et al., 2009; Gregson et al., 2001).

The literature however, falls short of providing evidence on why and how families are involved in specific comprehensive school health or HPS activities. There is also a lack of specific direction on how to involve families. A review of the literature has identified limited research on specific influences of family participation or involvement with comprehensive school health. One article has identified the attitude of parents and their behaviours to be quite a powerful influence on the health and health behaviours of their children (Booth & Samdal, 1997), supporting the importance of this research. As determined in the literature, the same is true for educational outcomes in children (Eccles & Harold, 1993; Epstein, 1995; Deplanty et al., 2007).

It is in this literature gap that this research is located: to explore family involvement in comprehensive school health. Can we apply the lessons learned from parental

involvement in education to comprehensive school health? The study has attempted to describe family involvement with comprehensive school health, through seeking to interpret how and why families are involved or are not involved. From this, suggestions can be made on how best to involve families, perhaps in conjunction with the current literature from education.



## **CHAPTER 3      METHODOLOGY**

To begin, it is important to locate myself as a researcher. I am currently a graduate student in the Master of Arts in Health Promotion program at Dalhousie University. From September 2010 to October 2013, I was involved with the CLASS II research project (a follow up to the original CLASS conducted in 2003). During this time, I had the opportunity to speak with students, teachers, health promoting school advocates, school board officials, and government officials; conversations/experiences that have shaped my thoughts and beliefs about comprehensive school health in schools, the current political climate, and the role of parents or families. From these experiences, I have knowledge and thoughts that cannot be removed from the research I have conducted. Based on my experiences and knowledge, I believe that my worldview is more of a constructivist making sense of the meanings people have about a given subject, with a tendency for pragmatism as it lends itself to be action oriented, focusing on the outcomes of the inquiry (Creswell, 2007).

### **3.1      Methodological Approach**

The methodological approach that has guided this research is interpretive, or hermeneutic phenomenology. This has oriented the research towards the interpretation of the texts of life (Creswell, 2007) and the lived experience for a group of people; in this case, families of elementary school-aged children in Nova Scotia. As the experiences of families' involvement with comprehensive school health are relatively undocumented in the literature, this methodology was chosen to describe those experiences, interpreting texts into meaning. Other methodologies seek to form theories about experiences that are grounded in data from research and can then later be tested and verified (Weaver &

Olson, 2006) and require a significant amount of time to analyze and interpret. By using this methodology there is also a fit with the timeframe and scope of the graduate program being taken by the researcher.

Interpretive phenomenology falls under the constructivist paradigm where the aim of the inquiry is to understand (Guba & Lincoln, 2005). Interpretive phenomenology and constructivism fit well with the proposed research questions that aim to explore the experience of families with comprehensive school health in Nova Scotia, giving voice to their lives and experiences. Constructivists are interpretive, seeing individuals in the world surrounding them and their experiences differing upon their lived experience creating multiple realities (Creswell, 2007; Weaver & Olson, 2006). Other paradigms, such as the positivist paradigm posit that knowledge is universal, obtained objectively and that the findings are generalizable (Weaver & Olson, 2006).

A number of assumptions are carried throughout the research that directly relate to the methodology and paradigm chosen for this research. First is the ontological assumption that refers to the nature of reality (Creswell, 2007). The ontological assumption is that there are multiple realities that are constructed by the individual in the context of their own experience (Guba & Lincoln, 2005) influenced by their social, cultural, and political worlds. Another assumption is how the knowledge is obtained or the epistemology (Creswell, 2007). Using the interpretive phenomenological approach, the knowledge (or findings) derived from the data will be subjective and co-created by the participant and the researcher (Guba & Lincoln, 2005). While the participant is the expert in their own experience, the experience and knowledge held by the researcher are valuable to the research process. The researcher is more than just the recorder, but also

an active participant in the construction of the meanings of the lived experience (Lopez & Willis, 2004).

This methodology is hermeneutic, which goes beyond describing the experience but interpreting the experiences into meanings (Lopez & Willis, 2004). It is a cyclical approach that first attempts to make sense of the participant's experiences by drawing on forestructures, such as experience of the participant and researcher, and literature. The researcher then looks to see what was missed, or unseen, in the original interpretation (Baumgartner & Hensley, 2006) and then goes back to make sense of the experience. This methodology requires the researcher to be immersed in the data, reading and rereading, writing and rewriting, to grasp the understanding of the lived experience. Using interviews as a method of data collection and a thematic analysis approach provided the frameworks to enable the researcher to fulfil this portion of the methodology.

## **3.2 Study Participants**

### **3.2.1 Participant demographics**

Nova Scotia has seven public regional school boards across the province, as well as two provincial boards for the Francophone and Mi'kmaq communities. For the purposes of this study participants were recruited from two school boards – the Halifax Regional School Board, a more urban/suburban region, and the Annapolis Valley Regional School Board, a more rural school board. These school boards were also selected out of convenience, as the Halifax Regional School Board is closest to the location of the researcher and the support of the Annapolis Valley Regional School board facilitated recruitment in the area.

The population under study was care giving family members – parents or guardians – of elementary school students. This could include extended family such as aunts, uncles, or grandparents as well as foster parents or adoptive parents. Eligible participants included adults over the age of 18 years who had lived in Nova Scotia for at least 12 months and caring for at least one child currently attending an elementary school (Grade 4, Grade 5, or Grade 6) in Nova Scotia (at the time of the interview). Rationale for these criteria is that individuals 18 years of age and older can provide their own consent for participation. Having lived in the Province for 12 months would increase the experience the participant had with the school their child attends. Elementary school was targeted as most of the literature focuses on this age group and to align with current research that has occurred in the Province. Interested individuals who were employed or affiliated with the local regional school board, Department of Education or Department of Health and Wellness were not eligible to participate, as there may be a conflict of interest.

### 3.2.2 Participant recruitment

The method used to obtain a representative sample of this population was two-fold. First a more purposeful sampling method was used that allowed for the selection of individuals meeting the pre-determined criteria, as these individuals had the specific experiences being targeted with this research (Creswell, 2007). Recruitment posters – paper and electronic versions – were used to inform and recruit potential participants (Appendix A). The first phase of recruitment was in partnership with the Provincial home and school organization that shared the recruitment poster (Appendix A) through email or printed posters with their membership and networks. Additionally the poster (electronic and/or print) was shared with personal and professional contacts to share with

their networks as they saw fit to do so. In addition, posters were put in public spaces such as community libraries and stores where potential participants would be visiting and also placed on free public websites such as Kijiji.

It was expected that through individuals recruited by these initial methods, a snowball sampling method would take effect to establish contact with other possible participants who may not have been targeted through original recruitment methods (Bryman, Teevan, & Bell, 2009). A question in the interview guide (Appendix B) asked specifically if other possible participants were known to the participant and might be interested in participating. While participants were able to think of others interested and took the information to share, additional participants did not contact the researcher to participate in the research through this method.

During the research proposal stage, the researcher indicated that 10-12 participants would be recruited. As data collection began, recruitment of participants became difficult as fewer individuals contacted the researcher to participate and the end of the school year was approaching (June) with summer vacations potentially impeding recruitment further. As the researcher began analysis (described below), in consultation with the research supervisor it was agreed to end recruitment with eight participants.

### **3.3 Methods**

#### **3.3.1 Data collection**

Data collection was conducted through semi-structured individual interviews lasting approximately 30-90 minutes with eight participants. Interviews were conducted at a location mutually agreed upon by participant and researcher that was private, quiet and with minimal disturbances. The researcher started by introducing herself as a

graduate student of Dalhousie University in the Master of Arts program studying health promotion followed by the purpose of the research. Significant time was spent with each participant reviewing and explaining each section of the information and informed consent form (Appendix C). Additionally the participant was given time to review the information at their own pace and time allowing for additional questions. In addition to the writing on the consent form, the interviewer verbally asked participants if they would provide consent to participate, to be audio recorded, and to allow the use of direct quotes without identifying information. Appropriate signatures were obtained from the participant and the researcher, and the participant was provided with their copy of the forms as well as their honorarium in a sealed envelope. Once this was completed, the audio recorder was started and the interview commenced.

Interviews consisted of a dialogue between research and participant guided by the interview guide (Appendix B) that was developed as a framework of the topics with specific questions related to the research. The interviewer did not always follow the exact order of questions but used cues from the participant to ask probing, or follow up questions to gain a further understanding of the topics being discussed (Bryman et al., 2009; Patton, 2002). At the end of the interview, participants completed a demographic questionnaire (Appendix D) to assist with the analysis process and identifying trends.

Before and after the interview, the interviewer recorded field notes to capture details of the interview that could not be heard such as facial expressions, body language and general initial thoughts and reflections on the interview (e.g. was the participant talkative?, were new areas of interest discussed?). Field notes were recorded with as much clarity and detail as possible to prevent possible confusion at a later date and during

the analysis phase (Bryman et al., 2009). These notes provided assistance with the development of the interviewer as well as data analysis process and establishing trustworthiness.

During the process of obtaining consent prior to the interview, participants had the option to be contacted with preliminary results as a way to ensure accuracy with the data. Those who provided consent were contacted and provided the opportunity to comment. Two participants responded but no changes were identified to be incorporated.

### 3.3.2 Data management

Transcripts, typed field notes, and audio files were stored on an encrypted USB drive. The USB drive and any documentation containing information about the participant – field notes, completed consent forms – were stored in a locked cabinet in a locked room with access granted only to the researcher and supervisor/committee.

Data collected from the interviews were transcribed by the researcher within a week or two of when the interview was conducted. The process involved removing fillers such as “umm” and “ahh”, and any information such as names, places, or specific programs that would potentially identify the participant. Transcripts were verified by the researcher (listening to the interview and reading the transcripts) prior to the transcriptions being entered into a data analysis computer software program, ATLAS.ti, to assist with the organization and management of the data. Information stored with the program selected was password protected and the researcher used the clean versions of printed data during data analysis.

### 3.3.3 Data analysis

Data analysis began as soon as the first interview was completed with initial thoughts captured in the researcher's field notes. Transcribed interviews were entered into ATLAS.ti, using the thematic analysis the researcher began to analyze the data – reading, making notes, and beginning to assign codes. Looking across all interviews conducted, thematic analysis aims to discover repeated patterns of meaning (Braun & Clarke, 2006).

Phases outlined by Braun and Clarke (2006) was followed for the analysis. The next step undertaken was to read over each transcript and complimentary field notes making initial notes on ideas that arise from the data. Generating initial codes and then grouping the codes into themes were the next steps. Once an initial set of themes had been developed, the transcripts and initial analysis notes were reviewed again to verify the themes in relation to the data – this was an ongoing process throughout the analysis procedure.

While the research proposal was to invite 10-12 individuals to participate, with the initial analysis with the eight interviews, patterns were beginning to emerge throughout the interviews with an amount of consistency. In consultation with the research supervisor, based on the initial analysis and timeframe, it was decided to continue with the analysis of these interviews. As analysis continued and themes were constructed from the data, the research believed that there was saturation with this group of interviews and that further recruitment may not have resulted in the generation of new ideas.



As part of rationalizing and conceptualizing the results, the ladder of participation model (Arnstein, 1977; Connor, 1988) and the social ecological model (Cottrell et al., 2009; Gregson et al., 2001) were used as frameworks to organize the themes identified. The ladder of participation provides a framework for the level or depth of involvement (Arnstein; Connor) and the social ecological model provides a conceptual framework that suggests influences of health behaviour (DiClemente, Crosby, & Kegler, 2002). Once themes had been clearly defined within the social ecological model and/or ladder of participation, the researcher began the reporting phase, using excerpts where necessary to strengthen reported findings or themes.

#### 3.3.4 Trustworthiness

As a new researcher it is important to establish trustworthiness, or rigor, within the research (Porter, 2007) as a means to demonstrate integrity and competence (Tobin & Begley, 2004). Scholars have stated that terms used to assess the rigor with quantitative data are not appropriate and that qualitative research should have its own terminology (Krefting, 1991; Tobin & Begley, 2004). Guba (1981) defined four aspects that transferred to qualitative research: (a) truth value, later termed by Lincoln and Guba (1985) as credibility; (b) applicability or transferability; (c) consistency or dependability; and (d) neutrality or confirmability – of the data, not the researcher as the research adds value to the research through their values and experience.

Strategies to establish trustworthiness in the research aim to address credibility, transferability, dependability and confirmability. One strategy employed was the prolonged engagement before, during and after the interview to establish rapport with the participant (Krefting, 1991). Through involvement with the CLASS II research, rapport

was built with individuals in the comprehensive school health community in Nova Scotia through attending meetings, conferences, and various presentations.

To establish transferability, it is first important to look at the orientation of the research to determine how best to evaluate. The research set out to describe experiences of families with comprehensive school health; accepting that there are multiple realities and not to make generalizations. Dense, or thick description allows others in the future to assess the transferability of this research (Krefting, 1991). To ensure that there is rich description, peer examination or debriefing was also carried out with the thesis supervisor and committee. Throughout the interview, analysis, and reporting process the researcher shared the applicable sections with the group to provide an external view of the data analysis process and also ensured the researcher remained honest by asking questions about the methods and interpretations (Creswell, 2007). Peer debriefing will also added to the evaluation of dependability and ensure consistency of findings (Krefting, 1991).

Finally, to establish trustworthiness through credibility, dependability, and confirmability, the researcher exercised reflexivity, being aware of one's own location in the research. The researcher used a field journal to record notes on the researcher's thoughts, perceptions about topics that arose throughout the research process including initial thoughts before, during and after interviews with participants (Krefting, 1991; Tobin & Begley, 2004; Creswell, 2007).

### **3.4 Ethical Considerations**

#### **3.4.1 Informed consent**

Each study participant was required to provide signed active and informed consent to participate in the research. Each participant was provided with a detailed information

and consent form (Appendix C) clearly stating the purpose, procedure, risks and benefits associated with participation in the research to ensure participants were fully aware and voluntarily provided their signed consent to participate. Participants were given as much time as needed to read and understand the information provided. It was also made clear to participants that they could stop the interview at any time and any information provided would be removed from the study without repercussion.

### **3.4.2 Privacy and confidentiality**

Privacy is a fundamental human value. To conduct ethical research, access, control and dissemination of personal information must be taken into consideration in the planning of the project (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2006). As expected, during the interview process, participants shared personal and private information. While signed consent from participants was obtained and the researcher also verbally reiterated how privacy and confidentiality would be maintained before starting the interview and confirming consent for audio recording, the researcher also reminded the participant that names of places, people and any other identifying information would be removed to ensure anonymity of participants and their information. Participants also had the option to stop the interview or to have their information removed from the project. Appropriate contact information was provided to the participants in order to exercise this option.

To ensure privacy and confidentiality following the interview, all electronic transcripts and audio files were stored on an encrypted USB drive and in a locked cabinet in a locked room with access granted only to the researcher and thesis supervisor and

committee. Similarly, information stored on a computer using the data management software was password protected. Electronic file names did not include any identifying information. As the researcher conducted analysis, only clean versions of the transcripts were used and in a private space to avoid any potential breach of privacy.

### **3.4.3 Ethical approval**

Research ethics board approval was received from Dalhousie University initially in December 2012 prior to the start of the thesis project and renewed in December 2013. Additional approvals were not required for this research, however the support of the Annapolis Valley Regional School Board was obtained as a courtesy.

## CHAPTER 4 RESULTS

In total eight participants were recruited and participated in one-on-one interviews. This chapter describes and presents the results of these interviews. Beginning with some context pieces which include a description of the participants, their definition of a healthy school and then moving into the description of involvement with education and comprehensive school health – this is followed by the presentation of three key themes emerging from the interviews. These are 1) involvement vs engagement; 2) school community; and 3) role of leadership.

### 4.1 Participants

Table 1 is a summary table of the participant, family and child characteristics at the time of the interview. Seven participants identified as female and one as male with an age range of 35-50 years. At the time of the interview, participants had a range of educational backgrounds, from completion of post-secondary (n=6), to college (n=1) and high school (n=1). In terms of work status, participants were employed at full-time paid work (n=3), part-time paid work (n=4) and full-time unpaid work (n=1). Paid work was defined as employment, enrolment in education; where unpaid work included volunteer work, domestic labour including childcare and household maintenance (Beaujot & Liu, 2005).

Three participants cared for children who attended schools in the Annapolis Valley Regional School Board located in a rural area of Nova Scotia and five were from the Halifax Regional School Board, centered in the Halifax Regional Municipality. All participants were the natural parents of the child in the specified grades. The gender breakdown of the children was six males and two females. Six of these children were in

Grade 4, one in each Grade 5 and Grade 6 (Table 1). The majority of the participants (n=6) identified having two children in their care, one participant had three children and one had four.

Table 1. Participant characteristics

	Participant	Family Characteristics	Child Characteristics
Participant 1	Female, post-secondary education, part-time paid work	Married/common law with two children, four person household	Female, oldest child, enrolled in Grade 4
Participant 2	Female, post-secondary education, employed part-time paid work	Married/common law with two children, four person household	Male, oldest child, enrolled in Grade 4
Participant 3	Female, college education, part-time paid work	Married/common law with two children, four person household	Male, youngest child, enrolled in Grade 4
Participant 4	Female, high school education, full-time unpaid work	Married/common law with four children, six person household	Female, oldest child, enrolled in Grade 6
Participant 5	Male, post-secondary education, full-time paid work	Married/common law with two children, four person household	Male, oldest child, enrolled in Grade 4
Participant 6	Female, post-secondary education, full-time paid work (leave of absence)	Married/common law with three children, five person household	Male, oldest child, enrolled in Grade 4
Participant 7	Female, post-secondary education, full-time paid work	Married/common law with two children, four person household	Male, oldest child, enrolled in Grade 4
Participant 8	Female, post-secondary education, part-time paid work	Married/common law with two children, four person household	Male, youngest child, enrolled in Grade 5

#### 4.2 Defining a Healthy School

Participants were all asked what they thought contributed to a healthy school.

Overwhelmingly participants provided responses related to a positive environment where students and staff are friendly and happy to be there. There is a fostering of community in that there is mutual respect, cooperation between school and families, no bullying or

behavioural issues, and everyone expects the best from each other. Participants described a healthy school as one where everyone is welcome and there is involvement from the students and families, as well as the greater school community – a community hub. Strong leadership within the school from administration and teachers, as well as parents, also fostered a healthy school according to the participants. Specifically mentioned were the principals who were visible and interacted with families, showed dedication and care for the school and students. Open and engaged teachers were also significant to the participants' definition as well as resources by way of finances and materials for the classrooms.

A few of the participants indicated school programming, such as rewarding positive behaviours, and supportive programming before or after school, as part of what is included in a healthy school. Very few participants mentioned specific health measures or healthy activities as part of a healthy school. Healthy children, by way of their learning at school, cafeteria/canteen menu options, having enough to eat, and physical activity, was mentioned by less than half of the participants.

### **4.3 Participant Involvement**

Participants were asked about their involvement with their child's education, school activities, and comprehensive school health or HPS activities. This included describing their involvement, motivation, and any challenges to that involvement. Table 2 outlines the form and function of their involvement in education and HPS for each participant.

Table 2. Participant involvement form and function for education and CSH.

	Form of involvement	Function
Participant 1	Education: Home-related; some school	Checking in with child. Occasional volunteering and providing items/supplies.
	HPS: N/A	N/A
Participant 2	Education: Home-related; some school	Checking in with child. Volunteering for other school programs.
	HPS: School-related	Leader of HPS activity, responsible for recruiting volunteers, organizing events around the HPS activity.
Participant 3	Education: Home- and school-related	Checking in with child. Leader in extra-curricular activities – leading the sessions, organizing, volunteering time.
	HPS: N/A	N/A
Participant 4	Education: Home-related, some school	Checking in with child. Attends school events
	HPS: Home-related	Supports child involvement in HPS, promotes health at home
Participant 5	Education: School-related	Leader in school-parent organization.
	HPS: School-related, some home	Planned and led HPS event, promotes and advocates for policy related to health
Participant 6	Education: Home- and school-related	Leader in school-parent organization, responsible for leading, recruitment of volunteers, volunteering time, organizing support for school activities. Carries out extra activities at home to support curriculum (i.e. field trips).
	HPS: School-related	Not explicitly involved unless school-parent organization asked to provide support in response to school needs (i.e. food, fundraising, chaperones)
Participant 7	Education: School-related, some home	Leader in school-parent organization, responsible for leading, organizing group, responding to school needs (i.e. food, fundraising, chaperones)



		Carries out extra activities to support and enhance child's learning (i.e. community volunteering, traveling).
	HPS: Some school-related	Responding to school needs may include support for HPS activities (i.e. food, fundraising, chaperones)
Participant 8	Education: School-related	Volunteering time when asked (i.e. chaperone).
	HPS: Home-related	Supports child participation in HPS.

#### 4.3.1 Involvement in Education

All participants were involved in their child's education to some degree at the school level or home level with most participants having more than one type of involvement. Participants' home-related involvement included checking in with the child about their time at school or homework, encouraging completion or assisting with homework, and participating in activities complementary to the curriculum, such as visits to museums and family vacations. School-related involvement included supporting the school through volunteering, providing goods or supplies such as food for events, as well as attending events or activities to support their child and/or school (i.e. Spring Fling). Half the participants emerged as leaders, taking on leadership roles in school activities or school-parent organizations/committees. This type of involvement included attending meetings and working with school administration, recruiting parents or families for committees or other volunteer roles, supporting school needs such as organizing the raising of funds, supervision or chaperones, and providing supplies or food.

All participants had a variety of reasons for being involved (Table 3). Six main reasons emerged from participant statements about why they were involved with their child's education. Many simply wanted to know more about their child and their life in

the school and also felt that it was part of their responsibility as parents with a sense of valuing the engagement with their child and the school. Others saw their involvement as an opportunity to be a part of the school community; to meet other families, students, and school staff; and learn more about the school from an inside perspective. Participants also indicated that involvement in some of the activities was enjoyable and that it felt good to give back to the school community. Participants indicated that they also had the time to be involved based on their current work schedules or family responsibilities. And finally, participants saw that there needed to be a balance and that their involvement complemented curriculum enhancing their child’s learning outside of the classroom.

Table 3. Participant reasons for involvement in education.

Reason for Involvement in Education	Context	Quote
To know more about child and school	Participants wanted to understand the interactions between their child and the school. Participants wanted to know what activities the child took part in at school. To identify concerns.	P1 “... <i>I want to know what her life is like and I want to help her with any struggles...</i> ” P5 “... <i>I get to see how my child’s working in the classroom and how my child functions in the classroom...</i> ” P3 “... <i>I have a rapport with the teacher and that she’s kind of like my eyes in the classroom...</i> ”
Responsibility as parents	Some participants felt that it was part of their duty as a parent to be engaged in their child’s education.	P2 “... <i>we have a responsibility as parents to be involved and helping out at the school level...</i> ”
To be part of community	Participants saw this as an opportunity to meet other families, students, and school staff	P3 “ <i>Well I get to know my kids’ friends... I know their parents...</i> ”

Enjoyment	Participants enjoyed participating in school activities; they had fun spending time in the school and with their children.	P1 “... <i>I always volunteer for that because it’s a lot of fun.</i> ” P3 “... <i>I love it, I love seeing what they do and seeing their response...</i> ”
Time	Participants who had time in their schedules or could make time were able to be involved with their child’s education.	P5 “... <i>my scheduling... I was able to do more in the schools...</i> ” P6 “... <i>They needed someone and I was like well I’m going to be on leave, I’ll have a bit more time...</i> ”
Complement curriculum	Participants felt that by being involved they knew more about curriculum and were better able to add to it thereby enhancing the overall learning.	P2 “... <i>the [schools] need...that parent support and volunteer time in order to round out a child’s education.</i> ” P3 “ <i>You do have to take up the mantle because teachers can’t cover it all.</i> ” P1 “... <i>your child might need a sort of broader experience...if you don’t know what’s going on at school then you can’t offer them like all the pieces.</i> ”

#### 4.3.2 Involvement in HPS

When it came to describing involvement in comprehensive school health or HPS at the school, as with involvement in education, participants described a mixed involvement in home- and school-related activities, but less of this type of involvement overall. While two participants did not describe any involvement with comprehensive school health activities, others described involvement at the school (n=4) or home levels (n=2).

At the school level, involved participants described two different ways of participation. One was responding to the needs of the school as it pertained to a HPS activity, and included similar activities from education involvement, such as fundraising,

providing supervision, food and other goods – this was often through existing involvement with the school (e.g. school-parent organizations). The other type of participation described was taking on a leadership role where there was a responsibility for organizing and leading HPS activities at the school. For those participants who indicated involvement at the home, involvement was described as supporting and encouraging the child to participate, and promoting health in the home or with the family; i.e. active transportation.

When asked to explain why they were involved with HPS, participants provided a range of reasons (Table 4) some were more related to the person such as having the time to be involved, recognized skills that could be shared with the school, and were able to identify where to fit in. Similar to involvement with education, participants displayed an interest in complementing the school curriculum. Additionally, families were involved in HPS due to existing involvement with the school (i.e. in education through a school-parent organization).

Table 4. Participant reasons for involvement in HPS.

Reason for Involvement in HPS	Context	Quote
Time	Participants who had the time or were able to manage their time	P2 “... <i>I have the time to do, so I’m stepping into more of the daily tasks...</i> ”
Personal skills	Participants who recognized the value that their skills, including professional skills, could contribute to HPS activities felt that they had something to offer the schools.	P7 “... <i>you have unique knowledge and skills that’s going to be able to contribute to the health of your school... I feel like an obligation to do that for my kid’s school because I have that knowledge...</i> ”

		P2 “...being able to spread that knowledge... the kids get that knowledge...”
Identified gaps and fit	Participants were able to identify gaps and saw a fit for themselves	P2 “...I can just sort of see opportunities and just say why not [be involved].”
Complement curriculum	Where a link between curriculum and CSH activities was clear, some participants saw value in supporting messages from the school in the home.	P1 “...it’s good to have that feedback that comes from all different places.”
Existing school involvement	Due to the participants other school involvement, they were involved with CSH activities.	P5 “...they [parent-school organization] do nutrition nights...because we had funding from the [local health board] ...” P5 “...we were trying to encourage...a healthy school through nutrition and healthy living.”

Each participant provided a unique perspective on involvement with education and HPS that was based on their experiences as well as personal and family characteristics outlined in Table 1. Their experiences and perspectives have been captured and organized into three themes to further understand involvement. Results are presented by themes and through the appropriate overarching framework used in the analysis process (i.e. ladder of participation (Arnstein, 1969) and social ecological model (Cotrell et al., 2009; Gregson et al., 2001).

#### **4.4 Theme 1: Involvement - Participation or Engagement?**

All participants agreed that it was important for families to be involved in their child’s education and school activities even if involvement was minimal. Participants’

reported involvement is visualized through the categorization using Arnstein’s (1969) ladder of citizen participation (Table 5). Participants reported a range in levels of participation with comprehensive school health activities that align with the categories previously described through the work of Arnstein (1969) and Connor (1988). Some participants reported involvement at a low level or non-participation with CSH and others true participation or engagement as defined by filling a leadership role.

Table 5. Categorization of participant involvement with CSH

Ladder of Participation		Participant Involvement
8. Citizen control	Degrees of citizen power (high level of participation)	Leading CSH initiatives in partnership with the school. Being involved or responsible for decision-making with regards to CSH initiatives. (school-related)
7. Delegated power		
6. Partnership		
5. Placation	Degrees of tokenism	Responding to the needs of the school for a particular CSH initiative (i.e. fundraising, providing volunteer time). Promoting and advocating for policy related to health of students. (home- and school-related)
4. Consultation		
3. Informing		
2. Therapy	Nonparticipation (low level of participation)	Supporting child’s participation in CSH activities and programs. (home-related)
1. Manipulation		

By categorizing the involvement described by the participants into Arnstein’s (1969) ladder, a corresponding pattern of involvement can be visualized. The relationship between the ladder and described involved ranges from nonparticipation, or low-participation, where families are more involved at the home level, to varying degrees of tokenism where families begin to move into more school-related involvement, to the

degrees of citizen power with partnerships with the school to having a clear and strong voice of leadership in the school.

#### 4.4.1 Barriers

With the range in the forms of involvement described by participants, associated barriers were also discussed that prevented participation or that participants felt would hinder moving from low levels of involvement to higher levels. These barriers are organized using Arnstein’s (1969) ladders and presented in Table 6 showing where the specific barrier is preventing deeper engagement.

Table 6. Categorization of barriers to participant involvement.

Ladder of Participation		Barriers to achieving the level
8. Citizen control	Degrees of citizen power (school-related)	Process of involvement unknown Roles defined by school Time and money
7. Delegated power		
6. Partnership		
5. Placation	Degrees of tokenism (home- and school-related)	Families are not asked Process of involvement unknown Roles defined by school Perception of being unwelcomed Time and money
4. Consultation		
3. Informing		
2. Therapy	Nonparticipation (home-related)	Lack of communication/vague communication Lack of knowledge of CSH Roles for families are unknown
1. Manipulation		

The barriers presented can also be categorized in line with the social ecological model (Bronfenbrenner, 1977). Barriers described by participants are not at every level of the model, but do fall within the individual level – lack of knowledge, time; interpersonal – being unwelcomed by school and peers; and organizational – where the

school is defining roles. This is not to say other levels do not have influence, but that these are the only relevant to the data in this research.

#### **4.5 Theme 2: School as a Community**

Community arose as a common theme throughout the conversations with the participants regarding education and HPS. Simply put, community was a reason for families to be involved in education and when asked to describe a healthy school. For those involved in CSH, they described reasons for being involved that relate to being part of the existing school community or having that existing involvement with the school where they feel welcomed and a sense of belonging.

Participants indicated that community was an essential factor in discussing school and all its activities. They noted that the school and families had a shared responsibility for the students. One participant stated, *“I feel it’s important as a community to be able to support them [the students]”* (Participant 7). Another noting *“...the more people watching them [the children], the better.”* (Participant 1)

Schools were seen as a place where families had a sense of belonging, a place to gain social support from other families, where school leaders were visible, open and welcoming. When participants felt a sense of community they indicated that they felt more comfortable going to the school to volunteer, interact with teachers to solve issues that might arise with their child, or share ideas. One participant indicated that making people feel welcome could foster greater involvement and could overcome barriers presented earlier.

Community also arose as a central component when participants were asked to describe a healthy school. This is depicted in a word cloud, Figure 3, where the dominant





that strong leadership was a component of a healthy school and it was felt that leadership played a major role in fostering a welcoming environment where families could be involved.

Participants identified that it was important for the school leadership to be open and visible to families – whether that was through direct communication with families or by being physically visible on the school grounds on school days or during school events. Participants felt that school leadership, in particular the principal and teachers, needed an active role in supporting involvement through recruitment and communicating with families about involvement. Participants who were heavily involved with the school, identified that strong parental leadership was also essential and that they had a role in supporting parent involvement, encouraging involvement, and communicating with other families.

#### **4.6.1 Communication**

A sub-theme for the role of leadership that emerged from participant interviews was that of communication – sharing information, gathering information. Participants reported a number of communication methods that included newsletters and emails from the school or school-parent organizations as well as in-person communication at school events or parent-teacher meeting. However, participants identified gaps in communication from the school.

Communication was perceived as lacking detail surrounding comprehensive school health activities. *“I’m really not very aware of those things [activities related to health], maybe if they [the school] are doing some activities which they are not putting on their schedule...”* (Participant 8). When communication was sent out asking for family

participation, there was a lack of details pertaining to how families could be involved – often a general ask for involvement. “*Chaperone... that bugs me because well what does that mean?*” (Participant 3). It was clear that participants wanted clear direction as to what they are being asked to be involved with and what they are being asked to do. Communication was also perceived as mainly one-way, in that what communication existed pertaining to involvement came from the school and either there was no opportunity to provide input or the planning had already taken place and it was too late for input. “*Everything is planned and then we are informed.*” (Participant 8). This was also evident from the participants who had a higher level of engagement noting that as a member of a school-parent organization, they would be asked by the school to support the event that had already been planned. “[School-parent organization] *pays for it, but the school brings them.*” (Participant 6).

#### **4.7 Summary**

This purpose of this chapter was to present the findings that emerged from the semi-structured interviews with participants. The chapter described the participants – education, work and family situations – and presented three main themes: themes were participation vs. engagement; school community; and the role of school leadership. In addition, participant descriptions of a health school are presented to provide more context to the family’s understanding of health.

The participants were all natural parents of the children but varied in the family and personal characteristics. Participants described involvement in both education and comprehensive school health as a spectrum of participation from low levels of involvement to higher level of engagement. Theme 1 reports this involvement spectrum

in line with the ladder of participation (Arnstein, 1969), where low levels of participation were reported as checking in with the child at home, encouraging or supporting the child's participation. Higher levels of participation, or engagement included attending and volunteering for school activities, and leading parent-school organizations and/or activities. Reasons for involvement ranged from general interest to fulfilling the role as a parent.

Barriers to involvement were presented as they fit into the ladder of participation (Arnstein, 1969) representing reasons why higher levels of involvement were not being achieved. Many of the barriers fit into the social ecological model (Figure 2) putting into a larger context the family and the systems that influence their decision to be involved.

In the second theme, community was presented a common thread throughout the data. Participants saw the school as a community and wanted to be a part of it – regardless of participation level. Participants also reported that community was an important part of a healthy school. How this community is built and fostered led into the final theme, role of school leadership.

School leadership included principals and teachers, as well as parent leaders. Participants reported leadership was key in fostering a welcoming and positive environment for students and families, but also in recruiting and encouraging participation from families. A subtheme that arose was the communication between school and home and the potential is has to further family involvement and create a positive community. A number of gaps were also identified in the communication in that there was lack of detail at times, and that it was primarily one-way or top-down. This will be discussed further in the next chapter.

## **CHAPTER 5 DISCUSSION AND CONCLUSIONS**

This study sought to understand how families of children within the Nova Scotia elementary school system are involved with comprehensive school health, what roles do they play, what understandings do they have, and what influences their involvement. Partnerships or collaborative engagement is a key pillar of comprehensive school health (JCSH, 2012) that has not been fully explored in the context of family involvement. Through semi-structured qualitative interviews with eight participants, three key themes emerged. As presented in the previous chapter, these themes were participation vs. engagement; school community; and the role of school leadership.

### **5.1 Understanding of Comprehensive School Health**

It is important to understand how participants view a healthy school, as this is an overarching goal for comprehensive school health. If families are on the same page as the schools in terms of understanding the goals, then more support and potential involvement. As presented in Chapter 4, participants describe a healthy school as a community, where parents are involved, it is positive and fun, and safe. There was little mention of the food environment in the school, the amount of physical activity opportunities or the link between health and learning – all components that are part of a comprehensive school health framework. This was interesting and may have set some of the tone for the remainder of the interview as this was asked prior to the questions surrounding involvement in comprehensive school health. The question was meant to get the participants thinking about health – healthy activities, the health of their child – but their views of healthy schools were outside the idea of health and health behaviours

(healthy eating, physical activity) that are often put within the comprehensive school health framework.

When the participants were asked about their involvement with comprehensive school health, some prompting was required as they viewed their general involvement as contributing to a healthy school based on their definition. Once a brief explanation of comprehensive school health was provided, participants were able to then more clearly articulate if they were in fact involved in such activities.

## **5.2 Family Role in Comprehensive School Health**

In describing participant involvement, particularly in the education context it is important to reflect back to the literature reviewed in Chapter 2. This chapter presented a simplified definition to describe forms of involvement – home-related and school-related. In tables 2, 5, and 6, these terms were used to define involvement. These terms were drawn from the literature that explained involvement in more complex terms. The work of Epstein (1995) is particularly interesting with the results achieved in this research. Epstein (1995) described six types of involvement: parenting, communication, volunteering, learning at home, decision making, and collaborating with community. It is interesting to see that the study participants were representative of these types. As this definition of involvement has been in the literature for a number of years, it provides some validity to the research conducted here.

As the participants involved in comprehensive school health described their roles (Table 2), congruency between the categorization of responses and that of involvement with education can be seen – this is for the simplified definition of home-/school-related as well as parts of Epstein’s (1995) model. For example, parenting or home-related was

seen with participant 4 who supports the child's involvement in comprehensive school health activities and promotes health in the home. Volunteering was a key component as those involved were volunteering their time and skills to the schools; whether lending their time to plan activities or time spent supporting HPS activities through fundraising efforts, etc. Decision making within comprehensive school health was only seen in a couple of participants (Table 2) as most comprehensive school health activities were planned within the schools themselves. Learning at home in the context of health was not a type that was discussed by these participants. This could have been due to their definition of health or that they did not see a role in the home as the term comprehensive school health lends itself to be more school centered than in the home.

### **5.3 Reasons and Influences of Involvement**

The first theme, participation vs. engagement, is interesting because it describes family involvement in comprehensive school health and the barriers that exist preventing various levels of involvement. Following the ladder of participation (Arnstein, 1977), true engagement is a collaborative partnership; placed in this context, between the school and the families of their students. From the data it can be seen that only half the participants had such an engagement with the school, however not always in the context of comprehensive school health.

When participant involvement is categorized with the ladder, a trend can be seen in two ways: first that involvement happens at a variety of levels and second that involvement at the higher rungs of the ladder tended to be in the form of school-related activities, whereas involvement at the lower rungs tend to be in the form of home-related activities. As we see the breadth of forms of involvement, there is a need to look at how

families are being asked to be involved and what they are being asked to do. It is not to say that participation at any level is better or more important than the other but to say that there are a number of roles for families and it may not look the way the school has it defined.

Within the three main categories from the ladder – nonparticipation, degrees of tokenism, degrees of citizen power – descriptions of involvement from the participants align to show a relationship between the use of this model in other areas outside of citizenship; in this case comprehensive school health. This shows that the ladder has a level of appropriateness when discussing participation outside of citizen engagement for which it had been originally developed. It is important to note that Arnstein's (1969) ladder was developed nearly half a century ago. The language of the eight ladder rungs is a little out dated, however along with the three main categories that the rungs are divided into (Figure 1), new rungs can be determined that are more appropriate – nonparticipation, education, consultation, partnership, and participant control. The ladder also implies that there is a hierarchy and does not fully recognize the importance of involvement at all levels – even if there is not true engagement, participation at any level can still have benefits to the organization and the participant or school and student in the case of this research.

The barriers to involvement discussed by participants ranged from perceived barriers to physical barriers. By categorizing the barriers with Arnstein's (1969) ladder of participation, a relationship is formed showing that if families are to be involved there are specific barriers within the levels that need to be removed to foster greater participation. Some participants discussed that they did not feel welcomed at the school,



that there was an established group of close-knit people involved, that the same people were volunteering, and there was no place for them. Even the participants who were highly involved noted that it was generally the same people who were volunteering and getting involved in different school activities. This is an interesting point to note as there appears to be a lack of diversity in the family involvement and this is acting as a barrier for families.

A further point to discuss is that participants who were not involved noted that they were unsure of a place for them, or where they could fit in. If we go back to the top-down, bottom-up school of thought, this could be due to the fact that schools are prescribing what involvement looks like, with little variation apparent. For example, if volunteering shifts for a health fair are two hours long and a parent has one hour in the morning and one hour in the afternoon, they may perceive that they cannot be involved. But if the school and parent were able to discuss involvement, an agreement may be sought to have the parent fit into the schedule. Another point that was raised was not knowing how to get involved or what the process was to indicate interest. If communication was lacking or parents were not being asked to be involved, participants noted that they were unsure of whom to talk to but also unsure of what to ask about and how they might fit in. While the onus should not be fully with the school, the school does have a role in fostering involvement if they truly wish to adopt a comprehensive school health framework and all its components.

Another barrier presented in the results, was that participants perceived that the school was not open to their input – that activities were planned without input or that the process to provide input was unknown. This was not the case for all participants but is

linked to the previous barrier where there is not always a clear fit seen by families. Some participants were able to approach the school directly and provide their input – this was often due to previous involvement or personal factors such as confidence that these participants possessed. It is important for schools to recognize that if families are silent, as in their voice is not heard in person or in writing, this does not mean they do not want to be informed or involved, but that they may not understand how to navigate the system to provide their voice.

These barriers are interesting because there seems to be a disconnect with the sharing of information. Involvement seems to be in the control of the school and does not always match the realities of families or lacks the flexibility to foster involvement. In the case of those interviewed for this study, all had more than one child and a number with young (under age five) children requiring full-time care. Flexibility can be an offer of support that can create the community that families frequently mention and show the families that their involvement is wanted and valued. For example one participant noted that a babysitting service was offered during meeting times so that parents who had younger children could attend and participate in the meeting – without this flexibility participation would not have been possible. Another participant noted that while the school was keen on having involvement, there was rigidity to what that involvement looked like that did not fit with her reality and therefore was not able to participate and the school was left to look for someone else. The participant added that had there been a conversation with the school to co-create the role, participation might have been possible and less time spent by the school looking for others to volunteer their time.

When looking at this barrier in particular, it brings about something that is fundamental to social justice issues in that initiatives, even if led by governing bodies, should come from within the community. In the case of comprehensive school health, if a school is planning and acting on their own devices to create healthy spaces, this is considered a success as top-down influences are minimal. However, from the data presented in this research there appears to be a top-down approach within this bottom up world. Promotion of a comprehensive school health framework must include ideals of community building and social justice where everyone has a role and their voices are heard.

When taking these barriers presented (Table 6) and categorizing with the social ecological model (Figure 2), a third trend is noted where participants mainly report barriers at the lower or more individual centered levels (individual, interpersonal). These include the lack of knowledge of comprehensive school health, around their own skills, how to fit in, and the process to become involved. A small number of barriers were reported at the organizational level – school’s defining of involvement, locked door policy (this was around more general involvement) – and none from the community or public policy levels. This is not to say that community norms or public policies were not an influence but that these were not reported by participants. For example a community norm that parents are involved in their child’s school may have influence on involvement but this may not been seen as an influence with these participants. These responses are not completed unexpected as the nature of the involvement in comprehensive school health is about social interactions and that participants responses were more related to their own feelings about the situation.

The second theme presented in Chapter 4 is the school as a community. It became clear that every participant saw the school as a community regardless of their level or form of involvement. It was a reason to be involved – to have an interaction with those who share values and beliefs and are known, and it was part of a healthy school – the school was seen as a hub within the larger community.

This is interesting when taking a look into the literature around community and the definition presented by Ife and Tesoriero (2006). The values and importance of the community that the participants report is in line with the authors' definition that is presented in a set of characteristics. Participants discussed a level of interaction with other families and teachers from the school, which is a smaller group of people than the general community (i.e. town or city) and that was important to them. This aspect relates to the characteristic of human scale where members get to know one another through these interactions (Ife and Tesoriero). This could be through volunteering for an afterschool program or working together within a parent-school organization.

Community was also defined by Ife and Tesoriero (2006) as a place where individuals are welcomed and they feel wanted. This is particularly interesting because some participants reported not feeling wanted by the schools and not welcomed. One participant mentioned that the school was not a welcoming place due to the doors being locked throughout the day and having to go through a cumbersome process to enter into such a positive space. Note that this participant understood the safety reasons for these procedures, but that this is how she felt about the situation. Another participant who was previously discussed, felt that her participation was unwanted when the school would not be flexible in their terms of involvement. If families do not feel welcomed and wanted, it

cannot be expected that they will be involved, mainly in the schools and with activities happening around the school.

Gemeinschaft, which is another form of human scale where the interaction occurs with people who are familiar and well known to the individual (Tönnies as cited by Ife & Tesoriero, 2006). The difference with Gemeinschaft and the human scale mentioned earlier is the notion of familiarity. When we know people and are familiar or comfortable with them, we feel that sense of community and value that feeling. Participants noted that it was often the same few people getting involved in the school. This involvement could have been linked to the familiarity between those individuals, being familiar with each other, with the school – that fostered a greater participation. However, as mentioned earlier this could also be seen as a barrier to participation for some. The familiarity and sameness of people involved could be perceived as unwelcoming for newcomers as they look for a place to belong and fit. One participant noted that as a newcomer to the school she felt it was important and wanted to be involved but saw the same people involved and it appeared things were taken care of with no place for others. It is essential to be aware of the potential for this to work against family involvement.

Finally, school is a part of culture and culture is a characteristic of community (Ife & Tesoriero, 2006). Culture is a shared set of beliefs and values with customs and traditions. All participants believed that education was imperative and their involvement was an essential part in the education process, and involvement with comprehensive school health was valued as important. However, regardless of importance they did not always feel part of this community and able to shape the culture that has been formed.

The participants did not discuss other cultural influences, such as faith-based cultures, as part of this research.

Community is important. The participants valued community in the sense of belonging and being involved, and it was also prominent in their definition of a healthy school. The link between families understanding of healthy school and what the comprehensive school health framework presents as a healthy school needs to be connected if success in partnerships is desired.

The final theme is interesting because it ties everything together – it is the role of school leadership. As reported by participants in Chapter 4, the role of leadership is important to family involvement. Leadership can set the stage for creating community or managing its development into something meaningful for all, has the role to promote participation at all levels and foster greater engagement. Participants also identified school leadership or the school administration as part of a healthy school (Figure 3).

A small number of participants who were in leadership roles at the school – through parent-school organizations or comprehensive school health activities – talked about their role in fostering involvement, reaching out to their peers and asking them to be involved. They believed that this was an important aspect of their role but it also helped them to fill their mandates in supporting the school activities, whether it was asking for chaperones or food to support a school event.

As participants who were not in leadership roles discussed their knowledge about involvement, how to be involved, what roles they could fulfill, and in discussing comprehensive school health activities, it often came back to the communication they did or did not receive from the school. Communication is an important part of life and is no

different in the context of the family-school dynamic. One of the reasons a participant explained for their involvement was so that there would be a direct link into the loop of communication within the school. This shows that even parents who are involved, value good communication and the information thus provided.

Participants felt that communication needed to be clear and direct – what is it that they will be chaperoning for, what do you need and how much, and why. This is not to be taken in direct conflict with previous discussion about the top-down approach some participants experience where the parent voice is lost and involvement is prescribed by the school (which is at the top). There must be a balance in the information that is being sent to families – some of the communication will be one-way or top-down, but there must be a balance with two-way communication and greater efforts made to truly include the parent voice and not just as a token (Figure 1).

#### **5.4 Research Question Summary**

The research was guided by four questions that have been answered through the analysis of the research and presented through the results in Chapter 4. Section 5.1 of this chapter addresses the first research question looking into the understanding families have regarding comprehensive school health. It was found that families do not have a full understanding and that this needs to be addressed to gain further involvement.

The second research question is explored through section 5.2 – the role of families in comprehensive school health. The role of families is on a spectrum from nonparticipation to high engagement and was congruent with the education literature on family involvement. This suggests that parallels may be drawn between involvement in

education and comprehensive school health, including strategies and lessons learned to foster greater involvement.

The third and fourth research questions can be combined as both are addressing why families are involved and what is influencing that decision to become involved. This was addressed through the themes of community and school leadership. Both of these themes are constructs that participants noted either fostered involvement or played a role that negatively influenced participants to not be involved.

All research questions and themes are linked – as we look at involvement and where families are on the ladder of participation, we look to leadership to build the community that includes parents and fosters involvement at all levels.

## **5.5 Strengths and Limitations**

The strengths of this research begin with the participants recruited for this study. While a gender balance may not have been achieved, there was a balance in the range of involvement with the schools – not all of the participants were within one particular level of involvement. This allowed for the creation of a full picture of family involvement by exploring and describing low levels of participation and high levels of engagement.

This study also provides merit through the use of interpretive phenomenology, which seeks to explain the lived experience in the contexts of life (Creswell, 2007) and by using interview as a method. Interviews are the best way to understand the lived experience and to construct stories or descriptions of these experiences (Nunokoosing, 2005). Through the combination of this methodology and method, the research was able to gain the best insight into family involvement in comprehensive school health, describe that involvement, and provide the beginnings for further inquiry.



Another strength of this research was the use of theories and frameworks not commonly associated with comprehensive school health. The use of the ladder of participation (Arnstein, 1969) in the context of comprehensive school health is unique, as it has not previously been done. Community building is another area not commonly related to comprehensive school health; however community was important to this study's participants. Additionally, the researcher compared this study's findings with the research on family involved in education that has been extensively explored and published. By using these theories and frameworks, this research was able to draw conclusions that are aligned with previous scholarly work, providing validity to the study but also another area of literature that can be explored to further involvement in comprehensive school health.

As with most research, limitations are a reality and this research is no different. A number of limitations were encountered and observed throughout this research. The most obvious is the small sample size. Ideally larger numbers would be recruited to create a more robust picture of family involvement, however this would have been beyond the scope for the level of this research project. The small number of participants is of concern more to the analysis portion as one does not want to overgeneralize the study's implications. For example the participants were from two of Nova Scotia's seven school board regions, it is not feasible to expect that their thoughts and feelings are that of families from another region of the province nor with all families in their own respective boards. It can be said however, with this small sample that a snapshot of family involvement has been described that can assist with future work in this area.

Another limitation with this sample is the self-selecting nature of recruitment. Participants were asked to respond to an advertisement indicating interest in participation. Participants who responded could have done so due to the fact that they are the type of person who likes to be involved and is involved in their child's schooling. While the researcher was aware of this, as recruitment occurred and data analysis began, it was evident that there was a range of participants and their level of general involvement. Participants, as outlined in Chapter 3, had a range of involvement from low participation to high engagement, thereby making the sample a truer representation of the participant variations.

Another limitation relates to personal biases of the researcher that is always a risk with any qualitative research, especially with new researchers. The researcher tried to be aware of and to be vigilant of any potential for bias. Although it is impossible to eliminate bias, the researcher factored this out by clearly stating previous experiences and knowledge that may have played into the bias, took notes, and conferred with the thesis supervisory committee. The researcher is confident to have achieved valid findings, which can be used to guide future comprehensive school health practices and research.

Other limits of this study include the use of semi-structured interviews. While this is a common method in qualitative research, it does not lend itself for in-depth conversations as you are asking the participant to explain their experiences within boundaries. These boundaries may limit what they report and rich description not feasible. The researcher was aware of this when selecting the interview method, however it was important to maintain a level of boundary to guide the conversations and ensure the interviews were directed towards the research objectives. This method of interview also

allowed the researcher to gain experience with qualitative interviews – having the main questions as guidelines with the opportunity to listen and probe where required to gain further descriptions. It is also important to note that the amount of data and timeline for the Masters of Arts program limited any great depth that could have been achieved through analysis.

## **5.6 Implications for Health Promotion and Recommendations**

This research adds to current literature by exploring family involvement with comprehensive school health through qualitative inquiry. Previous research has explored the benefits of comprehensive school health quantitatively (Kuhle, et al., 2011; Florence, et al., 2008; Veugelers & Fitzgerald, 2005), the implementation of comprehensive school health (Deschesnes, et al., 2003), and the structuring the comprehensive school health framework has been clearly defined (JSCH, 2012). At the time of this research family involvement had not been explored qualitatively.

This study adds to the practical knowledge of comprehensive school health, as with greater understanding, schools will be better able to foster involvement and create a positive school community which leads to better health and educational outcomes for students (Kuhle, et al., 2011; Florence, et al., 2008; Veugelers & Fitzgerald, 2005). Through the following recommendations schools and health promoters can work together to take the steps toward further implementing a comprehensive school health framework and enhancing partnerships.

In terms of the overall understanding of comprehensive school health, parents do not fully understand the language that is being used and what it truly means for their child. Participants could easily articulate their involvement in education, therefore the

use of more educational terminology and clearly framing comprehensive school health activities as an extension or in support of education may foster a deeper understanding and potentially involvement.

When looking at the overall role of the family in comprehensive school health, it is clear that all types of involvement need to be fostered to support this framework. With a deeper understanding of health and comprehensive school health, families may be able to see a better fit for themselves and find the types of involvement that fit their lifestyle and skills.

Another key component to this research is the use of Arnstein's ladder of citizen participation (1969) and its potential use for describing forms of involvement to then be used by school leadership (who are most likely to foster involvement) to increase or modify involvement (i.e. change from nonparticipation to consultation) by identifying the barriers. This research has shown that the ladder can be used in this context, however warrants modifications to the ladder rungs. Some of the terminology, such as manipulation and tokenism, while in their purest meanings represent what is occurring at each stage, are not necessarily words that are accepted or fully understood, therefore potentially being open to misinterpretation. Connor (1988) revised the ladders and substituted the term education where Arnstein used manipulation, therapy, and informing. Using terms presented in the original ladder (Figure 1) and Connor's revision, the following terms are recommended to align with the study's results: nonparticipation, education, consultation, partnership, and participant control (low participation to high engagement). In addition to terminology modifications, the shape of the model should be considered for change as the ladder implies a hierarchical relationship and that one rung

must occur before the other for high participation to occur. Does the model need to be vertical or such that it implies a step by step process, or is it more cyclical in nature? Future research can investigate these possibilities and connections to establish a visual model that is more representative of the relationship. With this redesign, it may be a more simplified way to describe involvement but it is important to note that it is not hierarchical, one level does not have to occur before the next, but that involvement at any level is valuable and should be fostered.

Another recommendation is more of a warning to schools and their practices – to be aware of the top-down/bottom-up nature of their actions. While this may not be an intention of the schools (to approach it as a top-down) and there may be time where this approach may be warranted. Schools need to evaluate their actions, ensuring their inclusivity, and promote further involvement. This can be done by looking further into the practice and theories of community building. The school community plays an important role to support and foster comprehensive school health practices and stronger communities can be built using these practices. It is also recommended that as the social ecological model (Figure 2) is used to explain behaviours, it should be utilized as an overarching framework within which practices and policies are considered.

Future research should explore family involvement from the perspective of the school. This research could gain an understanding of what the school (such as administration, teachers) sees as their role in fostering participation, what successful or unsuccessful practices may be in place, and provide insight to the thoughts and beliefs about family involvement. Future research could also explore the differences between grades or ages of the students, rural and urban settings, as well as between cultures.

A recommendation from this study is the reframing of the ladder of participation. Future research could explore the use of the modified ladder of participation to create a framework of participation in the context of schools. The research could also further define the barriers as they are related to moving from lower levels of participation to full engagement and provide recommendations for policy and practice. Further research looking in the influences of the community and public policy (social ecological model) would also be beneficial to create a full picture of factors that positively and negatively influence participation in comprehensive school health initiatives.

Finally, as suggested in Chapter 2, much of the literature regarding family involvement is from the education literature. This study provided a glimpse into parallels that could be drawn and future research should investigate the use of strategies in the education literature to increase and involve families to move comprehensive school health practices to the next level.

## **5.7 Summary and Conclusions**

This study has provided an understanding how families of children within the Nova Scotia elementary school system are involved with comprehensive school health, their understanding of comprehensive school health, how they are involved, and why they are or are not involved.

Involvement can have many forms for comprehensive school health and are parallel to forms of involvement in the education literature. In the home it can be supporting the student's participation on activities and creating a healthy home environment. In the school, it can be volunteering time or leading the way through a parent-school

organization. Involvement ranges from low levels of participation to higher levels of engagement as depicted through the ladder of participation (Arnstein, 1969) in Table 5.

There is a disconnect in communication and language, and what the parents view as involvement and what the school is asking for in terms of involvement. This disconnect should be addressed through the role of school leadership and community building practices.

Partnership is a vital component of the four pillars of comprehensive school health (JCSH, 2012). If we are going to promote health in the school setting using this framework model, we should foster true partnerships with families by meeting them where they are in life and working together to explore and define involvement roles. This research has provided insight into the types of involvement with recommendations to move forward and foster greater family involvement. Together with strong implementation of the remaining three pillars – teaching and learning, social and physical environment, health school policy – students have the opportunity and support needed to learn and be healthy.

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## PARTICIPANTS NEEDED FOR RESEARCH STUDY

### FAMILY INVOLVEMENT IN SCHOOL HEALTH



- ✓ Are you a parent or guardian of a child in Grade 4-6?
- ✓ Have you lived in Nova Scotia for at least one (1) year?
- ✓ Are you currently over 18 years of age?

If you answered “**YES**” to **ALL** of these questions, we want to hear from **you**. You are invited to participate in a research study that aims to understand family involvement with comprehensive school health in Nova Scotia.

**You will participate in a one-on-one interview  
(approximately 60-90 minutes).**

If you are interested in participating in this research, or wish to learn more about it, please contact Michelle Patrick at 902-494-4599 or [mc757325@dal.ca](mailto:mc757325@dal.ca).



To learn more or schedule an interview please Michelle Patrick at (902) 494-4599 or email <a href="mailto:mc757325@dal.ca">mc757325@dal.ca</a>
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## APPENDIX B Interview Guide

I am interested in hearing about your experiences, views, and ideas related to your involvement in your child's school (such as reasons for involvement, types of involvement). I am also interested in your views, opinions, or ideas about healthy school initiatives happening at your child's school. Answer the questions to the best of your ability. There are no right or wrong answers, and you can choose not to answer questions or to come back to them at any point throughout the interview.

1. Can you tell me the age of your child that is in [insert school name]?
2. What grade is your child currently attending?
3. Has your child attended any other elementary school? If so, what school?
4. Is this your first child to attend elementary school?
5. How involved do you feel you are in your child's education? [By education I mean their learning, homework, etc.]
  - a) What is it that makes you feel this way?
  - b) How are you involved? [Probe: Homework, parent-teacher meetings]
  - c) Why are you involved? [What factors play a role in your decision to be involved?]
  - d) Do you think it is important for you (or families) to be involved? Why or why not?
  - e) What (other) roles might families play in their child's education?
6. How involved do you feel you are in your child's school activities? [By school activities, fundraisers, assemblies, presentations, other events put on by the school]

- a) What is it that makes you feel this way?
  - b) How are you involved? [Probe: Home-School, PTA, attending events, volunteering]
  - c) Why are you involved?
  - d) Do you think it is important for you (or families) to be involved? Why or why not?
  - e) What (other) roles might families have in their child's activities?
7. Does the school (principal, teacher) encourage family involvement in school activities?
- a) Why or why not?
  - b) How or how could they? [What do/could they encourage families to do?]
8. What do you think makes a healthy school?
- a) Would you say that your child's school is a healthy school?
  - b) What makes you say that? [Can you provide examples of...]
  - c) What does the school do to make it a healthy school?
- If yes;
- a) How did or do you become aware of the programs?
  - b) Can you tell me more about this program (current or past)?
  - c) Do/did families have a role in this program? [What were these roles?]
9. What do you think makes a healthy home environment?
- a) Would you say that your home environment is a healthy one?
  - b) What makes you say that? [Can you provide examples of...]

10. Are you involved in this program or any healthy school activities?
- a) Why or why not? [What factors play a role in your decision to be involved?]
  - b) How are you involved? What about others? [What roles are there for families?]
  - c) Would you like to be involved? Why or why not? [What role could you fulfill?]
11. Do you feel that this program adds value to your child's health and/or education, other students or families? [Benefits of the program? Is there something that can be taken away from the program?]
- If yes;
- a) What do you get out of these programs?
- If no;
- a) How could the programs add value?
12. Does the school (principal, teacher) encourage family involvement in healthy school (Health Promoting School) activities?
- a) Why or why not?
  - b) How or how could they? [What do/could they encourage families to do]
13. How often are health-related materials sent home (if at all)?
- a) Are you satisfied with the frequency? Why or why not?
  - b) What kind of materials? What information do they consist of?
  - c) Are these relevant for you and your family? Why or why not?
14. What would motivate you to become involved with healthy school initiatives at your child's school?
- a) How could you get involved? [What roles could you play?]
  - d) What do you think might encourage you or others to become involved?

15. Are you aware of healthy school initiatives in schools across Nova Scotia?
- If yes;
- a) How did you become aware of the initiatives?
- b) Can you tell me what you know about these initiatives?
16. Is there anything else that you would like to add about your involvement, the school's activities or healthy school initiatives?
17. We wanted to interview you because of your relationship with schools. Are there other parents/guardians we should also interview?
18. Where are the best places to post flyers to recruit participants for the study (physical, print or internet)?

**APPENDIX C Participant Information and Consent Form**



**PARTICIPANT INFORMED CONSENT FORM**

**RESEARCH STUDY**

**FAMILY INVOLVEMENT IN COMPREHENSIVE SCHOOL HEALTH**

**Principal Investigator**

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**Degree Program**

Master of Arts, Health Promotion  
Dalhousie University

**Research Supervisors**

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School of Health and Human Performance  
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**Contact Person:**

Michelle Patrick  
School of Health and Human Performance  
Dalhousie University  
Telephone: (902) 494-4599  
Email: [mc757325@dal.ca](mailto:mc757325@dal.ca)

Please feel free to contact Michelle Patrick by phone or email if you have any questions, comments, or concerns regarding this research, or if you require further information.

## Introduction

You are invited to take part in a research study being conducted by Michelle Patrick who is a graduate student at Dalhousie University, as part of her Master of Arts in Health Promotion. Participation in this study is completely voluntary and you may withdraw from the study at any time. You do not have to answer any questions that you do not want to answer.

The study is described below. This description tells you about the risks, inconveniences, or discomforts that might be experienced. Participating in the study might not benefit you, but we might learn things that will benefit others in the future.

Michelle Patrick's Master of Arts thesis supervisor, Dr. Sara Kirk will be assisting with all aspects of the research process. Please contact Michelle Patrick by phone (902-494-4599) or email ([mc757325@dal.ca](mailto:mc757325@dal.ca)) if you have any questions about this study.

## Purpose of the Research

The purpose of this study is to understand **family involvement in comprehensive school health**. Comprehensive school health is the approach taken by schools to create healthy living and learning environment for children, teachers, staff and the surrounding community. The information you give may be used to develop better ways to involve families in creating healthy school environments.

## What you will be asked to do

By volunteering to participate in this research study, you are being asked to participate in a one-on-one face-to-face meeting or interview. You will be asked questions about your

involvement in your child's school activities that are related to health, provide recommendations or suggestions for participant recruitment, and relevant demographic information. You will be able to ask questions and receive feedback from the interviewer. With your permission, the interview will be audio-recorded. The interview will last about 60-90 minutes.

You will be asked whether you would like to be contacted to discuss preliminary results and give feedback. You can also choose to receive a summary of the results from the study. Giving permission to be re-contacted is completely voluntary and not needed to participate in this research. You will also receive a copy of this consent form for your records.

#### Who Can Participate in the Study?

Any adult (aged 18 or older) caring for at least one (1) student currently enrolled in a Nova Scotia elementary school – including grades Primary to Grade 6.

#### Possible Risks and Discomforts

There is minimal risk to taking part in this study (e.g. negative experiences you have had with school personnel or other families). You do not have to answer any questions that you are not comfortable with. **Participants are only asked to share information that they feel comfortable talking about.** An information sheet will be made available to you related to comprehensive school health activities if you have further questions about healthy schools

If at any point you no longer wish to participate in the study you may simply end the interview. If you decide after you have been interviewed that you no longer want to be

part of the study, and do not want your information used, call or email Michelle Patrick. This will only be possible up to three (3) weeks after your interview.

#### Possible Benefits

Talking about family involvement with comprehensive school health or healthy school activities may not directly benefit you, but it may help us to better understand how and why families are involved in school health. Through this research, we hope to gain a better understanding of family involvement, which may help to inform future comprehensive school health programs and policies.

#### Compensation

Any participation in research is greatly appreciated, so you would be thanked for your time should you choose to take part. You will receive \$20.00 at the beginning of the interview for your participation.

#### Confidentiality and Anonymity

All information that you provide will be treated with strictest confidence. The researcher will type the audio recording of your interview with all personal or identifying information removed (i.e. any names, places, school name, etc.). You will not be identified by name in any documents related to this research **with the exception of the consent form** that will be stored in a separate location from your interview data. The interview data (your responses: audio and typed) including the researchers written notes will be kept in a secure place where only the researcher and thesis supervisor will have



access to them. The researchers will attach a code rather than your name to any records associated with your participation in this study.

All information and documents related with this study will be kept in a locked filing cabinet at Dalhousie University for a minimum of 5 years, after which all information will be destroyed. Only Michelle Patrick, thesis supervisors, Dr. Sara Kirk and Prof. Barbara Hamilton-Hinch, and the thesis supervisory committee will have access to the study documentation (including interview data). Complete anonymity cannot be assured, as the interviews will be conducted in person.

Participants will **not** be personally identified in any reports, publications, or presentations of this study. Major themes identified in the interviews will be reported and direct quotes from the participants may be used to illustrate these themes, but the quotes will only be described by an assigned participant number. The research team will make every effort to protect the identity of all participants.

The exception to confidentiality will be if you discuss the abuse of someone under the age of 16 or a vulnerable person, or if the interviewer suspects that someone under the age of 16 years, or a vulnerable person is in need of protection. This may include physical abuse, sexual abuse, emotional abuse, or neglect. In this case, the interviewer has a legal requirement to contact Community Services (as is required under the Child and Family Services Act). The interviewer would not be able to ensure confidentiality or anonymity in this situation.

### Questions

If you have any questions about the study, its purpose or procedures, and results, you can contact Michelle Patrick at (902) 494-4599 or by email at [mc757325@dal.ca](mailto:mc757325@dal.ca).

Problems and Concerns

**If you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Catherine Connors, Director, Research Ethics, Dalhousie University for assistance at (902) 494-1462, [ethics@dal.ca](mailto:ethics@dal.ca).**

**FAMILY INVOLVEMENT IN COMPREHENSIVE SCHOOL HEALTH**  
Participant Informed Consent Signature Page

I (the participant) have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I hereby consent to take part in this study. However, I realize that my participation is **completely voluntary** and that I am free to withdraw from the study at any time, and can withdraw my information at any time.

Yes       No

I hereby consent to my interview being audio-taped.

Yes       No

I agree to let the researcher use direct quotes from my interviews in the study findings. I understand that my name and/or other personally identifying information will **not** be revealed.

Yes       No

I would like Michelle Patrick to contact me to discuss the study's preliminary results.

Phone: \_\_\_\_\_

**OR** Email: \_\_\_\_\_

I would like Michelle Patrick to send me a summary of the final results

Email: \_\_\_\_\_

**OR** Mailing Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Full name (print):** \_\_\_\_\_

**Full Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Researcher's Name (print):** \_\_\_\_\_

**Researcher's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**FAMILY INVOLVEMENT IN COMPREHENSIVE SCHOOL HEALTH**  
Participant Informed Consent Signature Page

I (the participant) have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I hereby consent to take part in this study. However, I realize that my participation is **completely voluntary** and that I am free to withdraw from the study at any time, and can withdraw my information at any time.

Yes       No

I hereby consent to my interview being audio-taped.

Yes       No

I agree to let the researcher use direct quotes from my interviews in the study findings. I understand that my name and/or other personally identifying information will **not** be revealed.

Yes       No

I would like Michelle Patrick to contact me to discuss the study's preliminary results.

Phone: \_\_\_\_\_

**OR** Email: \_\_\_\_\_

I would like Michelle Patrick to send me a summary of the final results

Email: \_\_\_\_\_

**OR** Mailing Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Full name (print):** \_\_\_\_\_

**Full Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Researcher's Name (print):** \_\_\_\_\_

**Researcher's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Researcher Copy

APPENDIX D Demographics Questionnaire



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**Demographic Information Form**

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**Date of Birth:** \_\_\_\_\_(m) \_\_\_\_\_(y)

**Gender:**  M  
 F  
 Prefer not to answer

**Family status:**  Single  
 Married or common law couple  
 Prefer not to answer

**Number of Children in household:**  
\_\_\_\_\_ Age: 0 – 4 years  
\_\_\_\_\_ Age: 5 -7 years  
\_\_\_\_\_ Age: 8-12 years  
\_\_\_\_\_ Age: 13 years and older

**Highest education level:**  High school  
 College  
 Post-secondary  
 Prefer not to answer

**Household income level:**  Below \$35,000  
 \$35,000 to \$75,000  
 Above \$75,000  
 Prefer not to answer