The Relationship between Primary Schools and Health Services in New Zealand

A Multicase Study

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Abstract

Education and health are interrelated. Education has a positive association with health behaviours, life expectancy, and morbidity and is an established social determinant of health. However, for learning to take place, children need to be healthy, ready, and able. All too frequently, ill-health compromises learning and school attendance, leading to long-term negative consequences throughout life.

Positioning health services alongside schools, and upholding collaborative inter-sectoral working, has been shown to positively impact both education and health outcomes for children and young people internationally. In New Zealand, however, the education and health sectors work in silo with no formal directive to do otherwise. Achieving and maintaining inter-sectoral collaboration is, therefore, challenging, piecemeal, and time-consuming. It is further complicated by system structure, competing priorities, and differing perspectives of the two sectors and those working within them.

This multicase study of three Auckland urban primary schools explored the relationship between primary schools and health services and the influences on this relationship. The study focused on the experiences and perspectives of participant principals, teachers, teacher aides, administrative staff, and Special Educational Needs Co-ordinators of working with health services. Data were collected through semi-structured interviews, observations, and reviews of staff professional development and related learning opportunities.

The findings highlight the uncoordinated working relationship between the health and education sectors in New Zealand and the current barriers to achieving workable, inter-sectoral collaboration. This study has confirmed the need for better inter-sector alignment while acknowledging the interdependence of both sectors. Collaborative inter-sectoral work between education and health is critical. The findings from this study recommend the development and implementation of a national policy enabling these sectors to work together to achieve optimal education and health outcomes for children and young people in New Zealand.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

10th July 2022

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Signature Date

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In order to succeed, we must first believe that we can… Nikos Kazantzakis

Ethics Approval

This study has received ethical approval from the Auckland University of Technology Ethics Committee (Ref no: 17/359, November 2017).

Chapter 1 Introduction

Health and education are mutually interdependent, with pathways linking the two emerging early in life (Case et al., 2005; Mirowsky & Ross, 1998, 2005; Raghupathi & Raghupathi, 2020; Ross & Wu, 1995). Healthy children learn better; correspondingly, better-educated adults tend to live healthier lives (Basch, 2011b; Basu et al., 2018; Zajacova & Lawrence, 2018). Whilst it is acknowledged that the overarching purpose of schools is to realise educational standards, there is a reciprocal relationship between the health status of children and their academic achievement (Basch, 2011a; Costante, 2006; Lleras-Muney, 2005; Michael et al., 2015).

Providing health services in schools enables the education and health sectors to form a collaborative partnership and promote improved education and health outcomes for children and young people (Borg & Drange, 2019; Kolbe, 2019; Kolbe et al., 2015; Matingwina, 2018). A key strength of school health services is that they are community-based, capture where children reside and are accessible to families. School health services can reduce inequities by removing barriers to accessing health care, such as transportation, appointment schedules, and inconvenient locations (Bidwell, 2013; Caan et al., 2015). In addition, the services offer an opportunity to address the broader determinants of health (Braveman & Gottlieb, 2014; Clayton et al., 2010).

This chapter introduces a research study undertaken to explore the working relationship between primary school staff and health services in New Zealand and the factors influencing this relationship. Within this chapter, I outline the motivation and foundation for the research project, and clarify my professional positioning in this work. I present the overarching research question and study aim, including relevant background information about the historical, socio-political and practice contexts shaping the current relationship between the education and health sectors in New Zealand.

Situating the Research and Setting and Scene

The World Health Organization (1997, 2011b) has, over time, continued to endorse intersectoral collaboration as a key strategy for improving the health of populations. In

economically developed countries, such as New Zealand, where primary and secondary education are compulsory, schools have been long regarded as a suitable location to deliver health services to children, families, and, in certain contexts, entire communities (Caan et al., 2015; Marx et al., 1998; Mason-Jones et al., 2012; Tooher, 2017; World Health Organization, 2015). There have been calls for better intersectoral and interprofessional collaboration between education and health services for children for decades (Allensworth et al., 1997; Borg & Drange, 2019; Chantal, 1962; Garvis et al., 2016; Healey, 2004; McAleer, 1959; Tipple, 1959; Tooher, 2017). However, facilitating such collaborations has been notoriously difficult to achieve (Altshuler, 2003; Burgess et al., 2015; Hillier et al., 2010; Johnson et al., 2003; Keshavarz et al., 2010; Mandel, 2008). Successful collaboration between two complex systems, such as health and education, requires commitment, dedication, and the skills and resource capacity at an implementation level (Burgess et al., 2015; Ministry of Health, 2005b; World Health Organization, 2015).

Globally, increasing numbers of children are entering schools with physical and mental health needs. School staff, trained primarily in education, are challenged in managing these needs (Council on School Health, 2008; Green et al., 2005; Ministry of Health, 2012, 2018c). Supporting children's health needs within the school environment frequently requires school staff and health services to work with and alongside each other. This necessitates consideration of several factors, including available space in the school for health providers to see and deliver care to children. In addition, acknowledgement of the impact poor health can have on educational achievement, alignment of common goals to the core business of both schools and health providers, and established communication pathways between the education and health sectors are all factors to be considered (Burgess et al., 2015; Dilley, 2009; Tooher, 2017). Of central importance to these factors is the perceived relationship between people working in the health and education sectors and the influences on their perceptions of the 'other'.

Researcher Professional Positioning

I have spent over 18 years as a community child health nurse. I developed my interest in the relationship between the health and education sectors across two specific

community roles. My first role was as a clinical specialty nurse for the Before School Check (B4SC), providing a free universal health and wellness assessment for all New Zealand children aged four years. The B4SC aims to identify and address health, behavioural, developmental, and social concerns that may impact a child's ability to enter school ready to learn (Ministry of Health, 2008). Assessment at the age of four years allows for any necessary interventions to be put in place before school entry.

My second occupational role was in a primary school situated in a low socioeconomic community where, over three years, I delivered nursing care and support to children and their families. A key requirement of this role was working alongside school staff, particularly teachers, to support them in referring to and accessing health services when student health issues were identified. In addition to delivering individual nursing care, I attended and contributed to special educational needs and interdisciplinary meetings.

What became apparent while working in these roles and through my other community nursing experience was the lack of consistent models or agreements on how the education and health sectors should work together in primary schools. Health service delivery varied across different school deciles, with the extent of engagement between the two sectors relying on interpersonal relationships at a service level with no national, regional or locally agreed on structure or framework to support engagement.

Over time, much of my community nursing experience has involved working across various clinical and senior nursing roles in the community, including reviewing service delivery models and clinical practice. As a direct result of my experiences, before and during this research study, I have designed and led two service initiatives to ensure health services are more visible and accessible to school staff, students, and families.

One of the service initiatives, the *Whare Hauora* (literal translation: *home of health*) (Appendices A & B), is a relocatable, modular, purpose-built clinic space. Two Whare Hauora units are currently situated in two different urban schools; these units are specifically designed to accommodate interactions between schools, children, and visiting health professionals. Purposefully locating a health clinic on school grounds has created a more accessible means for collaboration between the two schools and

health providers. Responsibilities and ownership of the Whare Hauora were outlined in a Memorandum of Understanding (MoU) between the two sectors. The MoU pertains to insurance, utilities, cleaning and supply resourcing.

Historically, District Health Board (DHB) funded school health services have prioritised services in more disadvantaged socioeconomic communities. However, anecdotally, health practitioners and school staff working in schools in more advantaged communities report a significant proportion of students with unmet health needs. Due to fiscal and resource constraints, extending health service resources to service these schools has previously been a challenge, necessitating the need to think more creatively about how services could be delivered. Prompted by an opportunity within my organisation (Auckland DHB) to review service delivery options, I initiated a pilot project to improve the visibility of nursing services to a group of schools situated in a more advantaged socioeconomic area in regional New Zealand.

In the pilot project, a nurse was assigned to a Community of Learning/Kāhui Ako (CoL), a cluster of schools that share professional learning resources (Ministry of Education, 2016). In the pilot study, the selected CoL comprised 12 schools within moderate to high socioeconomic community locations across a defined geographical area. The nurse represented the health sector at CoL level meetings, including those with Special Educational Needs Co-ordinators (SENCO) and health and wellbeing meetings. This project was successful and gained very positive feedback from school staff. Having a named and visible person representing the health sector in these schools resulted in a significant increase in referrals to health providers for children with health concerns. Over half the children referred for health service input in the first six months were for absenteeism related to health and social needs.

As I read more about the evolution of school health services in New Zealand, I understood that the relationship between primary schools and health service providers has become increasingly complex. This complexity is primarily due to differences in structure, governance and individual agendas of the education and health sectors that have ensued over time in New Zealand. Implementing the two initiatives mentioned previously prompted me to think more about the role of nurses in primary schools and the need for a more consistent approach to providing school

health services nationally. The question central to my thinking was: how could school health services be redesigned to make them more effective and accessible, and what were the potential barriers? However, if I were to consider future health service delivery models, I would need to do this with the key stakeholder in mind; what works and does not work for them? What are the perceived needs? As such, gaining a more explicit understanding of school staff's current relationship with health services was essential to informing future health service support and delivery models in primary schools.

Once I had identified a potential idea for the research project, the next step was to develop a research question. There are different ways to develop a research question (Agee, 2009; Charmaz, 2006; Flick, 2007). One way is to define and formulate the question(s) upfront and proceed to pursue an answer through the exploratory research process. The other is to start with a general observation and to create the research question once the study is underway. I chose to create a broad overarching question at the beginning of the research process as this provided a sound starting point for thinking about the specifics of my study and what data I would need to collect, and how. Beginning with an overarching question provided the necessary backbone for my research; it allowed me to capture the fundamental goal of the study and provided direction for the study design and data collection. In addition, this broad question helped serve as a basis for developing more specific sub-questions.

The overarching question that formed the basis of this research study was:

What is the perceived relationship between primary school staff and health services in New Zealand, and how is this relationship influenced?

The phenomenon of interest was the intersectoral relationship as perceived by school staff, who are key stakeholders in the relationship. To situate these perspectives, I also needed to understand better the contextual influences on this relationship.

Within this broad research question, three specific enquiries were explored:

- How is the relationship between school staff and health services enacted in the current primary school setting in New Zealand?

- What are school staff views and experiences of health services in schools?
- What are the enablers and barriers to school staff accessing health care for children in New Zealand primary schools?

Study Aim

This study aimed to explore in depth the experiences, perceptions, influences and barriers for primary school staff in accessing and interacting with health services within different school contexts. The study also aimed to gain awareness of school staff's understanding of the interrelatedness of education and health and how they considered this when there was an identified learning need. The information and understanding gained from this study will inform how health services might be designed and delivered in primary schools in the future.

From my professional experience, I understood there were perceived challenges to the relationship between primary schools and health services, such as accessibility and reduced opportunities for collaboration. I was unsure of why this was and wanted to explore this further to gain insight and understanding into what might assist in navigating these challenges.

Primary schools have not been a focus for the advancement of accessible health service delivery in New Zealand. However, the role of primary schools as a hub for the community provides the potential to afford opportunities for early health-related interventions, particularly for children living in low socioeconomic communities (Lear et al., 2008; Richardson & Juszczak, 2008; Wade et al., 2008). The New Zealand Ministry of Health (2022a) funds School Health Based Services (SBHS) to provide health services specifically to low decile secondary schools. In contrast, services and programmes delivered to children and young people in primary schools are contained within a more generalised funding specification alongside preschool health services. This service specification emphasises greater levels of service provision in schools and preschools in lower socioeconomic areas (Ministry of Health, 2021b).

Conceptual Framework

In response to my disquiet regarding education-health sector relationships over time in New Zealand and how school staff perceived this relationship, I framed a qualitative multicase study approach to explore this phenomenon further. Qualitative studies are contained within a theoretical framework that builds from the research question and are based on existing experiential and theoretical knowledge about the studied issue (Creswell & Porth, 2018). Working within a qualitative paradigm was appropriate for seeking insight and understanding to my overarching research question as it provided a means to explore the experiences and meaning that school staff ascribe to their relationship with health services. Furthermore, adopting a qualitative approach allowed for consideration of context. These factors were central to the overarching research question and subject of inquiry.

In addition to aligning with a qualitative paradigm (Baškarada, 2014; Bhatta, 2018; Stake, 1995a), the decision to use case study as a methodological approach was justified as it provides an opportunity to explore in-depth the characteristics of the relationship between school staff and health services within a real-life context. A case study approach accommodates the uniqueness of single cases and actively seeks to understand the nuances and dynamics that shape these (Bhatta, 2018; Simons, 2009; Stake, 1995a; Yin, 2009). In contrast to single case studies, a multicase study allows the researcher to explore the phenomenon under study across various cases and arguably provides better overall descriptions of the issues (Herriott & Firestone, 1983; Stake, 2006). A more detailed methodological discussion describing the chosen research approach and methods to address the research aim and question is provided in Chapter 3.

Historical and Socio-Political Context

The following section highlights the current legislative and policy frameworks that serve to shape and influence obligations, relationships, and service provision in schools from a health sector perspective. Considering the broader situational context clarifies why and how the relationship between the two sectors currently operates. It also

enables consideration of contextual factors that could be leveraged or proposed to support collaborative practice between the two sectors.

International legislative and policy context

International human rights law is relevant to the provision of health services in schools for several reasons. Firstly, under international human rights obligations, school-aged children have a right to both education and health, including health education (United Nations, 1948). Secondly, in 1993, New Zealand ratified the United Nations Convention on the Rights of the Child (CRC) (United Nations, 1989). This human rights agreement outlines the rights of all children and young persons under 18 years of age. The Convention sets the standard for how children should be treated and identifies their political, economic, social, health, and cultural rights. Countries that ratify the CRC are bound to the convention by international law; compliance is monitored by the United Nations Committee on the Rights of the Child. Several measures outlined in Article 24 of the CRC relate to the provision of accessible health services and health promotion. It could be argued that providing an opportunity for health providers to be active in school settings would help advance the provisions of the CRC.

The third linkage to international human rights law that relates to the provision of health services in schools is through the United Nations International Committee on Economic, Social, and Cultural Rights (ICESCR). The ICESCR General Comment No. 14, Article 12.2 (2000) specifies the right of children and young people to have equitable access to health care and that vulnerable children's specific healthcare needs must be addressed. Whilst it may not be the responsibility of schools to ensure access to health care, positioning health services in schools, particularly those in low-socioeconomic communities, is one way to support this fundamental human right.

In 2015, the United Nations signed up for the Sustainable Development Goals (SDGs) as part of the 2030 Agenda for Sustainable Development (United Nations, 2015). The 17 SDG goals set a universal agenda to address and achieve sustainable development globally. New Zealand is committed to engaging in and advancing the 2030 SDG agenda. In 2019, New Zealand's first Voluntary National Review (New Zealand Ministry of Foreign Affairs and Trade, 2019) was published. The review outlined how SDGs

relevant to the New Zealand context would be delivered. Three SDGs relate to this study:

- SDG 3: *Good Health and Wellbeing*
- SDG 4: *Quality Education*
- SDG 10: *Reduced Inequalities*

The commitments relating to SDG 3 (Good Health and Wellbeing) aim to reduce barriers to accessing health and disability services and achieve more equitable health outcomes for all New Zealanders. The ability to access health services in schools would help in supporting this aim.

In regards to SDG 4 (Quality Education), inequity is acknowledged in the New Zealand Voluntary National Review as "remaining a persistent and serious issue, with insufficient progress toward equity of educational outcomes, particularly for Māori and Pacific students and those with disabilities and learning support needs" (New Zealand Ministry of Foreign Affairs and Trade, 2019, p. 37). This inequity has implications for this study because of the contexts of school staff working with children and families experiencing significant social disadvantages, which contribute to children's health and impact their learning.

The Voluntary National Review report to SDG 10 emphasises areas where inequalities and inequities exist. In the current New Zealand context, these areas include health and disability, education, employment, income and housing, with inequalities and inequities occurring by socioeconomic status, gender, ethnicity, and disability (Bishop et al., 2009; Bolton, 2017; Committee on the Rights of the Child, 2020; Dale, 2017; Expert Advisory Group on Solutions to Child Poverty, 2012; Stansfield, 2017). As with SDGs 3 and 4, these inequalities and inequities are particularly relevant to this study when considering access to education and health services for children living in New Zealand.

There has been criticism about the lack of momentum and appreciable progress in reducing the inequities impacting many New Zealand children and young people. Māori and Pacific Island children experience disadvantages across a wide range of socioeconomic indicators. The lived experience of persistent disadvantage has

detrimental effects on health and wellbeing outcomes (Simpson et al., 2015; Simpson et al., 2017a, 2017b). The interrelatedness of health and education provides further justification for positioning health services alongside education providers and for supporting better working relationships between health and education.

National legislation, policy and practice

In New Zealand, Te Tiriti o Waitangi was signed in 1840 between indigenous Māori chiefs and representatives of the British Crown. Te Tiriti o Waitangi is New Zealand's founding document, developed to "guide the relationship between the Crown in New Zealand and Māori" (Ministry of Justice, 2020). There are two versions of te Tiriti: the Māori text and the English text. Although Māori believed, when negotiating and signing te Tiriti, that the English and Māori versions provided the same partnership and commitments, this was not the case (Came et al., 2020; Durie, 1989). The English translation emphasised protecting Māori interests during the British settlement, providing for the settlement and maintaining peace and order by establishing a ruling government. Conversely, the Māori translation of Te Tiriti o Waitangi had a different emphasis, whereby the Crown promised to secure the right of Māori people to rule themselves and secure Māori land ownership (Orange, 1987). Currently, there remains no accepted interpretation of te Tiriti by both the crown and Māori, and it remains a much-contested space regarding securing universal agreement on its principles and objectives (Came et al., 2020; Durie, 1989; Kidd et al., 2022).

From a historical perspective, Te Tiriti o Waitangi was partly motivated by the deteriorating health of Māori, which was identified in 1837 by James Busby, the British Resident in New Zealand at the time (Durie, 1989; Orange, 1987). Busby proposed that the Crown implement measures to protect Māori health and wellbeing, which had primarily arisen from the effects of colonisation (Durie, 1989; Orange, 1987). Ōritetanga, Article Three of the ensuing treaty, was designed partly to afford this protection and Article Four, Wairuatanga, to protect Māori customs, including customary practices relating to health and wellbeing. In 1986, the Department of Health (Department of Health, 1986) stipulated that Te Tiriti o Waitangi be integrated into health service provision in New Zealand. As a result, health concepts are now based on Māori culture, with increasing emphasis on service providers achieving

health equity for Māori through accessible health care. Access to health services in the school setting is one way to support this aim.

Whilst te Tiriti is considered the founding document fundamental to social and health policy in New Zealand, children were fortunate if they received any formal education at that time as it was not free or compulsory. The 1877 Education Act changed this by establishing a free, secular and compulsory education system for all children in New Zealand at the primary level (discussed in more detail in Chapter two). However, education for Māori did not become compulsory until 1894 (Dakin,1973; Hoskins, 2015). Following the implementation of the 1877 Act, the curriculum focus was on reading, writing and numeracy. In 1904 a new curriculum for primary schools was developed, which included, for the first time, the teaching of health, focusing on exercise, infectious diseases and first aid (Ewing, 1970). This addition to the curriculum brought closer the working relationship between the education and health sectors, and in 1912 the School Medical Service was established (Dow, 1995; Sinkinson, 2011).

Following the first world war (1914-1918), increased emphasis was placed on teaching hygiene, nutrition, dental health and posture (Robertson & Dixon, 2017; Sinkinson, 2011). The focus of health education in schools was on individual responsibility: "it should be impressed on all the pupils that health is our greatest gift, and that healthful living is not only a duty to the individual himself but also a preparation for future efficient citizenship" (New Zealand Education Department, 1928, p. 202). Teachers supported by nurses working in schools were required to comply with delivering health education topics set by the Department of Health and supporting information leaflets provided by the School Hygiene Division (Dow, 1995; Tennant, 1991). The health sector directed the education sector on the content of its health education curriculum: "It is the duty of every teacher to co-operate to the fullest extent with the Officers of the Health Department who periodically visit the school to examine pupils or who require the children's attendance at school dental clinics" (New Zealand Education Department, 1928, p. 59).

Over time, as more was understood about the holistic concept of health, health education in schools continued to expand, focusing increasingly on emotional and wellbeing needs and promoting positive behaviours (New Zealand Department of

Education, 1973). However, the emphasis continued to be on individual responsibility with seemingly minimal consideration given to the social, historical and cultural inequities that had contributed to poor health of the most disadvantaged since colonisation (1841-1907). Associated with the expansion of health education was the number of people teachers were expected to interface with to support their students. In addition to school nurses, medical officers and dental nurses, teachers liaised with speech therapists, advisors of deaf education, special education psychologists and support teachers, and social workers. Implicit in the New Zealand Department of Education's report: *Health: Suggestions for Health Education in Primary Schools* (New Zealand Department of Education, 1973, p. 25) was the expectation that teachers would engage with these services to support the school health programme. At this time, the relationship between schools and health services was underpinned by expectations outlined in education and health ministerial goals, policies, legislation and practices. Educating about health was viewed as a collaborative process with involvement and responsibility extending beyond that of the classroom teacher (Sinkinson, 2011; Tennant, 1991).

Today, health in the school curriculum is considered in conjunction with individual wellbeing (Ministry of Education, 2020b), drawing on Bronfenbrenner's ecological model of health (MacBlain & Gray, 2016; Sinkinson & Burrows, 2011). This holistic health concept contrasts with health services provided to primary schools that still uphold a predominantly biomedical approach to health. These services focus on the absence of illness and disease through the early detection and treatment of health-related ailments affecting a child's overall development, including their hearing, vision, and behaviour (Ministry of Health, 2021b). Notably absent in the current health provider service specifications is any reference to wellbeing; however, there *is* a requirement to provide health education and information to users of the service, which ostensibly would include schools and school staff (Ministry of Health, 2018a, 2021b). Some studies have reported that these different working concepts of health can affect each sector's expectations of the other, potentially undermining the relationship between school staff and health providers (Burgess et al., 2015; Tooher, 2017).

Corresponding with an increasing focus on upholding the wellbeing of children in 2019, the New Zealand government launched the Child and Youth Wellbeing Strategy (Department of the Prime Minister and Cabinet, 2019a), which focuses on improving the wellbeing of all children and young people under the age of 25 years. The Strategy establishes a framework for achieving the government's vision that New Zealand be the best place in the world for children and young people to live and grow up and on understanding what children and young people value and need to optimise their health and wellbeing. The Strategy also outlines what the government is currently working on, puts forward plans to support children, and emphasises the need for agencies to work together. A key outcome of the Child and Youth Wellbeing Strategy is that "children and young people are happy and healthy" (Department of the Prime Minister and Cabinet, 2019a, p. 43). One of the government's key actions in this area is to "extend and enhance nurses in schools [through] School-based Health Services" (Department of the Prime Minister and Cabinet, 2019a, p. 45). However, this key action point is only specific to secondary schools and does not include primary schools. In contrast, funding for mental health and well-being resources includes primary, intermediate, and secondary schools, yet primary schools do not feature in the provision of nurses being located in school-based health services.

Another outcome aim of the Child Youth and Wellbeing strategy is that all "children and young people are learning and developing" (Department of the Prime Minister and Cabinet, 2019a, p. 47). An immediate priority identified in the strategy is an increased focus on children who need extra learning support in the education system. Conceivably, if the support needed relates to health and wellbeing, the health sector should play a key role in assisting schools in providing this. Further supporting this notion is public feedback suggesting schools and early learning centres be used as community hubs to deliver services, such as counselling and dental care. Doing so would help to deliver on this particular Child Youth Wellbeing Strategy outcome area (Department of the Prime Minister and Cabinet, 2019b).

New Zealand schools: Structure and governance

The New Zealand schooling system is characterised by a devolved system of local-level governance (Education and Training Act 2020). School Boards govern each school,

comprised of democratically elected parent representatives, an elected staff representative, and an elected student representative in the case of secondary schools (Education and Training Act 2020, s118). The School Board, in all state schools in New Zealand, is the governing body that has overall responsibility and accountability for the school, including its students and staff whom it employs. The School Board is also responsible for ensuring that the school adheres to Te Tiriti o Waitangi and key legislation, including the Human Rights Act (1993) and the Health and Safety at Work Act (2015).

The Ministry of Education (MoE) is a policy-setting authority. It has an advisory role to the Government on education, including the development of a strategic direction for education in New Zealand (MoE, 2022a). The MoE determines and delivers funding to schools and ensures the schooling system in New Zealand is legally governed, a task that has devolved to the schools through their School Boards. The Education and Training Act (2020) came into force in August 2020, repealing the long-standing Education Act of 1989. The Education and Training Act (2020) incorporates system-wide changes such as: providing clarity to the School Boards (pre-2020, referred to as Boards of Trustees) on their obligations under Te Tiriti o Waitangi (Education and Training Act 2020, s127); entitling children to attend school full-time irrespective of any disability or special educational needs (Education and Training Act 2020, ss33-34); and attendance flexibility related to wellbeing concerns (Education and Training Act 2020, s42). The Act does not, however, remove self-governance. The practice of self-governance directly influences how each school chooses to interact with external agencies, such as health services. Given the system changes outlined in the 2020 Education and Training Act, it would seem judicious for School Boards to promote collaborative working practices between the education and health sectors.

Professional standards for the teaching profession

New Zealand teachers work under a Code of Professional Responsibility and Standards administered by their professional body, the Teaching Council of Aotearoa New Zealand (https://teachingcouncil.nz/). The Code specifies the standards of professional behaviour expected of all teachers practising in New Zealand (Education Council New Zealand, 2017) and comprises four key commitments: Commitment to the

Teaching Profession; Commitment to Learners; Commitment to Families and Whānau; and Commitment to Society.

In addition to the four commitments, there are six fundamental standards to which teachers practising in New Zealand must adhere:

- **Te Tiriti o Waitangi partnership**: Understand the status of indigenous Māori, including culture, heritage and use of the Māori language and practices
- **Professional learning**: Engage in ongoing professional learning
- **Professional relationships:** Engage in professional collaborative relationships to support the learner, including relationships with external agencies
- **Promote a learning-focused culture:** Create a culture focused on learning that is inclusive, empathic, collaborative and safe
- **Teaching:** Teaching in ways that are inclusive and responsive to all learners and their aspirations

Both commitments and standards are underpinned by four core values, one of which is whanaungatanga: "to engage in positive and collaborative relationships with our learners, their families and whānau, our colleagues and the wider community" (Education Council New Zealand, 2017, p. 2). The commitments, standards, and values stipulated by the Education Council provide a basis for upholding collaboration with providers of health services in schools as an obligation for teachers.

New Zealand health services: Structure and governance

The delivery of health and disability services in New Zealand is managed through a complex and devolved system (Ministry of Health, 2005b, 2014c; Office of the Auditor General, 2013; Quin, 2009; Tenbensel et al., 2008). As the leading health advisor to the government, the Ministry of Health (MoH) holds overall responsibility for the health and disability system. Currently, twenty District Health Boards (DHBs) have oversight of health services in the different geographical areas of New Zealand. Primary healthcare is delivered through 31 Primary Health Organisations (PHOs) that receive part-funding from the MoH. Public health services are provided mainly through 12 DHB-owned Public Health Units (Cumming et al., 2014; Ministry of Health, 2022c).

Health services in New Zealand are predominantly publicly funded and operate as a universal coverage system. Funding responsibility and authority exist at all health sector levels, both nationally and locally. Almost 75 per cent of health funding is administered by DHBs, who plan, purchase, manage and provide health services for their designated local populations and communities (Ministry of Health, 2014c). The formula for public funding considers the size and demographic makeup of each designated DHB district and its past health service funding use.

Each DHB remains autonomous in setting and developing a subset of strategies that are in keeping with the local community's needs and correspond to the strategic direction of the MoH. This is seen in the Auckland DHB Annual Plan 2020-21 (Auckland District Health Board, 2020). Concerning child health, this plan links DHB activity to two of the three key Government priority outcomes: *Make New Zealand the best place in the world to be a child* and *support healthier, safer and more connected communities* (Ministry of Health, 2020c). The DHB activities include improving immunisation rates, oral health, mental wellbeing and access to mental health services, and reducing hospital admission rates for Māori and Pacific children in the region. It is acknowledged in this plan that improving child health requires the DHB to work collaboratively with other social services, including education, and facilitate better access to primary health care services for all children. Canterbury DHB has a similar focus in its annual plan concerning improving child wellbeing, citing a need to address oral health and immunisation rates for children under 15 months of age and addressing the growth in demand for child mental health services (Canterbury District Health Board, 2021). Consistent with their geographical location, improving access to primary care for children and families in rural communities is also a priority. Similar to the Auckland DHB annual plan, a stated activity for Canterbury DHB is strengthening an ongoing partnership with the education sector. Lacking in both plans is *how* the proposed collaboration and partnerships with the education sector will be implemented.

The New Zealand health system is currently under review, with plans to transfer to a new national entity, Health New Zealand-Hauora Aotearoa, on 1 July 2022. A new Māori Health Authority, Te Mana Hauora, will be positioned alongside and work in partnership with Health New Zealand (Future of Health, 2022). The existing 20 DHBs will be disbanded in favour of four regional divisions. Given the planned move to a

regional focus, any proposed cross-sector collaborative partnerships, such as education and health, must be championed at a high level of authority to ensure that activities are consistent and sustainable.

Professional standards for health professionals

Each separate health profession has its own standards of practice, and most are registered under the New Zealand Health Practitioners Competency Assurance Act (2003). Key provisions in this Act include not being able to work outside an identified scope of practice and holding certification competency by the relevant professional regulatory body. Nurses are currently the most prevalent provider of health services in New Zealand schools and are regulated by the New Zealand Nursing Council (https://www.nursingcouncil.org.nz/). Nurses are required to abide by a Code of Conduct (Nursing Council of New Zealand, 2012). Eight principles provide the framework for applying this Code of Conduct. Of these, principle two, *respect the cultural needs and values of consumers*, includes understanding and upholding the needs of Māori, integrating Māori models of health into everyday practice, reducing inequities, and promoting access to services that meet the needs of Māori. Providing access to health services in schools reduces the inequity many Māori experience in accessing health care in the community (Ellison-Loschmann & Pearce, 2006; Jeffreys et al., 2022).

In addition to abiding by a Code of Conduct, registered nurses must achieve four domains of competence (Nursing Council of New Zealand, 2007). Domain three of these competencies focuses on interpersonal and therapeutic communication with consumers of health services and other health professionals (Nursing Council of New Zealand, 2007, Domain 3). Arguably, teachers working in schools are indirect consumers of health services as they are the ones who will usually initiate access to health support for students in their care.

School health services in New Zealand

Health services have been situated in schools for some time, both internationally and in New Zealand (Allensworth et al., 1997; Lambie, 1951; Rogers, 2002; Struthers, 1917; Tennant, 1991; Williams & Dickinson, 2017). In New Zealand, the School Medical Service (SMS) was established in 1912, linking schools to health services and medical surveillance for the first time. The Department of Education initially ran the SMS, and

in 1921 the school hygiene division of the Department of Health (Dow, 1995) began to oversee the programme. Nurses were responsible for managing the SMS, including visiting schools and homes, addressing health issues and providing health education. By the late 1940s, all children, on entering school, underwent a medical examination. These examinations aimed to identify children who were not considered 'thriving' in their home environment (Bryder, 1991; Dow, 1995; Tennant, 1991). These children were commonly sent to state-funded health camps where they received education and health care appropriate to their needs. Some children were referred to health camps directly by their teachers, and others through examinations by a doctor or nurse. Seven health camps remain in existence today across New Zealand; they provide an imagining of the possibility of what a more formal collaboration between the health and education sector could achieve going forward.

Over time, schools became the focus of introducing health-related programmes such as immunisation and dental services, which are still in place today. In addition, over the years, various other initiatives to support the nutrition and health of school children have been implemented, including free milk to school children each day between 1937 and 1967 and the free distribution of apples until 1948. The milk in schools programme was briefly revived between 2013-2017 for children attending schools in low socio-economic communities. The scheme has since been replaced by the Kickstart breakfast programme open to all schools in all areas (Kickstartbreakfast, 2020).

Currently, health services offered in schools are operated and overseen solely by the Department of Health, and services vary between districts and individual schools. The self-governing nature of New Zealand schools and District Health Boards' different operating models influence this. Public health nurses and secondary school nurses are currently the leading providers of school health services and either visit periodically or are situated permanently within a school setting. To date, in New Zealand, investment and advancement in health service delivery and support have favoured secondary schools, with primary schools in New Zealand receiving less attention and focus despite their potential for early intervention.

Nursing services in schools generally include physical, mental and emotional assessments through teacher referrals and preventative care such as immunisations and vision and hearing screening. In the past, school health services focused on the early detection of disease and the provision of health education such as healthy eating and personal hygiene (Bryder, 1991; Dow, 1995; Williams & Dickinson, 2017). Over time services have evolved and now include treatment of particular conditions and preventative measures such as immunisation programmes.

An example of a current model of health service delivery in primary and intermediate schools is Mana Kidz (Healthpoint, 2022; King et al., 2022), a publicly funded, nurse-led school-based programme in the Counties Manukau district of greater Auckland. The service provides free primary health care for children attending schools in low socio-economic communities where there are often barriers experienced to accessing health care. Mana Kidz currently operates in 88 primary and intermediate schools in the region.

The Mana Kidz model is complex, with many key stakeholders contributing to its functioning within the health sector alone. These stakeholders include partnering leads, the National Hauora Coalition (NHC) and Counties Manukau (CM) Health; the funders, the Ministry of Health and CM Health; and service delivery provided through a network of Māori and Pasifika primary care providers as well as Kidz First Public Health Nurses. An Alliance Leadership Group (ALG) provides governance of the programme with representatives from the partnering, funding and service delivery arms. Whilst schools have been included in both evaluations of the Mana Kidz model (King et al., 2014; King et al., 2022), they are not represented on the ALG; in addition, it is unclear what extent they have involvement in informing service delivery models. It is also unclear how consistent the health care and support offered by the various providers are. Whilst the most recent evaluation demonstrates the reach of the service and the extent of health needs identified, programme data does not provide direct evidence of the impact on health and wellbeing (King et al., 2022).

International studies that have measured the impact of school-based health services and collaboration efforts on academic outcomes have demonstrated these have a positive effect and repeatedly demonstrate significant improvements over time,

particularly for high-risk, disadvantaged children and young people (Blank, 2015; Dilley, 2009; Geierstanger et al., 2004; Kocoglu & Emiroglu, 2017; Murray et al., 2007; Walker et al., 2010). These studies support the legislative position taken by the United Kingdom in promoting collaborative partnerships to ensure better health and educational outcomes for all children. In the absence of similar legislation in New Zealand, this current study explored the relationship between school staff and health professionals, particularly focusing on what influences collaborative practices.

In New Zealand, health service delivery to children and young people in all DHBs must adhere to the MoH (2022b) Services for Children and Young People service specifications. The specifications are broad and attend to three tiers of service. Tier 1 provides the overarching service specification for health services for children and young people (Ministry of Health, 2014d). Tier 2 focuses on service delivery in schools and early childhood centres (Ministry of Health, 2021b). Tier 3, Additional School-Based Health Services (SBHS), focuses on the provision of services to young people attending secondary schools (Ministry of Health, 2018a). How DHBs deliver the tiered services is largely self-determined; however, the MoH can require DHBs to refocus on current national and regional health priorities, meaning relatively frequent changes to funding, models and focus.

Certain school-based health initiatives are funded by the government and delivered directly to schools through the MoH. These include the Health Promoting Schools programme (Ministry of Health, 1991); the Fruit in Schools Programme (Ministry of Health, 2005a); and the Healthy Families New Zealand initiative (Ministry of Health, 2021a). The programmes and initiatives are all targeted toward low-decile primary and intermediate schools. Hearing and vision screening services are also funded for all New Zealand pre-school and school-aged children, and free dental services are available for all children and young people up to the age of 18 years. These services can make onsite visits to schools, and static dental clinics are also available in the community. This study considered that the programme mentioned might influence school staff's perceptions of their relationship with the health sector.

Nurses in schools

Nurses are publicly funded by DHBs and PHOs to deliver health services predominantly to low-decile primary schools in New Zealand (Buckley et al., 2012; Ministry of Health, 2021b), and are the most prevalent provider of health services in schools. There are a small proportion of publicly funded secondary school nurses, but these are limited primarily to low-decile schools (Ministry of Health, 2009). High-decile secondary state-funded schools and private schools may employ nurses to work onsite, but the government does not provide public funding for these nurses.

School nursing is not a recognised specialty focus area in the New Zealand health system (Buckley et al., 2012; Williams & Dickinson, 2017), contrasting with countries such as the United Kingdom, parts of Australia, and the United States of America. In these countries, school nursing practices are fashioned around established standards and frameworks for service delivery (Australian Nursing and Midwifery Association, 2019; National Association of School Nurses & American Nurses Association, 2017; Royal College of Nursing, 2022; Welsh Assembly Government, 2009). In addition to nurses, although not as prevalent, are other publicly funded health professionals, including speech and language therapists, psychologists, and occupational therapists who work in schools to assist individual students on an as-needs, specialist referral basis (Bose & Hinojosa, 2008; Glover et al., 2015). Social workers in schools are another publicly funded, health-related resource available in some New Zealand primary schools; this service is funded separately by the Ministry of Social Development and is limited to schools situated in low socioeconomic communities (Jiang et al., 2018; Oranga Tamariki Evidence Centre, 2020).

Health Conceptualisation

In 1946 the World Health Organization defined health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (World Health Organization, 1946, p. 1). In 1984, the World Health Organization revised this definition, describing health as “the extent to which an individual or group is able, on the one hand, to realize aspirations and satisfy needs; and on the other hand, to change or cope with the environment” (World Health Organization, 1984, p. 4). From these definitions, health is viewed holistically and considers a range of functions within

individuals and communities and the ability of individuals and communities to maintain their health and wellbeing in environmental challenges.

Current health challenges are markedly influenced by social environments and habits (Currie, 2009; Moore & Oberklaid, 2014; Palmer et al., 2019). In relation to child health, there has been a global rise in the number of children with developmental, behavioural and psychosocial problems (Breslau et al., 2009; Garvey et al., 2020; Haggerty et al., 2003; Ministry of Health, 2018b). Equally, there is a rise in chronic conditions such as diabetes, asthma, mental illness, and heart disease, which require long-term health and lifestyle management (Ministry of Health, 2013). These health conditions and challenges have led to healthcare practitioners and researchers supporting the inclusion of wellbeing into the concept of health (Huby & Bradshaw, 2007; Moore & Oberklaid, 2014; Underdown, 2007).

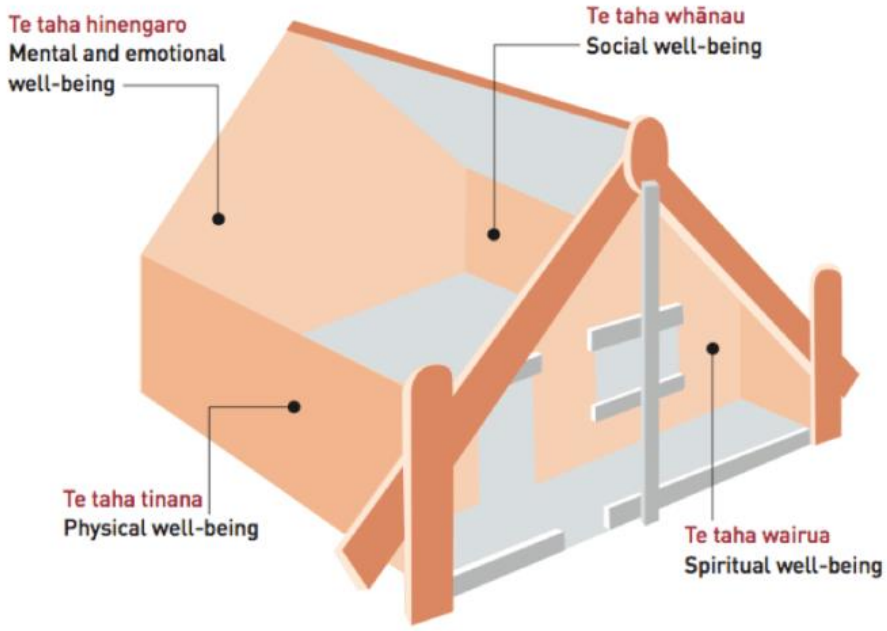
There is no clear consensus on what child wellbeing involves or how a child or young person experiences wellbeing (Aldgate, 2010; Huby & Bradshaw, 2007; Pollard & Lee, 2003; Underdown, 2007). Despite an evolving effort to develop indicators that measure a sense of wellbeing in children and young people, these indicators are constantly changing. Some researchers propose that wellbeing is multi-dimensional and should consider the context and complexity of children's relationships in their everyday lives (Huby & Bradshaw, 2007; Underdown, 2007). When child health and wellbeing are viewed as an entity, child health is often considered the foundation of wellbeing (Moore & Oberklaid, 2014). Without a basic level of health, children's ability to engage in day-to-day activities, such as schooling, is impacted.

Many measures of wellbeing focus on objective wellbeing assessed through routinely collected data, including educational achievement and health outcomes. However, the measurement of subjective wellbeing focuses on *how* individuals experience life for example, their level of happiness and satisfaction. Cram (2019) argues that providing both objective and subjective measures would better reflect New Zealand's responsiveness to the United Nations Conventions on the Rights of the Child (UNICEF, 2008). However, Cram also argues that current wellbeing measures do not consider Māori and Pasifika world views (Cram, 2019; Henare et al., 2011). Mason Durie (2006) provides a way to consider this by recommending four key principles for measuring

Māori wellbeing: indigeneity (wellbeing is not able to be separated from the natural environment); multiple indicators (outcomes for Māori are assessed through a range of measures); commonalities (shared characteristics bind Māori peoples) and integrated development (Māori development is built on cohesion). The latter principle of integrated development acknowledges the importance of cohesive development across cultural, social, environmental and economic contexts, including education and health.

Considering the aforementioned perspectives on how child health and wellbeing are defined, and given that this study was specific to New Zealand, it was appropriate to draw on an indigenous Māori view of health to support this research study and its approach. My references to child health and wellbeing throughout this study are considered through the lens of Te Whare Tapa Whā (Durie, 1994), a Māori model of health that incorporates four cornerstones of health: taha tinana (physical); taha hinekaro (emotional); taha whānau (social); and taha wairua (spiritual) (see Figure 1). This holistic framework is reflective of a Māori worldview and provides health providers, both Māori and non-Māori, with a model of health and wellbeing that interconnects the health and wellbeing of individuals and their whānau (Durie, 2006; Rochford, 2004). The framework also allows imagining the positive impact that fostering collaborative relationships between sectors such as education and health might have on the lives of children and young people growing up in New Zealand.

Figure 1. Te Whare Tapa Whā (Durie, 1994)



The Interconnectedness of Education and Health

There is extensive evidence that education and health outcomes are reciprocally related and that the relationship is bi-directional (Basch, 2011a; Cutler & Lleras-Muney, 2006; Gan & Gong, 2007; Grossman, 2008; Low et al., 2005; Silles, 2009). Poor health is a significant factor in preventing or limiting learning opportunities and, as a consequence, is a contributor to poor academic outcomes for many children and young people (Basch, 2011a; Costante, 2002; Dilley, 2009; Michael et al., 2015; Pradhan et al., 2018).

Education as a determinant of health

Education is a well-recognised social determinant of health and is a powerful precursor to long-term health outcomes (Braveman & Gottlieb, 2014; Healey, 2004; Low et al., 2005; Ma et al., 2018; Shankar et al., 2013). Education plays a significant role in supporting positive health behaviours, including eating well, being physically active, limiting alcohol intake, and avoiding tobacco use (Mirowsky & Ross, 2005; Rosas-Salazar et al., 2012; The Lancet Public Health, 2020). With respect to educational attainment and its effect on health outcomes, research has generally focused on individual health practices and health-seeking behaviours, with less consideration given to the contributions of policymakers and health service providers to educational

outcomes for individuals (Braveman et al., 2011; Braveman & Gottlieb, 2014; World Health Organization, 2011a).

Education is strongly associated with an individual's life expectancy, morbidity, and health behaviour (Feinstein et al., 2006; Silles, 2009; Zimmerman & Woolf, 2014). Educational attainment plays an important role in maintaining health through its influence on life-long opportunities such as employment, social standing, and income potential (Center on Society and Health, 2014; Feinstein et al., 2006; Haycock, 2010; Raghupathi & Raghupathi, 2020; Shankar et al., 2013; Silles, 2009). Some studies report that individuals with more years of schooling experience better health and wellbeing overall (Feinstein et al., 2006; Goldman & Smith, 2011; Ma et al., 2018; Pradhan et al., 2018; Woolf et al., 2007). These studies indicate that schooling is positively linked to health and determinants of health such as health behaviours, use of preventative services, and avoidance of contexts that incur undue risk (Commission on Social Determinants of Health, 2008; Feinstein et al., 2006; Goldman & Smith, 2011; Ma et al., 2018; Pradhan et al., 2018). In relation to supporting positive health behaviours, Mirowsky and Ross (2005) suggested that education helps individuals become active agents in their own lives and develops the capacity to realise, consider, and put into effect new information and knowledge. Education also assists in developing the habits and skills of self-direction, self-concepts, and attitudes. Together, these can be effective when seeking good health (Feinstein et al., 2006; Fletcher, 2015; Woolf et al., 2007).

The impacts of health on education

Health issues can significantly limit or prevent learning opportunities for children and young people through educational interruptions and health-related absenteeism (Basch, 2011a; Michael et al., 2015). Health disparities feature significantly in both academic and long-term social outcomes: including school readiness, poor educational achievement and attainment, adult earning capacity, and participation in the workforce (Basch, 2011a; Boardman et al., 2012; Case & Paxson, 2006; Costante, 2002; Crosnoe, 2006; Fleming et al., 2019; Jackson, 2009, 2010; Poulton et al., 2002; Power, 2002). In addition, there is increasing evidence that children and young people who are repeatedly absent from school, choose to withdraw or are excluded from school early

are less likely to succeed academically and can go on to develop significant mental health issues (Basch, 2011a; Clark et al., 2010; Collins, 2018; Epstein et al., 2020).

Contribution of this study to existing knowledge

Few studies have focused on the day-to-day working relationship between schools and health services in New Zealand, particularly in primary schools. This is relevant to the context of early intervention and the avoidance of academic and health issues for children and young people (Elek et al., 2017; Moore & McDonald, 2013; Powell et al., 2019; The Royal Australasian College of Physicians Paediatric & Child Health Division, 2013). The significance of this study was in seeking to understand the relationship school staff have with health services in New Zealand and the influences on this relationship. The study provides a unique New Zealand stakeholder perspective from those central to this relationship and whose viewpoints have not previously been heard.

There are many benefits to understanding the current relationship between primary school staff and health services in New Zealand. The findings from this study will encourage further discourse on opportunities for collaboration between the two sectors and highlight policy priorities and the need for service-level agreements to support such collaboration. Importantly, the findings will inform how school staff and health services might work together more effectively to benefit children and young people in the New Zealand context.

Thesis Outline

Chapter One of this thesis has revealed the motivation and foundation for this study and my professional positioning relating to this work. Justification for this study was provided as well as some of the relevant context and background. The overarching research question that provided a focus for the choice of study design and methods was also introduced.

Chapter Two provides a theoretical context for the research question through the assimilation of current literature and research relating to the genesis of the relationship between schools and health services and how this has evolved to the present day. The literature review relevant to the study focus is presented in two

sections. Section one focuses on the historical development of the relationship between schools and health services both in New Zealand and internationally. Section two focuses on the phenomenon of relationships as viewed from three different theoretical positions: intersectoral, interprofessional, and interpersonal. The two sections of the literature review relate directly to the broad research question and cover areas that were fundamental to consider when framing aspects of the study design.

Chapter Three provides a discussion of the methodology supporting the research approach taken in this qualitative study. This includes an overview of the philosophical paradigm and ontological, epistemological and axiological perspectives employed. Robert Stake's methodological approach to multicase study is introduced and discussed. The chosen philosophical and theoretical approaches were interwoven to provide a framework for proceeding with the study. Descriptions of the data-gathering tools and analysis methods, including the ethical considerations, are contained within this chapter.

Chapter Four details the findings of the individual cases in this study through the interpretation of the participants' experiences and perspectives of working with health services, field observation and a review of professional learning and development offered to school staff in each school. The findings are presented as three separate abbreviated case reports. The complete, in-depth case reports are included in the appendices section of the thesis.

Chapter Five discusses the study's cross-case findings with consideration of what is already known and understood about the relationship between schools and health services.

Chapter Six is the final chapter of this thesis and provides a conclusion by considering the implications of the findings from a policy and practice perspective. The limitations of the study are discussed and the recommendations that arose from the study, including suggestions for further research.

Chapter 2 Literature Review

This study examined the working relationship between primary schools and health services in New Zealand and the influences underpinning this relationship. The study focused on how participants in three case study schools experienced the health sector's role in their day-to-day schooling activities and their views about the benefits and challenges of maintaining a collaborative relationship between the education and health sectors.

Health and education are interconnected (Basch, 2011a; Costante, 2002; Fiscella & Kitzman, 2009). Educational outcomes are dependent upon children's health status, while concurrently, health is positively impacted by the level of educational attainment (Costante, 2002; Cutler & Lleras-Muney, 2006; Michael et al., 2015). The relationship between health and educational achievement is well recognised; the relationship emerges early in life, develops over time, and is cumulative and persistent (Case et al., 2005; Case & Paxson, 2010; Cheadle & Goosby, 2010; Jackson, 2015; Lê et al., 2013). Poor health in early life is associated with correspondingly poor academic performance and decreased educational attainment (Case et al., 2005; Ding et al., 2009; Eide et al., 2010; Jackson, 2009). Furthermore, health issues that occur in sensitive periods of early childhood development affect a child's readiness to learn and participate in academic activities; thus, promoting early inequalities in skill development and learning (Case & Paxson, 2006; Currie, 2005; Jackson, 2015; Welsch & Zimmer, 2010).

The impact of cumulative educational attainment on health outcomes is widely acknowledged (Feinstein et al., 2006; Fletcher, 2015; Haycock, 2010; Silles, 2009; Woolf et al., 2007). One contributing factor is enhanced literacy, which increases a person's understanding of health-related information (Prins & Mooney, 2014; Rudd et al., 2004). Another is that education supports social mobility by providing people with better opportunities for employment, income, and access to resources, contributing to better health and wellbeing (Adams & Hamer, 2005; Center on Society and Health, 2014; Feinstein et al., 2006; Haycock, 2010; Lahelma et al., 2004).

The education and health sectors in New Zealand have established goals and linked priorities of optimising learning and health outcomes for children and young people

(Department of the Prime Minister and Cabinet, 2019a; Ministry of Education, 2019a, 2020c; Ministry of Health, 2016, 2020b). Situating these goals within an interrelated context (Matingwina, 2018; Zajacova & Lawrence, 2018; Zimmerman & Woolf, 2014) highlights the importance of promoting collaboration between the sectors. Providing school health services is one such opportunity.

This research study was contextualised to current policy and legislation determining the structure and governance of schools and health services in New Zealand. In Chapter One, the overarching research question for this thesis was introduced: **What is the perceived relationship between primary school staff and health services in New Zealand, and how is this relationship influenced?** The research question poses several areas of relevance, including the historical context of education and health sector relationships and the relationship as it is enacted on an intersector, interprofessional and interpersonal level. The complexity of influences on the relationship in day-to-day working practice is described and conveyed within this chapter, providing the background necessary to consider the research question from a broad perspective - considering both the foundational and structural aspects of the relationship and the nuanced theoretical constructs at play.

This chapter provides a narrative overview of relevant literature pertaining to the relationship between schools and health services, and the influences that have shaped this relationship over time. A narrative literature review aims to deepen understanding of a particular research area by providing context and identifying gaps in the existing literature (Cronin et al., 2008; Green, 2006). A narrative review does not have a strict protocol to follow and can address one or more questions within a much broader scope.

As previously stated, the following review is presented in two sections, each informing key parts of the research question: the **relationship** itself and the **influences** on this relationship. Section one draws from the literature on the historical development of the relationship between schools and health services, globally and specifically in New Zealand. Providing this historical overview sets the scene for a deeper understanding of the practical characteristics of the present education-health relationship. Included is an overview of the 1980s neoliberal reforms and their effect

on the structure and management of the education and health sectors. The collective overview in part one provides insight into the socio-political and legal milieu of the contemporary education-health relationship.

Section two focuses on the current professional working relationship between schools and health services from three different theoretical positions: intersectoral, interprofessional, and interpersonal. Exposed are the complexities, interdependence, and contributing effects these three positions have on the two sectors' relationship. Understanding this is essential to contextualising the study and the influential elements in the different relationship positions between schools and health services.

Literature Search Criteria

The initial literature search was structured broadly. As the study progressed, searches became more focused. Literature about teachers' perceptions of their professional role in supporting students' wellbeing was sought in the latter stages to aid understanding, as was the "how to" aspect of interagency collaboration and coordination.

Inclusion criteria

- All works
    - Relating to health service provision in schools
    - Linking health with education, and education with health
    - Referring to interagency collaboration between education and health
- Historical literature on the history of health services in schools and the New Zealand health and education systems
- All works
    - Focussing on intersector collaboration (non-specific)
    - Relating to interdisciplinary and interprofessional working
    - Referring to the effects of interpersonal relationships on professional practice

Exclusion criteria

- Works related solely to education, where health services may be mentioned as an aside, but the emphasis was exclusively on pedagogy and curriculum development.

Search Strategy

The research question guided the literature search – specifically, the critical ideas that defined it. The search employed a range of databases in the fields of health, education, and social sciences. Specifically, CINHAL, Medline, EBSCO, ERIC, Ovid, Scopus, Google, Google Scholar and PubMed databases. In addition, library searches for relevant literature on education and public health - history and political systems, were conducted.

Section one of the literature review focuses on the historical and socio-political context of the education and health sector relationship. The search involved examining literature relating specifically to this focus from the late 1800s (when school health services first began) to the present. No absolute search date limiters were set because capturing the history and context as it evolved was essential to building knowledge and awareness of how current working practices became established.

Initially, simple keyword combinations such as: 'history of school health service*', 'relationships between education and health', and 'primary school health service*' were used. However, these word combinations sometimes proved either too broad or too narrow. As a result, additional techniques and operators were employed, for example: ['schools AND elementary AND health AND service*'] and ['health service* OR health system* OR health provider* OR health professional* OR nurse*'] and ['teacher* AND primary school* AND elementary school* AND health system* OR health service* OR health provider* OR health professional*']. These search techniques helped identify more specific and relevant information across all interest categories.

Section two of the review focuses more specifically on education and health sector relationships relative to being connected and how each sector regards and behaves towards each other on an intersector, interprofessional and interpersonal level. The literature search date parameters were restricted to relevant works from the 1980s (a time of significant reform in the education and health sectors in New Zealand) to the present day. Examples of the search terms used included: ['Interprofessional

collaboration in school* AND health system* OR health service* OR health provider* OR health professional* OR nurse* OR social worker OR mental health worker*'] and ['Intersector collaboration AND health AND education'].

Several gaps were identified in the literature, particularly concerning the practical workings of the education-health relationship in schools. In particular, minimal studies examined this relationship in the primary/elementary school setting. This gap is despite the acknowledgement of the principles and importance of early intervention (Elek et al., 2017; Moore & McDonald, 2013; Powell, Long, Bolton, Jarrett, & Kennedy, 2019). In contrast, many published studies describe the provision of health services in secondary schools, although they do not necessarily focus on the working relationship between the two. Many of these studies originated from North America, Europe, and the United Kingdom.

In regards to relationships, very few studies looked specifically at interpersonal relationships between school staff and health professionals from a functional and reciprocal perspective at a service level. Of the available studies, most centred on nurses working in schools. This study contributes to the general deficit in knowledge around functional day-to-day relationships between primary school staff and health services and aims to identify the influences on this relationship specific to New Zealand.

Section One: Historical and Socio-political Context of Education and Health Sector Relationships

This historical review provides a context for the origins of the relationship between the education and health sectors in New Zealand. This historical perspective is followed by a review of the public policy reform effects of neoliberalism and New Public Management (NPM) on the education and health sectors. Such understanding is necessary to appreciate the evolution of the working relationship between the education and health sector up to the present day.

The early development of school health services in New Zealand

The delivery of health services in schools has occurred for over 100 years globally and in New Zealand (Gardner, 1936; Gustafson, 2005; Hirst, 1989; Keeton et al., 2012;

Veselak, 2001; Williams & Dickinson, 2017). At the turn of the 20th century, the control of infectious diseases, disability, malnutrition, and the promotion of higher standards of hygiene and sanitation were the focus of health services in schools (Bryder, 1991; Dow, 1995; Kelsey, 2002; Tennant, 1991; Vessey & McGowan, 2006; Zaiger, 2013). Following the Boer War (1899-1902), interest in the school health services' role in improving broader population health increased, particularly in Great Britain (Hirst, 1989). The Interdepartmental Committee on Physical Deterioration (1904) recommended investment in school health services to "take stock of the physique of the whole population and securing to its profit the conditions most favourable to healthy development" (p. 88). At much the same time, school health inspections in New Zealand were formalised in 1908 (Tennant, 1991).

The role of community-based health services in contributing to the nation's health was championed in New Zealand in the early 1900s by Dr Truby King, who considered the health system overly focused on illness and disease rather than on promoting health (Bryder, 2003; King, 1906; Olssen, 1981). King established the Royal New Zealand Plunket Society (RNZPS) to support parents in raising healthy children. By doing so, children would develop into adults who would be of "greatest service to the Empire" (Health Department Division of School Hygiene, 1935, p. 1). Concurrently, the Inspector-General of Hospitals and Chief Medical Officer, Dr Thomas Valintine, championed monitoring the health and development of every child, believing this would contribute to healthier recruits into the New Zealand defence forces. Schools were considered a convenient place to access the majority of children and soon became a focus for these health reformist ideas.

In 1912, the establishment of the School Medical Service (SMS) heralded the start of a longstanding relationship between schools and health services. The SMS began as a scheme that acted as an extension to the Plunket society's early-years surveillance, providing ongoing access to children's health services. SMS recommendations included Dr Valintine's (the existing Inspector-General of Hospitals and Chief Medical Officer) proposal that teachers monitor their students for signs of illness, vision and hearing defects, and regularly record height, weight, and chest measurements. The costs to the Health Department of gathering this data were minimised by utilising teachers to do these tasks (Dow, 1995; Tennant, 1991; Valintine, 1911).

The New Zealand Department of Education (DoE) was initially responsible for running the SMS. The 1918 influenza pandemic resulted in public criticism of the New Zealand Department of Health (DoH) for its lack of preparedness and management of the pandemic (Dow, 1995; Rice, 1988), and led to a Royal Commission of Inquiry in 1919 to review the handling of the pandemic and in particular, the role of the Public Health Department. This responsibility transferred to DoH in 1921 (Dow, 1995; Tennant, 1991), after the 1920 Health Act ensured administrative reform, including the incorporation of the SMS into the DoH (Dow, 1995; Rice, 1988). This organisational shift of responsibility for the SMS removed teachers from playing a direct role in monitoring children's health. The Act permitted certain medical practitioners to enter schools and examine children "at all reasonable times" (Health Act, 1920 s. 139). Arguably, this repositioning of the SMS heralded the first signs of strain in the reciprocal working relationship between schools and health services (Maclean, 1983; Tennant, 1991).

Alongside this shift in responsibility for health in schools from teachers to health professionals, nurses, as opposed to doctors, began to lead health service delivery in schools. Fewer hospital admissions and a reduction in rates of absenteeism were attributed to the development of school nursing services, with early detection of disease and the delivery of health education seen as pivotal to improving health outcomes (Bryder, 1991; Dow, 1995; Lambie, 1951; Miller, 2015; Tennant, 1991). Nurses collaborated with school teachers and were utilised by assisting in teaching topics including diet, posture, and personal hygiene. These topics had been in the teaching curriculum for the previous decade and remained so for at least another 20 years (Burgess, 1983; Burrows, 2002; Quennerstedt et al., 2010). In addition to school nursing, the DoH established the New Zealand School Dental Service (NZDS) in 1921 (Hunter, 1932; Moffat et al., 2017). The NZDS commenced as a response to the generally poor state of children's teeth and aligned with a shift in focus to child health and welfare towards the nation's overall health; thus, upholding Dr Truby King's philosophy. Nurses who were specifically trained to treat children's teeth provided most school dental health services. With regard to the advancement of the New Zealand SMS and school nursing, this work became part of the District Health

Nursing Service in 1930, eventually being incorporated into the role of the Public Health Nursing service in 1953.

School health service evolution during an era of education and health reform

As a result of several health reforms since the 1950s, significant changes have occurred regarding monitoring children's health in schools. Modifications to the health care system that altered the provision of health service support in schools included the establishment of Area Health Boards (AHBs) in 1983 (Davis & Ashton, 2001; Gauld, 2009). Each AHB became self-determining in developing health services, including school health, with each AHB choosing how they prioritised and delivered services in line with perceived community needs. Neoliberal influences on health reforms in the 1980s meant decision-making became decentralised, and both institutional knowledge and shared lines of communication under the auspices of the DoH were diminished or lost (Dow, 1995; Hansen et al., 2007). Decentralisation, plus a shift in focus to measurable health outcomes, directly affected the role of the Public Health Nurse (PHN) and health service delivery in schools, with models of service delivery and relationships varying widely across New Zealand (Denny et al., 2012; Hansen et al., 2007; Shaw, 1991; Voyle, 2000). The impact of neoliberal-influenced health care reform on the health sector, and school health services in particular, is addressed in detail later in this review.

Since the aforementioned health reforms, there has been no nationally directed infrastructure for delivering school-based health services, despite being considered a universal health-promoting programme for all children and young people in New Zealand (Ministry of Health, 2018a, 2021b). Currently, government funding targets schools situated in low socioeconomic communities where health inequities are most prevalent (Ministry of Health, 2021b). What remains, however, is the role that nurses continue to play at the interface between schools and health services, mainly through their relationship with teachers (Costante, 2006; Council on School Health, 2008; Lambie, 1951; Nelson et al., 2011; Williams & Dickinson, 2017). Through dental health services, and the provision of immunisations and personal health care, nurses continue to provide an accepted and effective conduit to health services for schools (Allen, 2003; Baisch et al., 2011; Children's Commissioner, 2016; Fong, 2014; Kocoglu & Emiroglu, 2017). The continued nursing presence in schools has prevailed

despite significant changes in schooling and education systems in New Zealand and globally.

School education preceding and during colonisation

Before colonisation, Māori traditions of knowledge, learning, and teaching were interwoven into cultural practices and day-to-day activities of tangata whenua (Cacciopolo & Cullen, 2006). Early colonial teaching disregarded traditional Māori knowledge and ways of being (including approaches to health and wellbeing), with Christian settlers offering alternative perspectives that closely aligned with a British model of education (Stephenson, 2009; Tearney, 2016). Education was not viewed as a priority for those leading New Zealand's early settlement and was left primarily to the missionaries, whose resolve was to colonise Māori and convert them to Christianity (Stephenson, 2009). The first missionary schools commenced in 1816 and continued until their gradual demise in the 1860s (Cacciopolo & Cullen, 2006; Moon, 2019).

The governing colonial view was to regard education as essential to the protection and acculturation of Māori, including their health. However, missionary schooling was inadequately resourced. The Constitution Act of 1852 saw New Zealand divided into provinces, each with its own government (Cumming & Cumming, 1978). These provincial governments took responsibility for facilitating the development of their education systems, which took various forms; private schooling for the elite and middle class and missionary or charitable schools for the seemingly poor (Cumming & Cumming, 1978; Tearney, 2016). However, the organisation of these missionary and charitable schools was haphazard and, as a result, many disadvantaged children and Māori children failed to engage.

In response, the Native School Act 1867 removed missionary responsibility for the schooling of Māori and initiated a national system of village primary schools (Cumming & Cumming, 1978; Stephenson, 2009). Under the Act, Māori communities were responsible for requesting the establishment of a specific school, supplying the land, contributing towards building and teacher salary costs, and putting together a school committee. Paradoxically, the 1867 Act ruled that school instruction should be in English, despite significant efforts having been made by missionary teachers to teach Māori to read and write in their language (Cacciopolo & Cullen, 2006; Dow, 1995).

These efforts supported a need to educate Māori about infectious diseases and other risks to their health.

The directive of the Native School Act 1867 to educate in English impacted the progress of health education to the extent that a proposal was made to the Native Minister in 1884 for compulsory health education in schools (Dow, 1995). Observably, this proposal heralded the early integration of health into the education curriculum. The corresponding publication: *Health for the Māori: A manual for use in Native schools* (Pope, 1884), emphasised integration. With health education aimed at school children, it was envisaged that what children learnt at school would be conveyed home to their parents. Schools and overall school attendance by Māori increased due to the Native Schools Act, although attendance varied markedly between provinces (Cumming & Cumming, 1978; Stephenson, 2009).

The Education Act of 1877 legislated a national universal education system to provide free, compulsory primary school education for all settler children aged 7 to 13 years. Māori children were exempt from compulsory attendance due to the pre-existence of the native school system; however, there was no legislation to stop their attendance at public schools (Codd & Openshaw, 2005). The 1877 Act authorised responsibility for the funding, administration, and regulation of schools in New Zealand to the central government. The Act provided a three-tiered administrative structure consisting of a central body, the Department of Education (DoE), 12 District Education Boards, and local school committees. Funding was devolved into grants from the DoE to the District Education Boards, who then administered these grants at a local level to school committees. The DoE maintained the right to impose regulatory standards concerning student education, teacher training and certification (Codd & Openshaw, 2005; Department of Education, 1988; Ray, 2009). Although set within a different management framework, this system of devolved funding and imposition of regulatory standards and goals by the Ministry of Education (MoE) remains in 2022. This system arguably plays a continued role in shaping the intersector working relationship between education and health through its continued inward focus on meeting children and young people's learning and health needs separately, despite their known interdependence.

Impact on education of social reform following the Great Depression

The Great Depression in the early 1930s and the response of New Zealand's first Labour government caused economic, social, and political changes, which impacted both the education and health sectors. A shift from reliance on standardised assessments occurred instead of focusing on the child at the centre of their learning, inclusiveness, and achieving education equity (Cumming & Cumming, 1978; Stephenson, 2009). To address existing educational inequities, proficiency tests, which had previously allowed access to secondary school, were abolished. As a result, more New Zealand children and young people gained access to education beyond primary schooling (Clark, 2017; Stephenson, 2009). The Minister of Education at that time, Peter Fraser, and the Director of Education, Dr Clarence Beeby, were committed to reducing access barriers to education. A statement drafted by Beeby in 1939 outlined the Labour government's policy on education and is referred to as the Fraser-Beeby statement (Beeby, 1992). This statement expressed the Government's intent that every citizen had a right to free education and one that catered to their abilities.

Transition to a more diverse approach to education, from 1939, extended the welfare programme to include free education for all New Zealand children. Simultaneously, Beeby and William Thomas, a secondary school principal, jointly reviewed the secondary school curriculum. This review resulted in the Thomas Report (New Zealand Department of Education, 1944) and the introduction of a universal curriculum to ensure all children were educated to the same core curriculum regardless of individual ability. Critics of the curriculum argued that it did not prepare young people adequately for everyday life but, at the same time, there was agreement that it should provide opportunities to pursue individual interests and goals (Beeby, 1992; Ray, 2009). More recently, some educational researchers have stated that a universal approach did not cater sufficiently for those with diverse learning needs and children requiring learning experiences specific to their individual needs (Norwich, 2010), including those related to health.

By 1948 perspectives on health and the focus content in the education curriculum were broadening. Mental health and wellbeing were highlighted following the social and emotional effects of the Second World War (1939-1945) on families and children

(Barlow, 1990). School nurses, medical officers and dental nurses continued to provide and support health education in schools. Teachers were expected to cooperate with the goals of the DoH (New Zealand Education Gazette, 1945 as cited in Sinkinson, 2011) and those of the DoE.

Increasing access to education

In 1960, Arnold Campbell succeeded Dr Clarence Beeby as Director of Education. In a submission to the newly established Commission of Education (the Currie Commission), Campbell identified the need for future educational developments in New Zealand to be more student-centric, aiming to better meet the needs of children and adolescents (Jones et al., 1995; Tearney, 2016). The Currie Report (Currie Commission, 1962) highlighted inadequate funding and a lack of coordination within the public schooling sector. The Report also identified groups of children for whom the education system was not working equally: Māori children, children with long-term health conditions, children with physical and intellectual disabilities, children living rurally, and children in low socio-economic communities. Achieving equality of opportunity became the education system's focus at this time.

The Currie Report achieved little for the groups of children it had identified as needing help to access education (Jones et al., 1995; Ray, 2009). In 1974, the Educational Development Council Report (Educational Development Conference, 1974) deemed that the concept of equality of opportunity was outdated. Instead, the term *equity* was more representative; this change coincided with an increased understanding of the impact of socioeconomic status on learning and achievement and the impacts of health on education (Basch, 2011a; Jones et al., 1995; Michael et al., 2015; Sirin, 2005). To counteract the existing inequity, the Educational Development Council Report proposed that education funding be redistributed based on fairness and need; any child would be entitled to receive additional support with the education process if there were good reasons for doing so.

Following the Currie Report, the Nordmeyer Report (1974) focused on the organisation and administration of the education system. The Nordmeyer Report emphasised accepting education both as a service for individuals and a form of social investment. The Report promoted the self-governance of schools as the way forward and a belief

that the general public needed to be able to participate in and inform the organisation of the education system at a local level. Schools developing closer links with their local community and more involvement of parents were seen as ways to achieve participation. Developing closer links with the community to benefit children's educational outcomes did not extend to doing so with public sectors such as health.

Historical critiques of the aforementioned education reforms observe that the goal of achieving equality was challenged by the rhetoric of that time, whereby education should not be considered a 'public good'; rather an 'individual good' and, as such, should be paid for by the user (Latimer, 2002; Ray, 2009). Critics of this individualist stance highlighted its potential to minimise the social functions of education (Castagno, 2021; Clark, 2005; Hargreaves, 1980; Locatelli, 2018), including the role of education as a social determinant of health (Shankar et al., 2013; Zimmerman & Woolf, 2014). An essential factor in upholding the individualist perspective, however, was that education had become increasingly costly for the government (Hawke, 2002; Jones et al., 1995).

Funding for education was achieved through taxation, with the government responsible for collecting and redistributing money to fund public schooling. This funding model came increasingly under scrutiny in 1984 when the fourth Labour government came into power, with Treasury proposing that education be considered a tradeable commodity in the marketplace. This notion stemmed from a neoliberal ideology engulfing the globe, primarily due to economic inaction and the high global debt of the 1970s (Larner, 1997; Springer et al., 2016). The economic and social policy reforms in Britain and the United States strongly influenced the New Zealand Labour government. The reforms, later referred to as 'Thatcherism' and 'Reaganomics' (Marshall, 1999), viewed health and education as commodities that should be geared towards and become the individual's responsibility rather than solely provided through public policy (Benade, 2012; Larner, 1997).

Neoliberalism and New Public Management

Neoliberal ideology is based on an individual's right to personal and economic freedom. The state's policies and regulations should be justified in consideration of this essential freedom (Barnett & Bagshaw, 2020; Benade, 2012). Despite

acknowledging the need for an environment that supports individuals to be self-directed and self-actualising, neoliberal ideology considers individuals as essentially apathetic in this regard, and sustained economic growth as the best way forward to achieve human progress (Barnett & Bagshaw, 2020; Benade, 2012).

Neoliberal views are progressed through decreased public spending, deregulation, and increased privatisation. By focusing on policies emphasising self-sufficiency and responsibility, neoliberalism and its economic aspirations toward a world market embrace the liberal views of individualism and universalism (Barnett & Bagshaw, 2020; Springer et al., 2016). In New Zealand, neoliberal reform focused on monetary policy and restructuring state activity concerning commercial and service activities. Public sector reform was based on new management models akin to those in the private sector, such as deregulating financial markets (Barnett & Bagshaw, 2020). Over time, neoliberalism has been attributed to a range of societal, environmental, and economic problems, and many of its critics contend that social inequality and inequity have been exacerbated as a consequence of the neoliberal movement of the 1980s and beyond (Codd, 1993; Fishkin, 2014a; Hawke, 2002; Pihama, 2019; Springer et al., 2016). In this context, neoliberalism challenged the visions of early reformists, such as Beeby in education, who viewed achieving equity as the way forward for society.

Neoliberal reform in New Zealand focused on changing monetary policy and restructuring centralised state activity (Barnett & Barnett, 2003), resulting in many state activities becoming privatised. Public sector reform was based on a mix of private provision, contractual relationships, and competition. The work of those practising in these sectors became almost entirely outcome-driven, undermining professionality in some sectors (Benade, 2012; De Saxe et al., 2020; Foth & Holmes, 2017; Ornellas et al., 2020).

No public sectors in New Zealand were immune to the effects of neoliberalism, and the accompanying approach to economic and management responsibility was termed New Public Management (NPM). NPM is orientated around two main ideas; economic theories (informed by neoliberalism) and management systems based on private sector management practices and their application to the public sector. There are three main components of NPM: incentivisation, competition, and disaggregation, or

the separating of the provision of services (Lapuente & Van de Walle, 2020; Whitcombe, 2008).

The main criticism of applying NPM practices to the public sector is that NMP practices are at odds with the traditionally held values of impartiality or equity. At the time, taking methods that had proved profitable in a business context and applying these in another context would seem a pragmatic starting point in addressing an issue. However, the inability to ameliorate the adverse effects of a competitive marketplace on firmly held social values has proven a constant challenge for those working in the public sector (Diefenbach, 2009; Lapuente & Van de Walle, 2020).

The conflicting ideological positions of choice and equity have meant that some neoliberal policies have increased social inequities (Barnett & Bagshaw, 2020; Nairn, 2012; Podder & Chatterjee, 2002). Choice suggests something everyone possesses; however, neoliberal–reform ignores that choices are limited by social and individual circumstances such as poverty, socioeconomic status, ethnicity, religion, gender, and class (Fishkin, 2014a). The apparent differences in the ability to apply choice between population groups defined by these characteristics challenge the ability of neoliberalism to achieve sustainable societal progress (Simon, 1990). Some have suggested that a return to a more pluralistic approach would benefit society as a whole in the longer term (Codd, 1993; Fishkin, 2014b; Santos et al., 2017).

Public sector disaggregation

The disaggregation of public sector organisations such as education and health into smaller agencies was a feature of NPM. Agencification refers to creating semi-autonomous bodies (Pollitt et al., 2001; Verhoest, 2017). The creation of these bodies assists governments in achieving their objectives with a focus on outcomes and responsibility (Overman & van Thiel, 2016). Examples of agencification in the education sector include the creation of the Education Review Office, an independent body set up to monitor school performance (Department of Education, 1988), and the New Zealand Qualifications Authority responsible for administering secondary school educational assessment and managing the New Zealand Qualifications Framework qualifications (*New Zealand Qualifications Authority*, nd).

Agencification can unwittingly contribute to silos and siloed working practices (Bezes et al., 2013; Fenwick et al., 2009; Pollitt et al., 2001). In the context of public administration, Scott and Gong (2021) defined a silo as "a hierarchical organization which seeks to maximise vertical coordination at the expense of horizontal coordination. It is inward-looking and self-contained with little regard for outcomes other than those which affect its own narrowly conceived goals" (p. 20), aligning with the tenet of individualism. Siloed public administration could questionably undermine or even disregard the importance of collaboration and cross-sector relationships in achieving equitable outcomes for all members of society.

In addition to disaggregation, the NPM strategy promoted incentivisation and competition. Education sector examples included the increase in private schools and their permission to set fees and compete for students. In addition, state-funded and private schools started actively seeking overseas fee-paying students to generate increased revenue (Gordon & Whitty, 2010; Hawke, 2002). Correspondingly, in the health sector, the implementation of NPM saw a rise in specialist private health care facilities and incentive-based payments for certain services, particularly in primary care (Gauld, 2003, 2009). However, the competition was less marked in the health sector, with public hospitals continuing to have a public funding monopoly, particularly for delivering acute services (Ashton & Tenbensel, 2010).

Education system restructuring

The economic and management reforms in the late 1980s brought about dramatic changes to the structure and administration of the education sector in New Zealand. In 1988, the Labour government's education review task force produced a report titled *Administering for Excellence: Effective Administration in Education*. This report, widely known as the Picot Report (Taskforce to Review Education, 1988), focused on the administration of schools. The Picot Report stated that the education system was inflexible, unresponsive, and bound by unnecessary rules and regulations. The report recommended responsibility for staff employment, property and assets management, education provision, and operational funding shift from the state to locally elected Boards of Trustees drawn from the community. The justification for these changes was that applying NPM practices and encouraging schools to be independent would make the education system more cost-effective and efficient.

Building on the Picot Report recommendations, the Labour government released the Tomorrow's Schools Report (Department of Education, 1988) and commenced a radical restructuring of the New Zealand education system. The restructure included replacing the DoE with a Ministry of Education (MoE), a much smaller entity, and the removal of middle-layer administrative agencies. Individuals appointed to Boards of Trustees held collective responsibility for school governance, with the principal holding management responsibilities. Thus, since the implementation of Tomorrow's Schools (Department of Education, 1988), New Zealand's public education has been based on a system of independent, self-governing schools. The well-intentioned belief was that this would lead to improved learning opportunities for children and young people (Department of Education, 1988). This system of school self-governance is key to understanding why individual schools can choose with whom they form working relationships and highlights the challenges to implementing national guidelines that would support collaborative working relationships such as those between schools and health services.

Education and Training Act 2020

A review of Tomorrow's Schools in 2019 recommended transformative changes to the education system in New Zealand. These changes included advocating for better intersectoral and interagency relationships to promote student learning and attendance (Tomorrow's Schools Independent Taskforce, 2019). Despite these recommendations, there is no proposal made in the new Education and Training Act 2020 for schools to collaborate with health services to support children experiencing health issues that impact their attendance and learning. Making such a recommendation could feasibly assist in upholding the 2020 Act's primary provisions: To support the right of all learners to attend school full-time and renewed emphasis on achievement, physical and emotional safety for students and staff, inclusive schooling, and supporting students with differing needs. These primary provisions could be used as the drivers for establishing collaborative working relationships between schools and health services. From a positive perspective and as a potential starting point for more formal collaborative efforts, the Education and Training Act 2020 aims to implement greater oversight of school governance, including supporting the advancement of more formalised collaborative practices between schools and health services.

The pervasive effects of the Tomorrow's Schools reform have been a topic of much discussion since 1988 (Baker, 2001; Hood, 2019; Tomorrow's Schools Independent Taskforce, 2019; Wylie, 2000, 2009). Many in the education sector believed the reform lacked insight into the importance of intersectoral relationships for supporting schools' aims of improving education outcomes and stifling opportunities for collaboration. In addition, Wylie (2000) and Baker (2001) claimed that with self-governance, schools remain focused on their survival and wellbeing, not on the school system as a whole or students' educational outcomes. This survival focus limits the ability to form relationships outside the sector, particularly with those not perceived as directly contributing to education outcomes (Wylie, 2009). This may well include those working in the provision of health services.

The adoption of neoliberalism has been blamed for shaping New Zealand education reforms (Codd & Openshaw, 2005). Debatably, earlier and ongoing tensions continued between educationalists who wanted to engage more local involvement in schooling and provide equity and the government who, due to burgeoning costs, were advocating for more local control and choice (Codd & Openshaw, 2005; Larner, 1997). The equity versus choice debate has remained an ongoing theme in the current landscape of the education and health sectors in New Zealand and in many other countries that adopted neoliberal economies (Boyle, 2013; Codd, 1993; Codd & Openshaw, 2005).

Health system restructuring

In parallel with the education sector, neoliberal and NPM influences shaped the health sector during the 1980s and early 1990s. Comparable to the reforms in education, the health reforms aimed to reduce government expenditure and increase efficiency. Since 1983, New Zealand has undergone four healthcare restructures, the most of any health system globally during this time (Barnett & Bagshaw, 2020; Gauld, 2003, 2009). Claims in the 1980s that health services were being overfunded could not be substantiated (Keene et al., 2016); however, this negative rhetoric fed into the neoliberal ideology at the time. The public health care system's continual restructuring in the 1980s was based on neoliberal fiscal and managerial policies. The health sector was subjected to both mangerialisation and privatisation.

Before the 1980s, concerns were raised about inconsistencies in the quality and accessibility of healthcare services (Barnett & Barnett, 2003; Gauld, 2001). Alongside these concerns was ongoing apprehension about rising healthcare costs. The existing hospital governance system was seen as problematic, with decentralisation and new administration methods considered a solution (Barnett & Barnett, 2003). As a result, in the mid-1980s, the local hospital boards were replaced by 14 Area Health Boards (AHBs), which received population-based funding (Davis & Ashton, 2001; Gauld, 2009). The central government continued to fund primary and disability services separately, while funding for public health services became the responsibility of the AHBs (Ashton & Tenbensel, 2010; Dow, 1995). Decision-making became decentralised, which meant that each AHB could decide how to develop its services to align with perceived community needs.

Implementing AHBs was not without difficulties, particularly regarding funding allocation across regions. In 1988, a government review highlighted problems that public hospitals were experiencing related to a lack of efficiency, cost consciousness, and accountability processes (Ashton & Tenbensel, 2010; Gauld, 2003). The Gibbs Report (Gibbs et al., 1988) recommended a competitive operational market model with separate funding and provision arms within newly established Regional Health Authorities (RHAs). The Labour government at that time chose not to implement the changes recommended in the Gibbs Report. However, in 1993 the incoming National government did implement the recommended structure, separating the purchasing and provision roles through MoH-directed funding to four newly established RHAs. The RHAs did not last long; in 1998, the four RHAs were merged into a single Health Funding Authority (HFA), tasked with working closely with providers to plan service outputs and establish costs. A positive outcome of the HFA was that subsidies for primary care consultations and medical prescriptions were increased for children under six years of age, thereby orchestrating free primary health care services for young children.

The New Zealand Public Health & Disability Act (2000) introduced changes in the funding and provision of public health services, personal health services, and disability support services. The HFA was disbanded in 2000, and publicly-owned health and disability organisations, including District Health Boards (DHBs), were established the

following year. Explicitly stated objectives of DHBs (Public Health and Disability Act 2000, s22) included a clear expectation that DHBs would work towards improving health outcomes and reducing health disparities for their communities. In addition, there was an expectation that DHBs would foster a sense of social responsibility and community participation and optimise the delivery of health services to meet local, regional, and national needs. Health service delivery in schools falls into this category, with DHBs also required to "collaborate with pre-schools and schools within its geographical area on the fostering of health promotion and disease prevention programmes" (Public Health and Disability Act 2000, s23(1)(m)).

The impacts of health system restructuring on health service provision to schools

The impact of changes in health funding administration following the establishment of AHBs in the early 1980s through the following four decades has relevance to the provision of health services in schools and the working relationship between the education and health sectors.

The decentralisation of funding and administration of public health services likely contributed to a lack of development of school health services in New Zealand schools, a service traditionally delivered by public health nurses. Decentralisation resulted in the loss of shared lines of communication, loss of common frameworks for service delivery, and the depletion of the original public health nursing leadership. These changes indirectly impacted school health service delivery (Denny et al., 2012; Hansen et al., 2007; Shaw, 1991; Voyle, 2000).

Although running independently of school nursing services, the embedded school dental service (SDS) also experienced significant upheaval due to decentralisation and changes to funding policy. As the 14 AHBs took over the management of dental services in their regions, the SDS was confronted with a requirement to reduce costs and downsize the service (Moffat et al., 2017). Funding was redirected to other board services, limiting the capacity of the SDS to provide a comprehensive and effective provision of dental and oral health education and treatment to school-aged children.

The implementation of AHBs ended nationally directed and funded school nursing and dental services and other health and disability services and programmes. The

disaggregation of these services and programmes observably compromised collaboration within the health sector, limiting any capacity to ameliorate the adverse effects caused by intra-organisational siloed working practices. Negative effects are considered to be directly attributable to the quest for fiscal efficiency, outcome measured based approaches, specialisation, and contract reporting requirements (Bevc et al., 2015; Fenwick et al., 2009).

With reference to working with schools, Section 22 of the Public Health & Disability Act 2000 created the foundation on which DHBs could build a closer and more formal working relationship with the education sector in order "to reduce, with a view to eliminating, health outcome disparities between various population groups within New Zealand" (Public Health and Disability Act 2000, s 22. 1. (f)). The school-health relationship is implicit in this statement. For the DHBs to progress in this relationship, education providers must have a shared understanding of its benefits. To further support the potential for this partnership, Section 24 of the same 2000 Act outlines the capacity for cooperative agreements and arrangements between any person (not necessarily from within the health sector) and the DHB to assist the DHB in meeting its objectives under Section 22. Under Sections 22 and 24 of the 2000 Act, a more formalised relationship between the DHB and local schools could be established. The 2000 Act allowed for better intersectoral collaboration; however, these opportunities were hindered by a lack of reciprocal policy in the education sector. Seemingly, sections 22 and 24 of the Act provided some impetus for the DHBs to lead collaboration. However, the self-governing nature of schools made the consistent application of such agreements challenging.

Looking forward

Further reform of the education and health sectors has recently been proposed (Health and Disability System Review, 2020; Tomorrow's Schools Independent Taskforce, 2019), accepted (in part), and is progressing. If put fully into effect, the proposed education reforms would focus on five objectives: (i) learners at the centre of education; (ii) barrier-free access; (iii) quality teaching leadership; and (iv) learning that is relevant to the lives of New Zealanders today; and (v) world-class inclusive public education (Ministry of Education, 2019b).

Opportunities for increased cross-sector collaboration exist within these proposed reforms. The current government supports a move from a solely individualistic system approach to a more pluralistic one that is "deliberately networked and supported" (Ministry of Education, 2019b, p. 12). Furthermore, a return to a more aggregated and regional approach is aimed at supporting positive learner outcomes. This approach includes functions where "critical resources and expertise are scarce, and collaboration and coordination can play a crucial role in ensuring learner/ākonga success" (Ministry of Education, 2019b, p. 13). Potentially, this educational approach could favour the progression of relationships with other public sectors, such as health.

The Health and Disability System Review (2020) proposes a health system reform that will change the structure and delivery of health services. As is the focus of the proposed education reform, this health system reform upholds the need to reduce existing inequities. In an overt move from individualism to pluralism, and one that acknowledges New Zealand as essentially a plural society, the reform sees the establishment of a Māori Health Authority. This Authority will work in partnership with the MoH to ensure that the health system achieves its Māori health and equity goals. In addition, contrary to previous neoliberal influences, the reform creates a re-aggregation of the 20 existing DHBs through which health services have been delivered (since 2001) to between 8 and 12. The smaller number of DHBs will be overseen by a new entity, Health New Zealand, responsible for providing healthcare and managing services. Nevertheless, elements of a neoliberal influence remain, with no recommended changes proposed for activities such as a capitation-based funding approach for general practice, co-payments for GP visits or medicines, and the use of commissioning and contracting policies; while a continued role for private business and non-government organisations (NGOs) is retained.

Many similarities underpin the current proposed education sector reform and the imminent health reform in New Zealand. There is an apparent shift away from a previous and somewhat punitive stance based on neoliberal ideology to a position of a plurality of purpose and aspiration that acknowledges the changing and contingent nature of reality. This plurality of purpose emphasises the need for change, focusing on reducing the inequities that currently exist in children's health and education outcomes in New Zealand. Collaboration between the education and health sectors is

key to enabling this change. Understanding the current working relationship will guide future approaches and models of collaborative practice between the two sectors.

Section Two: Education and Health Sector Relationships

Relationships between the two sectors function at three levels; intersector, interprofessional and interpersonal. Understanding how the relationships at these three levels contribute to the current relationship is key to informing the research question. In part two, the focus shifts from providing an evolutional and historical socio-political understanding to considering the relationship between primary schools and health services in New Zealand from the three alternative positions.

Intersector relationships between education and health

Globally, both the education and health sectors are regarded as complex systems. Achieving sustainable collaborative relationships between these is considered difficult, time-consuming, and expensive (Burgess et al., 2015; Keshavarz et al., 2010; Ratnapalan & Lang, 2020; Resnicow & Page, 2008; Rowling & Jeffreys, 2006; Tooher, 2017). Education and health are interdependent. Fostering cross-sector relationships and understanding is imperative to support positive learning and health outcomes for children and young people (Allensworth, 2011; Allensworth et al., 1997; Kolbe et al., 2015). Yet, competing priorities and agendas are common issues between these complex systems, alongside both sectors continuously evolving and requiring those working in and across them to adapt efficiently to change (Keshavarz et al., 2010; Ratnapalan & Lang, 2020).

Imagining stronger relationships between the education and health sectors requires recognition of the diversity and complexities of these sectors (Deschesnes et al., 2003; Keshavarz et al., 2010; Rosas, 2015; Rosas et al., 2009). Rosas (2015) advocated for a systems thinking approach where complex processes, infrastructures, and outcomes require navigating, and the outcome is achieving maximum collaboration. Arnold and Wade (2015) defined systems thinking as “a set of synergistic analytic skills used to improve the capability of identifying and understanding systems, predicting their behaviours, and devising modifications to them in order to produce desired effects” (p. 675). The systems thinking approach is used to help understand the way that systems’

parts interrelate and the cause and effect of interactions within and between systems (Arnold & Wade, 2015; Maani & Cavana, 2007; Ndaruhutse et al., 2019; Rosas, 2015; Williams & Hummelbrunner, 2009).

Internationally, systems thinking has been used in the health sector to address complex issues such as disease transmission and pandemic planning, managing waiting lists, tobacco control and screening for disease (Lebcir, 2006; Ndaruhutse et al., 2019). The World Health Organization (2007) has supported the use of a systems thinking approach and, published a report outlining the essential building blocks for establishing a Health System Framework. In the intervening years, the health sector has taken a more systematic approach to health interventions and has frequently drawn on systems thinking when designing policies and programmes (De Savigny & Taghreed, 2009). An example of such is Public Health England's (2019a, 2019b) introduction of a guide for local authorities, which utilises a systems thinking approach to tackle obesity in the community. The guide proposes a six-phase process involving system mapping, stakeholder engagement and instigating action planning workshops. Evaluation of the guide implementation showed positive changes in stakeholder awareness of the importance of targeting the broader determinants of health to tackle obesity and the influence of collective action on public awareness.

Systems thinking has an equally important role in the transformation of education as it recognises the functional complexity of the education system whilst remaining focused on improving learning outcomes for all learners as an end goal (Ndaruhutse et al. (2019). Ndaruhutse et al. (2019) emphasised the need for system thinking approaches in this sector to enable collaborative work across organisational boundaries to improve outcomes for all learners. In the education sector, this means looking beyond measurable test scores and adopting a more inclusive, broader vision toward the end goal of improving learning outcomes. However, this is not without its tensions, given the interdependencies between education and wider public policies that are influential in social welfare, early childhood development, employment, and health.

Education-led policy and initiatives

There is currently no formal requirement in New Zealand for the education and health sectors to work together. This lack of a requirement contrasts with other countries,

such as the United Kingdom, where specific legislation stipulates the need for cooperation between key agencies such as education and health. Section 10 of the Children Act 2004 (United Kingdom) specifies that cooperation by all children's services, including schools, is necessary to promote child well-being. Responsibility is placed on the local area authority, and relevant agencies must co-operate with that authority. In the United Kingdom, effective partnerships that help address local children's needs are considered key to safeguarding and maintaining the well-being of children and young people at a service level (Burgess et al., 2015; Collins & McCray, 2012). In contrast, the New Zealand Ministry of Justice administers a similar statute, the Care of Children Act 2004, without stipulating such a requirement. Furthermore, the recent New Zealand Education and Training Act 2020 does not state a need for schools to collaborate with the health sector actively. In the absence of such requirements, in New Zealand, it is a health service provider's relationship with each school, and the responsiveness of school principals to the health service provider, that determines the extent and sustainability of health provider activity in schools (Denny et al., 2012; King et al., 2014).

To support those working in the education sector to assist children attending school with existing long-term health conditions, the New Zealand MoE (2006) produced a guide entitled 'Health Conditions in Education Settings: Supporting Children and Young People'. The guide focused on children with chronic health conditions and provided advice on establishing school policies and procedures that would support attendance and engagement in learning. Until 2021, this guide was the only direct reference provided by the MoE, for school staff, about managing and supporting children with health conditions in the early childhood and primary school setting. However, there was no obligation or mandate for schools to adhere to the recommendations provided in the guide, including working with health providers in schools.

More recently, the MoE has provided guidance for schools on its website regarding policies and protocols for supporting children with health conditions (https://www.education.govt.nz/). Missing is any overt mention of the education sector coordinating with health providers to support learners or information on access to government-funded universal school health services (Ministry of Health, 2021b). The MoE webpage does provide links to specific health conditions and details strategies for

teachers to use in support of classroom learning for affected children. However, there is no requirement for schools or teachers to comply with the guidance provided; the level of compliance stated on the webpage is 'Inform'. As a result, school health policies and protocols vary significantly between New Zealand schools.

The past decade has seen a steady increase in the number of programmes and initiatives from the education and health sectors aimed at supporting the health and wellbeing of children, young people, and their families. These initiatives correspond with an increase in reported social, emotional, and behavioural problems among children and young people living in New Zealand (Ministry of Health, 2018b, 2018c). In 2010, in response to the increasing exclusion, stand-down and suspension rates in New Zealand schools (Education Counts, 2021a, 2021b; Savage et al., 2011), the MoE implemented a Positive Behaviour for Learning (PB4L) initiative. This initiative aimed to improve the behaviour and wellbeing of children and young people by implementing several evidence-based programmes and interventions. The New Zealand PB4L initiative originated from the Positive Behavioural Interventions and Supports (PBIS) programme initiated by the University of Oregon in 1998 which focused on improving the effectiveness, efficiency, and equity of schools and other agencies in providing children and young people with social, emotional and behaviour support (Center on PBIS, 2021). The fundamental principles of PB4L are partnership, collaboration, and transparency (Boyd et al., 2014). In New Zealand, the PB4L initiative continues to be funded by the MoE and is aimed at individuals, groups, teachers, schools, parents, and whānau (TKI: Te Kete Ipurangi, n.d.). Within the PB4L initiative, seven programmes are currently targeted at different age groups and needs. One of the programmes, PB4L School-Wide (PB4L-SW), caters to primary and secondary school-aged students and aims to create a framework to build a school culture that promotes positive behaviour and supports learning for all students through maintaining the capacity to individualise learning needs and approaches. Although not compulsory for schools to participate in the programme, PB4L operates in many New Zealand pre-schools and schools.

In terms of behaviour, the PB4L-SW initiative operates on the understanding that when a child misbehaves at school, it is because they have not learned the appropriate social skills to interact positively (Savage et al., 2011). From a PB4L perspective, the response is to teach more acceptable ways to behave, thereby upholding the premise

that positive behaviour is a skill that is controllable by the learner. Yet importantly, from a health perspective, behavioural issues in children can be linked to undiagnosed medical, behavioural, or mental health conditions, such as attention deficit hyperactivity disorder (ADHD), autism spectrum disorder (ASD), anxiety disorder, oppositional defiant disorder (ODD), depression, and physical health conditions such as asthma, diabetes, and epilepsy (Loe & Feldman, 2007; Lozoff et al., 2000; Ogundele, 2018; Taras & Potts-Datema, 2005). In addition, mental and physical health issues can co-exist as associated diagnoses or as a consequence of each other (Butler et al., 2018; Levy et al., 2010; Russell et al., 2020; The Challenging Behaviour Foundation, 2021). Thus, from a health perspective, a child's inability to behave positively may be linked to underlying health conditions that require medical interventions and behavioural strategies to manage the observable behaviours positively.

While the PB4L-SW model aims to embrace diversity by focusing on environmental and practice changes to support positive behaviours (TKI: Te Kete Ipurangi, n.d.), the absence of early input from the health sector in this initiative can be questioned (Boyd et al., 2014). Arguably, health services working in schools are members of that community; furthermore, the inclusion of health services would align with the PB4L principles: partnership, collaboration, and transparency. Additional value in involving the health sector in the PB4L initiative rests in the knowledge that some emotional and behavioural problems experienced by children and young people can indicate an underlying medical and behavioural condition. Therefore, it is justifiable to support the view that those working with the PB4L programme employ a more holistic approach to identifying and managing concerning behaviour and consider timely collaboration with the health sector.

Several other education-led initiatives provide platforms to promote collaboration between the education and health sectors in New Zealand. One initiative - 'Investing in Educational Success' (IES) - was launched by the MoE in 2014 (Rawlins et al., 2014). Promoted as an initiative to lift student performance and create career pathways for teachers, IES aimed to encourage greater collaboration between schools by recognising and using professional expertise where it is most needed (Rawlins et al., 2014). Communities of Learning/Kāhui Ako (MoE, 2016) formed part of the original IES initiative, enabling cluster networks of primary and secondary schools and sometimes

including early childhood centres. These clusters are most often geographically determined. Their intention is to work together on shared activities to help students in the designated cluster reach their potential. However, the Communities of Learning (CoL) alliance is an inter-school arrangement, not inter-sectorial. These clusters could include health considerations to support student achievement and thus allow collaboration between the two sectors. The benefits of doing so derive from the interrelatedness of a child's health status and their ability to engage in learning activities (Basch, 2011b; Eide & Showalter, 2011; Fiscella & Kitzman, 2009; Gracy et al., 2017; Hoffman et al., 2018).

There are several examples of CoLs actively seeking collaboration with the health and social sector across the country. One example is Te Kāhui Ako o Tiriwā, a CoL in the northwest region of Auckland, who identified in their strategic plan that if they addressed the health and wellbeing issues of their student community, they would be better positioned to address children's learning achievement. One of the CoL's strategic action points is to collaborate with health agencies (Te Kāhui Ako o Tiriwā, 2018).

Lakes DHB has recently commenced another initiative involving CoL. The Wellbeing in Schools Project (WISP) aims to support the school workforce around child health and wellbeing. The pilot project will partner with two local CoLs in 2022 who will interact with the WISP multidisciplinary team (Lakes District Health Board, 2021). Despite these promising efforts to mobilise a collaboration with the health sector through CoL, Kamp (2019) cautioned that success is pre-determined by the degree of willingness of the CoL leaders to implement structures and processes that build sustainable active engagement with others, both within and outside of the education sector.

Other MoE-led initiatives to support children with learning and health needs at school include the Learning Support Action Plan 2019-2025 (Ministry of Education, 2019a). This plan aims to progress an inclusive education system by providing a range of learning environments where children with additional learning needs, including those resulting from health and disabilities, can be supported to learn. The Learning Support Action Plan is comprehensive and includes an intention to work with the health and disability sector. The plan provides an ideal opportunity for formal collaboration

between the education and health sectors but has little reference on how or at what points in the plan this should occur and with whom. This new opportunity could, however, establish relationships that support children with health needs that impact their learning to achieve.

Early in 2021, the MoE established Curriculum Wellbeing Leads (Ministry of Education, 2021) to provide frontline support for early learning services and schools in teaching mental health and well-being and integrate these into everyday learning activities. Some of the associated teacher resources, such as the wellbeing and mental health teaching resource (Fitzpatrick et al., 2018), make overt recommendations for teachers to connect with health service providers, such as school nurses and counsellors, to support their teaching. However, the lack of a formal collaboration agreement between the education and health sector means the responsibility remains with teachers to elicit this support when required.

As referenced in the preceding section, over the past 10 years, initiatives have been increasing that aim to improve the health and wellbeing of children and young people. However, these are currently acted upon separately and often lack a holistic approach. Notably, some of these recent education-driven initiatives (Ministry of Education, 2019a, 2021; Rawlins et al., 2014) desire more support from the health sector but in the absence of a formal collaborative agreement between the two sectors, the act of seeking such support remains the responsibility of individual schools and the teachers within them.

The ongoing New Zealand MoE-led plans and initiatives include specific Māori and Pacific education strategies. *The Māori Education Strategy: Ka Hikitia – Accelerating Success 2013–2017* (Ministry of Education, 2013) comprises five guiding principles: excellent outcomes; belonging; strengths-based; productive partnerships (between learners, whānau, hapū, iwi educators and *others*) and upholding the principles of Te Tiriti o Waitangi (Te Tiriti o Waitangi [Māori version], 1840). A revised Ka Hikitia was released in June 2020 (Ministry of Education, 2020c), emphasising a cross-agency strategy for the education sector. Despite an emphasis on building productive partnerships, the education strategy is focused on adopting a *within-sector* perspective while simultaneously acknowledging that the education system continues to

underperform for Māori learners. Notably absent is a focus on cultivating interagency across-sector relationships with the likes of health to achieve Ka Hikitia's vision. Such a focus would acknowledge the interdependence of education and health and the existing inequities for Māori children across both sectors.

The Action Plan for Pacific Education 2020-2030 (Ministry of Education, 2020a) also outlines key focus areas similar to Ka Hikitia but focused on Pasifika children and youth. Equally, the plan lacks any suggestion or inference to working collaboratively alongside health services to support its objectives. In the absence of policies and guidelines that proactively advocate for collaborative working or that emphasise the value of intersector relationships in supporting positive outcomes for children, it is debatable whether any significant progress is likely in the foreseeable future. Currently, from an education-led perspective, there are many missed opportunities for the education and health sectors to collaborate (Education and Training Act 2020; Ministry of Education, 2006; Rawlins et al., 2014)

Health-led policy and initiatives providing opportunities for collaboration

The current New Zealand Health Strategy: Future Direction (Ministry of Health, 2016) outlines the intended direction for the health system from 2016 to 2026. The strategy has five themes, two of which could leverage the provision of health services in schools as a way in which to support the strategy's goals. The first relevant theme, 'Closer to Home', focuses on providing healthcare closer to where people live, integrating health services, promoting wellness, and investing in health and wellbeing early in life by focusing on children, young people, and their families and whānau. The provision of health services in schools could encompass these health service goals. However, this strategy does not reference school health services as community-based services available to children and young people. This lack of reference may be due to the regional variation in national provision and visibility of such services. The second relevant theme, 'One Team', aims to achieve a more cohesive healthcare approach across the health and disability sector by fostering better collaboration. Repeatedly, and as evidenced in education strategies, this focus is within-sector rather than promoting external collaboration.

The 2014 *Māori Health Strategy: He Korowai Oranga* (Ministry of Health, 2014b) set a strategic direction for Māori health development in New Zealand. The framework to achieve the best health outcomes with Māori created by the Government and the health and disability sector, He Korowai Oranga, has four key aims: Pae Ora (healthy futures for Māori), Mauri Ora (healthy individuals), Whānau Ora (healthy families), and Wai Ora (healthy environments). The strategy includes four He Korowai Oranga framework pathways to guide and support its implementation. Of note, the fourth pathway, Te Ara Tuawhā, upholds a commitment from the invested parties to work across sectors and stipulates that this is not the health sector's responsibility alone. The strategy document promotes closer alignment between health and social services to create opportunities for delivering services more effectively to improve outcomes with Māori across a range of areas. In this context, working with the education sector is loosely implied but not explicitly stated.

The more recently released *Whakamaua, the Māori Health Action plan 2020-2025* (Ministry of Health, 2020b), provides a road map of actions to achieve health and wellbeing with Māori, the overarching aim of He Korowai Oranga (Ministry of Health, 2014b). The plan guides the health sector to elicit results in line with He Korowai Oranga. One promising element of this action plan is its stated "ability to evolve in collaboration with stakeholders" (Ministry of Health, 2020b, p. 21), potentially providing an opportunity for collaboration with the education sector to meet the needs of Māori students who may not have the resources to access primary health care services.

The equivalent national health action plan for Pacific people living in New Zealand is *Ola Manuia: The Pacific Health and Wellbeing Action Plan 2020-2025* (Ministry of Health, 2020a). Ola Manuia expands on a previous Pacific health action plan, Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014-2018 (Ministry of Health, 2014a). Ola Manuia sets out the priority outcomes and actions to assist Pacific people in achieving better health outcomes over a five-year period. The plan recognises that in order to improve health outcomes for Pacific peoples, services must be tailored to meet both individual and collective needs in a culturally appropriate manner (Health Navigator New Zealand, 2020). There is, however, no mention in the action plan of

working alongside schools as a strategy for supporting health and education outcomes for Pacific children and young people.

Information sharing between the education and health sectors

Information sharing supports effective working relationships across organisations but has inherent challenges (Yang & Maxwell, 2011). Currently, health professionals working in schools frequently face the dilemma of how much health information can be disclosed to school staff, potentially hampering collaboration efforts with those working in schools. Under section 22c of the Health Act (1956), which relates to the disclosure of health information, MoE employees are not referred to as a specified person with whom health information may be disclosed. Lack of clarity on the boundaries for information sharing can be challenging for health professionals invited to participate in multidisciplinary discussions. Special Education Needs Coordinator (SENCO) meetings fall into this challenging context category. The New Zealand Privacy Act 2020 may reduce these challenges. Section 141 of the Privacy Act states that two or more public sector agencies can enter into an information-sharing agreement. A formal process is required to construct an information-sharing agreement; nevertheless, this Act does allow for a more formal intersector agreement between education and health to be established, bolstered by legislation.

Community-focused initiatives that create opportunities for advancing intersector relationships

From a national programme perspective, an example of good intent in fostering intersector collaboration is Healthy Families New Zealand (HFNZ). A MoH-led initiative, HFNZ focuses on the health and wellbeing of whole communities, involving schools, councils, DHBs, community groups, social services, and local iwi. This initiative targets communities with increased risk factors for preventable diseases and high levels of deprivation. It recognises the inter-sector roles required in laying the foundations for a healthier future for children and young people (Ministry of Health, 2021a). Thus, the opportunity exists for health professionals to work in schools and play a significant role in the HFNZ initiative in communities. While HFNZ is an example of a focused policy that can create opportunities for promoting effective inter-sector working relationships, it has omitted a key player - the providers of school health services.

In contrast to these lost opportunities for inter-sector collaboration, several successful small-scale individual health-education sector collaboratives have occurred in recent years; including Mana Ake – Stronger for Tomorrow (https://manaake.health.nz/), an initiative providing support to children in school years 1-8 in the Canterbury region of New Zealand. The Mana Ake programme commenced in 2018 in response to the increase in mental health needs of children and young people following the Canterbury earthquakes of 2011. Mana Ake highlights the power of collaborative relationships by creating resources, building connections, and supporting communication between schools and other agencies such as health. The initiative supports health and education to work together from the outset, facilitated through Mana Ake kaimahi (workers) to support the needs of children and their families (Impact Lab, 2020). Interfacing with the Mana Ake initiative is the Stronger Schools Aotearoa platform (https://www.strongerschools.org/), which delivers health and wellbeing guidance to teachers and school staff involved in coordinating learning support and pastoral care. The platform explicitly outlines how to access education, health, and social services in response to the identified needs of individual children.

Current status of education and health intersector relationships

It is evident that the education and health sectors in New Zealand currently operate independently from one another, with few afforded opportunities to work together. Where opportunities arise, these are often overlooked, resulting in unlinked, separate initiatives and ad hoc planning to achieve essentially interdependent outcomes. Although widely acknowledged in the literature, an awareness of the interrelatedness of health and education does not translate well into policy and practice (Bevc et al., 2015; Zimmerman et al., 2018). Hindering any attempts at collaboration is the current siloed way of working between education and health in many countries, including New Zealand, as well as a lack of public understanding of the social determinants of health (Bevc et al., 2015; Kaufman et al., 2014; Ream et al., 2015; Zimmerman et al., 2018).

Education and health typically fall under different governmental authorities. Compounding this separation are the leaders in health and education, who rarely appear to connect their priorities and goals, or share information (Chahine et al., 2018; Ream et al., 2015; Zimmerman et al., 2018). Zimmerman et al. (2018) have reported

the negative impact of siloed working on the ability to champion the relevance of interagency collaboration between education and health as "another impediment that exists between policymakers and practitioners whose preoccupation with their own field often leaves them unaware of the great relevance of other fields" (p. 746).

Ream et al. (2015) reported that a competing demand for funding and public and legislative attention has nurtured silos rather than addressing the across agency needs and identifying common goals. This view is supported by Bevc et al. (2015), who suggested that while it is widely accepted that fostering interagency collaboration to achieve public health outcomes has advantages, the complex nature of doing so has made it challenging to translate the benefits into practice. The siloed nature of the education and health sectors in New Zealand will likely remain if there is no commitment made to establish a structure through which the two sectors can sustain effective communication and collaboration. Ironically, the two sectors are working towards common goals, yet, neither sector is entirely aware of what the other is doing or how interdependent their relationship is. If the interrelatedness between education and health is not fully appreciated at a systems level, the ability to perceive a shared purpose will remain limited.

Interprofessional relationships between education and health

When considering professional disciplines in general, it is necessary to acknowledge that each profession, including education and health, has its own culture. The specific cultures, which have evolved and are perpetuated by the members of a profession, include values, beliefs, attitudes, language, customs, and behaviours (Chipaco & Branco, 2018; Mowrey, 2020). Those entering professional occupations are socialised and encultured into ways of thinking, behaving, and valuing from early in their initial education. These patterns become ingrained over time with continued practice in the related field. This process has been referred to as 'professionalisation' (de Boer et al., 2018; Hall, 2005; Mowrey, 2020).

How a profession views itself is significant in forming and maintaining interprofessional relationships. Both Clark et al. (2002) and Hall (2005) have argued that professionalisation has orchestrated siloed working between different professions. Often, a limited opportunity is afforded at the undergraduate level for students to

interact with and learn from and about other disciplines and professions. Hall believed this contributes to perpetuating non-collaborative practices as individuals advance in their professional lives. Other related studies, not necessarily specific to health and education, support this notion and suggest the environment is set early for a propensity to work in professional silos, with communication skills usually focused on those needed to interact with stakeholders, rather than across professions (Clark et al., 2002; McCallin, 2001; Schot et al., 2020; Tsz-Sum Lee & Doran, 2017; Vanclooster et al., 2018).

Health care providers in schools, both internationally and in New Zealand, rely on opportunities for collaborative consultation with their education counterparts. Good relationships are pivotal to successful collaboration, particularly concerning teachers and health professionals (Burgess et al., 2015; Ødegård, 2005; Widmark et al., 2011). However, establishing working relationships across professional disciplines can be challenging (Beddoe, 2019; Villeneuve, 2009; Winitzky et al., 1995; Yu et al., 2016). Still, issues such as role ambiguity, availability, use of common language, and a shared understanding of the educational relevance of health service provision can complicate the relationship (Garvis et al., 2016; Hall, 2005; Hasselbusch & Penman, 2008; Mukherjee et al., 2002; Ødegård, 2005; Villeneuve, 2009). As a result of these issues, expectations among professional groups regarding the benefits of forming a working relationship can vary.

Barriers and enablers to intersector interprofessional relationships

Internationally, interprofessional collaborative practices are not always established or invested in as a matter of course, often resulting in ad hoc meetings and sub-optimal communication (Ball & Howe, 2013; Glover et al., 2015; Mukherjee et al., 2000, 2002; Vanclooster et al., 2018). Poor communication and unsatisfactory collaborative practices are highlighted in the teacher-health provider context when attempting to reintegrate children into school following significant illness, disability, or those who suffer from long-term health conditions (Mukherjee et al., 2000; Olson et al., 2004; Vanclooster et al., 2018).

Teachers and healthcare providers appear to welcome better collaborative working relationships and practices, including integrative education and collaboration but

recognise the challenges in doing so (Glover et al., 2015; Vanclooster et al., 2018; Villeneuve, 2009). One of the most significant challenges is time (Mukherjee et al., 2002; Ødegård, 2005). Healthcare providers and teaching staff are busy, and many profess that regular face-to-face contact between the sectors is difficult to organise around their day-to-day responsibilities. Yet, establishing relationships, reflecting, and navigating how best to work together and provide feedback is critical to effective interprofessional practice (Bronstein, 2003; Green & Johnson, 2015; Helleve et al., 2020; Weist et al., 2012). International studies identify an expectation that teachers and health staff will find time to meet and collaborate, but there is little evidence that their management lines provide support for this to happen (Bronstein & Abramson, 2003; Mukherjee et al., 2002; Ødegård, 2005; Tooher, 2017; Weist et al., 2012). Due to the lack of available studies, it is unclear how significant this finding is in New Zealand.

Communication is considered a key factor, alongside time, in supporting and sustaining interprofessional relationships. Respectful sharing of information and receiving feedback fosters successful collaborative efforts and is central to interprofessional relationships and teamwork (Baweja et al., 2016; Garvis et al., 2016; McCallin, 2001; Mukherjee et al., 2002). Regarding those who work with children but do not frequent the school setting, such as paediatricians and medical specialists, providing feedback or collaborating with schools is challenging (Bradley-Klug et al., 2010; Vanclooster et al., 2018; Villeneuve, 2009). There is a lack of research about such collaborative efforts in the New Zealand context. In a study by Bradley-Klug et al. (2010) in the United States, paediatricians were asked what influenced their communication and collaboration with school staff. They reported having little time, limited access to school staff, and not knowing whom to contact at the school as the main reasons for their minimal contact. Of significance in this study was that older, more experienced paediatricians were more likely to collaborate and communicate with school staff than those who had recently joined the professional specialty. A proposed explanation was that more experienced paediatricians may have established contacts with a particular school or had recognised the benefits of interprofessional collaboration over time.

Role clarity between professions is also considered pivotal to sustaining collaboration. Commonly, the adherence, by health care professional groups, to selective lenses for viewing health care with related priorities, and the use of profession-centric

terminology and language, can create an environment of misunderstanding and mistrust (Flood et al., 2019; Hall, 2005; Stone & Charles, 2018). Winitzky et al. (1995) described instances of cultural conflict from a professional perspective and the importance of recognising that different disciplines prioritised the same ideals of meeting the needs of children but in different ways. These findings are consistent with more recent studies relating to interprofessional relationships (Akkerman & Bakker, 2011; Cumming & Wong, 2012; Garvis et al., 2016; Glover et al., 2015; Hall, 2005; Hartas, 2004; McCallin, 2001; Mukherjee et al., 2002; Ødegård, 2005; Weist et al., 2012).

Relationships build over time. Frequent changes in health care personnel, particularly nurses working in schools, are detrimental to sustaining working relationships (Collins & McCray, 2012; Hasselbusch & Penman, 2008; Helleve et al., 2020). To minimise change and support the school-health care provider relationship, health professionals require time and effort to understand the school structure and the education culture as a whole (Hall, 2005; Maughan & Adams, 2011). Furthermore, a focus on understanding each school's ethos and unique context, along with the available resources, can assist with relationship building across the sectors (Hasselbusch & Penman, 2008; Saaranen et al., 2005).

Interprofessional training for school staff and healthcare providers has been proposed and should be a focused priority to nurture relationships through a shared understanding of each other's roles and responsibilities (Baweja et al., 2016; Frauenholtz et al., 2017; Hasselbusch & Penman, 2008; Oelke et al., 2016; Paavola, 1995; Yu et al., 2016). Currently, guides to interprofessional education sit mainly within the context of health settings, with limited information available to inform the process across sectors, between primary and secondary education and health professionals. Opportunities for interprofessional training and collaboration within the school setting are limited, primarily due to time constraints (Bronstein & Abramson, 2003; Friend & Cook, 2010).

Interprofessional relationships between teachers and health service providers

Historically, nurses have been considered trusted providers of health care in schools, acting as key advocates and liaisons between schools and other health care providers

for the children and young people for whom they care (Buckley et al., 2012; Chayer, 1953; Juszczak et al., 2003; Kolbe, 2019; Magalnick & Mazyck, 2008; Oda, 1974). Most contemporary research has focussed on school nursing, although this is limited in the New Zealand context. A study conducted in 2011 in the United Kingdom asked teachers, children, young people, and their caregivers to share their views and experiences of school nursing services to help inform future service development at a national level (British Youth Council, 2011). Resoundingly, all respondents described the necessity of access to a school nurse. They also suggested that nurses should spend more time and be more visible in schools, and should be introduced, along with the service provided, to students and their families from the start of a child's schooling (Department of Health, 2012).

Although not considered a health service per se, the relationship between social workers (SWiS) and school staff in New Zealand is reported as very positive (Education Review Office, 2019; Jiang et al., 2018). Most SWiS workers in New Zealand are employed exclusively by non-government organisations (NGOs) rather than by the MoE or MoH, with some schools having chosen to hire a SWiS independently. A recent review of SWiS suggested that the independent NGO contracting model can challenge relationship-building due to competing priorities and agendas between the contracted social worker and schools (Oranga Tamariki Evidence Centre, 2020). Conversely, when social workers maintain an unimpeded focus through not being employed directly by a school, it is less complicated for them to advocate for children and families in the community (Beddoe, 2019; Beddoe et al., 2018; Education Review Office, 2019; Jiang et al., 2018; Oranga Tamariki Evidence Centre, 2020; Sherman, 2016). Building relationships is considered an essential aspect of good school social work practice (Beddoe, 2019; Beddoe et al., 2018; Belgrave et al., 2002; Jiang et al., 2018). However, it is not always straightforward, with recurring issues raised on the lack of shared understanding between teachers and social workers, ambiguity over role expectations, the degree of visibility, and social workers adequately advocating for themselves as offering a legitimate service necessary to have available to schools (Altshuler & Webb, 2009; Sherman, 2016).

Studies of other health professionals who deliver services in the school setting include descriptions of speech-language therapists (SLTs) (Glover et al., 2015; Hartas, 2004)

and occupational therapists (OTs) (Bose & Hinojosa, 2008; Hasselbusch & Penman, 2008; Villeneuve, 2009). In regards to SLTs, both Hartas (2004) and Glover et al. (2015) reported that time constraints impact the SLTs' ability to collaborate with teachers and vice versa, a similar finding to that of nurses and social workers working in schools (Helleve et al., 2020; Jiang et al., 2018; Oranga Tamariki Evidence Centre, 2020; Schroeder & Smaldone, 2017). In addition, lack of communication, and a common language, and deficiencies in structure relating to how collaborative meetings should occur were cited as detrimental to interprofessional working and relationships (Bose & Hinojosa, 2008; Hartas, 2004).

Regarding OTs and their collaborative relationships with teachers, time is an issue for both parties. A lack of time to meet, combined with the limited availability of the OT at the school, significantly restricts opportunities to build collaborative working relationships (Hasselbusch & Penman, 2008; Villeneuve, 2009). From teachers' perspectives, there is a perceived need for greater clarity on the OT's roles and responsibilities to determine a starting point for collaboration (Bundy, 1995; Hasselbusch & Penman, 2008; Villeneuve, 2009). The need for OTs to better understand the school context, classroom practices, and curriculum is also highlighted (Bose & Hinojosa, 2008; Villeneuve, 2009)

Findings from studies that focus on the relationship of nurses, social workers, and SLTs, with teachers and school staff are remarkably consistent, both nationally and internationally (Altshuler, 2003; Fleming & Willgerodt, 2017; Glover et al., 2015; Hartas, 2004; Helleve et al., 2020). Considering the interprofessional relationships and collaboration between teachers and health providers, it appears that both professions welcome collaborative practice and the benefits to children and young people of doing so are mutually agreed upon. Ways to improve the working relationship include increased time spent together, shared language and understanding, role clarity, increased communication, and opportunities for interprofessional education (Flood et al., 2019; Nancarrow et al., 2013).

Professional interpersonal relationships between teachers and health providers

Examining the relationship between schools and health services involves understanding how this relationship functions between the two sectors at an

interpersonal level. Over 70 years ago, educator and scientist in speech communication, Professor Elwood Murray (1948), wrote that "although we live in a world of competition, every crucial problem now appears as a problem of men [sic] learning to work together in their various capacities as members of families, industries, communities, nations and the world" (p. 79). At that time, Murray suggested that 'communicating behaviour' was an essential factor in working with others on an interpersonal level. Parmar (2013) builds on this notion, suggesting that communication is necessary for people to orient and relate to different environments and that individuals' personalities evolve out of communication interactions. Parmar further claimed that conversation as a way of communication can often make or break the ability to solidify relationships with others.

Interpersonal workplace relationships are an inescapable reality, where positive relationships are associated with better individual and work-related outcomes (Reich & Hershcovis, 2011). Some authors have asserted that the relationships individuals have with others influence how they view themselves, with people feeling the need to 'fit' within the context of the interaction before being open to building trust and respect (Marzano et al., 2006; Reich & Hershcovis, 2011; Robertson et al., 2020). Heaphy and Dutton (2008) provided a helpful distinction between a 'connection' and a 'relationship' in the context of general workplace associations. A connection involves mutual awareness of each other's existence and that an interaction has occurred. In comparison, a relationship develops from the recurrence of these connections and interactions. Reich and Hershcovis (2011) advanced this notion by defining an 'interpersonal relationship' as: "an individual's subjective experience of repeated interaction or connection with another individual" (p. 5). These insights shed light on the perceptions school staff may have of their experiences interacting with health providers and whether these interactions are understood as part of an ongoing relationship or merely as ad hoc connections.

In terms of interpersonal relationships between teachers and health providers, Bose and Hinojosa (2008), in a study conducted in New York, explored OTs experiences of collaborating and interacting with teachers. From the perspective of OTs, the ease with which positive interpersonal relationships developed was teacher-dependent.

Receptive teachers were depicted as open, flexible, friendly, and supportive, and appeared to like their work and students. Conversely, teachers who were less receptive to building professional interpersonal relationships were described as resistant, apathetic, stuck in their ways, and standoffish (Bose & Hinojosa, 2008). Teacher responsiveness to the OT was seen as either an enabler or a barrier to collaboration. Nancarrow et al. (2013) described similar findings in their British study relating to interprofessional teamwork. Their findings revealed that individual characteristics and personal attributes affected interpersonal relationships, which in turn affected collaborative teamwork among health care professionals. Qualities considered beneficial to building interpersonal relationships and contributing to teamwork included approachability, ability to compromise, empathy, tolerance, patience, personal responsibility, and decisiveness.

Considering interpersonal relations from a social cognitive perspective, Tsz-Sum Lee and Doran (2017) explained that relationships result from interpersonal behaviour processes, with communication being a manifestation of a relationship. This notion is supported by others (Baker et al., 2011; Havens et al., 2010). The research focused on collaboration between health professionals has shown that good interpersonal relationships are positively associated with care coordination in outpatient clinics (Lee, 2013). This finding supports those from a similar study examining nurse reports of relational coordination between nurses and other providers, where respect played a significant part in maintaining positive interpersonal relationships across disciplines, as did allowing time and support for such relationships to develop (Havens et al., 2010).

Interpersonal relationships play a vital role in the very nature of the work teachers, and health professionals do. Relationships between individual team members are a significant factor in achieving successful collaboration (Marzano et al., 2006), with personal characteristics playing a critical role. Positive interpersonal relationships are also crucial for creating personal meaning in an individual's day-to-day work (Robertson et al., 2020). Conversely, in a study examining teacher relationships with four key stakeholders, Van Droogenbroeck et al. (2014) showed that negative interpersonal relationships within and across teams and professionals contributed to teacher stress and burnout.

With respect to interpersonal relationships between school staff and school nurses in Norway, Helleve et al. (2020) sought to identify barriers and facilitators of structured collaboration in the school setting. Both parties perceived the relationship between the principal and the school nurse as particularly important. This relationship, plus those of school nurses with classroom teachers, was built over time. Of note, one nurse in this study perceived that the relationship she had with each classroom teacher influenced whether she saw students from their class. Personal attributes (those of the nurse in this study), such as being positive, respectful, and available, influenced collaboration and relationship building from the teachers' perspective. These findings reflect a similar study conducted in California by Biag et al. (2015).

In New Zealand, forming professional interpersonal relationships between school staff and health providers is pivotal in facilitating student access to health services in the primary school setting. However, currently, there is no legislative intersector agreement that requires the two sectors to work together. Consequently, there is no agreed framework for forming and maintaining interprofessional working practices between teachers and health professionals. Hence, primary school teachers' relationship with health service providers relies on positive interpersonal relationships. Not surprisingly, therefore, in the current context, few New Zealand studies focus specifically on exploring *interpersonal* relationships between teachers and health professionals.

Concerning health professionals forming relationships with other professionals, a study conducted in New Zealand by McCallin and Bamford (2007) observed that few health professionals were educated and skilled in the art of interprofessional relationship building. Based on the findings of their hospital-based study, McCallin and Bamford promoted the influence of emotional intelligence on teamwork and interpersonal relationships, proposing that most people will experience some degree of anxiety in building interprofessional working relationships for many reasons. The authors claimed that a mitigating factor is when colleagues trust and feel emotionally secure with each other. In McCallin and Bamford's view, having expertise and cognitive intelligence is not enough; working in teams and building positive interpersonal relationships requires emotional intelligence to work effectively with colleagues, clients, and families. Self-awareness, self-management, social awareness, and social skills were

central to emotional intelligence, which McCallin and Bamford argued sits at the heart of effective teamwork. Evidence of how such attributes might apply to cross-sector interpersonal relationships, such as school staff and health providers, is lacking.

In a similar study, Flood et al. (2019) collected interview data from 12 health professionals across various disciplines to investigate inter-professional practice's understandings and perspectives. From an interpersonal perspective, the study highlighted the importance of seeking common ground as a starting point and of being open to others: "openness brings vulnerability and hope. In the moment of reaching out, one has no way of knowing how the other will respond" (Flood et al., 2019, p. 499). The study concluded that purposeful relational encounters with others on an interpersonal level are essential in working successfully in an interprofessional context' to which the individuals' interpersonal skills, capabilities, and attributes to the working relationship are central. Mutual trust and respect are also crucial in building good interpersonal relationships (Flood et al., 2019, 2021).

Information sharing is common practice between teachers and health professionals; however, the extent to which this occurs in New Zealand sits within the confines of national and sector-level privacy and confidentiality legislation. Understanding the factors influencing it from both perspectives is essential (Yang & Maxwell, 2011). Interpersonal relationships play a role in information sharing, with research highlighting the importance of factors such as motivation, mode, and approach (Jarvenpaa & Staples, 2000; Rioux, 2005). Interpersonal information-sharing barriers include privacy and mistrust in the sharing relationship (Razavi & Iverson, 2006); to counteract this, Yang and Maxwell (2011) claimed that interprofessional socialisation between individuals is essential in facilitating information sharing. Providing appropriate legislation and policies to support this increases trust. In the context of the relationship between schools and health services, this has relevance as an individual's perspective on information sharing can potentially impact the timeliness of supportive interventions.

Successful interprofessional collaboration relies on the strength of interpersonal relationships. Relationships are reciprocal; professionals spending time together to

engender trust, respect, and mutual understanding in the work context will help build positive interpersonal relationships.

Literature review summary

The establishment in 1912 of the School Medical Service marked the beginning of the relationship between teachers and providers of health services in schools. The Department of Education was initially responsible before transferring this responsibility to the Department of Health in 1921. At this time, nurses began to lead school health service delivery and taught specific health topics. This change in leadership marked the Department of Health's shift from environmental health to personal health and wellbeing (Tennant, 1991).

Neoliberalism strongly influenced education and health sector reforms from the 1980s onwards and shaped the relationship between the two sectors. Since then, there has been no nationally directed infrastructure for delivering school-based health services or any formally recognised benchmark for collaboration between education and health. In addition, there is no framework for what services should be provided or what health outcomes should be measured. As a result, there is potential for more variance and fewer opportunities to improve children's and young people's health.

The New Zealand education system is based on independent, self-governing schools, which creates challenges in delivering health services, particularly as schools are not required to collaborate with the health sector. However, acknowledging the two sectors' complexity, recent reforms provide an opportunity to improve the current siloed working practices and formalise collaboration and relationships.

Limited international and New Zealand literature focuses on the working relationship between primary schools and health service providers; despite acknowledgement by both sectors of the importance of early intervention to improve educational and health outcomes (Elek et al., 2017; Moore & McDonald, 2013; Powell et al., 2019), and the interrelatedness between learning and health (Zajacova & Lawrence, 2018; Zimmerman & Woolf, 2014)

In the absence of a directive for the education and health sector to work together, and given the constraints of the current operational structures, the relationship between health and education is almost totally dependent on and vulnerable to interpersonal relationships. Studies on teachers' relationships with specific health professionals have been undertaken, particularly regarding teachers and nurses working in schools. These relationships rely on positive personal attributes to support them and opportunities to build respect and trust and understand each other's professional culture and perspectives (Flood et al., 2014).

Relationships between schools and health services influence working practices from an intersectoral, interprofessional, and interpersonal perspective. These three levels of relationship are interconnected; without one, the others are invariably affected. If the end goal of an education-health collaboration is to improve learning and health outcomes for children and young people, sustained collaborative efforts must occur across all three levels.

This literature review describes how the relationship between education and health in New Zealand has evolved. Given the variable and non-mandated requirement for the two sectors to work collaboratively, this thesis seeks to answer the overarching question: **What is the perceived relationship between primary school staff and health services in New Zealand, and how is this relationship influenced?** In the context created by the evolution of the education and health care systems and their interrelationships, this review identifies the need to investigate the current working relationship between staff in primary schools and health staff in New Zealand and how this relationship is influenced. The importance of undertaking such an investigation is to support those children and young people whose health status precludes, hinders, or at worst, prevents their ability to learn in a school environment.

Chapter 3 Methodology

Education and health are interrelated, with education considered a social determinant of health and good health a prerequisite for optimal learning experiences (Costante, 2002; Cutler & Lleras-Muney, 2006; Michael et al., 2015). Currently, the education and health sectors work separately in New Zealand with no formal requirement to work otherwise. Whilst opportunities exist for collaboration, many of these are repeatedly overlooked. The pursuit of collaborative opportunities is often short-lived, unable to survive the current within and across-sector siloed working practices.

Little is known about how New Zealand primary school staff perceive health services in their schools or how the two sectors view their working relationship. This study aimed to explore current perceptions of this relationship from an education perspective to help inform future approaches to health service delivery in New Zealand primary schools.

This chapter presents the methodological approach to exploring the relationship between school staff and health services. The philosophical underpinnings of this study are described first, including discussion of the philosophical paradigm and the ontological, epistemological, and axiological perspectives engaged. This is followed by a description of the methodological journey and a more detailed discussion of the methods chosen to inform the research question: **What is the perceived relationship between primary school staff and health services in New Zealand, and how is this relationship influenced?** The research strategy used qualitative case study methodology to explore the relationship school staff have with health services across three primary schools. Data were collected using a combination of interviews, observation, questionnaires and review of professional learning and development offerings to school staff.

Conceptual Framework

This study explored the intersecting relationship between three primary schools and the health services supporting those schools. The study aimed to gain an in-depth

understanding of the perceptions and experiences of participants who interacted with health services in their professional and pastoral support of the students in their care.

Key stakeholder perspectives enable health service providers to assess whether existing health service delivery models require review to meet their aims and objectives (Ministry of Health, 2021b). This study contributed to gaining one such key stakeholder perspective. The objective of gaining such an understanding was to inform future health service delivery models and practices in primary schools.

Research paradigms

Philosophical or theoretical ideas are often hidden in the research process (Slife & Williams, 1995; Treagust et al., 2014), but these beliefs or worldviews directly influence how research is conducted (Guba, 1990). Also referred to as paradigms (Crotty, 1998; Davies & Fisher, 2018; Lincoln et al., 2011), a research worldview refers to common beliefs, assumptions, and agreements shared between researchers. The paradigm choice sets a framework for a researcher to consider and interpret problems and guides subsequent research design choices (Guba & Lincoln, 1994; Mack, 2010; Mackenzie, 2006). Each research paradigm holds unique ontological premises (concerning questions of being and reality) and epistemological assumptions (concerning questions of knowledge and its acquisition), shaped further by the researcher's axiology (beliefs and values) (Grix, 2002; Mack, 2010). Bateson (1972) proposed that a researcher is "bound within a net of epistemological and ontological premises which, regardless of ultimate truth or falsity, become partially self-validating" (p. 320).

Creswell (2013, 2014) highlighted five widely discussed paradigms: positivist, postpositivist, transformative, pragmatist and constructivist. The positivist paradigm maintains that there are facts about the human world that are objectively true; these are discovered and understood through a scientific method avoiding any metaphysical speculations (Davies & Fisher, 2018; Denzin & Lincoln, 2008; Mackenzie, 2006; Mertens, 2010). Positivists believe that truth is only what can be observed, measured, and verified. The postpositivist paradigm is an advancement on positivism in recognising that it is not possible to be absolute about claiming knowledge when the behaviour and actions of individuals are the focus. In the postpositivist paradigm,

research usually involves a process of testing theory through identifying and assessing cause-and-effect relationships. Positivism and postpositivism are often associated with quantitative research, although postpositivism is sometimes adopted in qualitative approaches such as grounded theory (Denzin & Lincoln, 2008; Grbich, 2007; Phillips et al., 2000). Contrasting with the positivist and postpositivist approaches to research, the transformative paradigm has an action agenda that focuses on advocacy to assist marginalised peoples (Jewiss, 2018; Mackenzie, 2006). This worldview maintains that research inquiry should be closely connected with current social issues and the political agenda to address suppression and reduce inequities (Creswell & Porth, 2018; Davies & Fisher, 2018; Mertens, 2010).

An alternate worldview is a pragmatic paradigm, which derives from philosophical pragmatism, of which there are many different forms making it challenging to define as a concept (Haack, 2004; Morgan, 2014; Ormerod, 2006; Posner, 2003). When adopted to inform a research approach, pragmatism is used for questioning and investigating ideas regarding their practical function and has an epistemological emphasis on the process and practicality of the inquiry (Davies & Fisher, 2018; Feilzer, 2009; Kelly & Cordeiro, 2020).

The final paradigm that Creswell (2013, 2014) highlights is social constructivism. The constructivist worldview (also referred to as a naturalistic or interpretive paradigm) is anti-positivist and grounded in a relativist ontology (Davies & Fisher, 2018; Lauckner et al., 2012). In contrast with a positivist approach, social constructivist theories arise from specific observations, not through testing. In this paradigm, individuals seek an understanding of the world in which they live and function; they develop subjective meanings of their experiences which are typically constructed in a social and/or historical context and are formed through interaction with other individuals (Creswell & Poth, 2018; Crotty, 1998; Denzin & Lincoln, 2008; Mertens, 2010). Constructivist researchers focus on interpreting meanings whilst acknowledging that their background and experiences will influence their interpretations of the data (Crotty, 1998; Lincoln & Guba, 2013; Mackenzie, 2006). The central tenets of constructivism aligned well with the aim of this study and provided the necessary foundational underpinning.

Research questions and rationale

As previously stated, the overarching research question for this study was: **What is the perceived relationship between primary school staff and health services in New Zealand, and how is this relationship influenced?** Within this broad agenda, three specific areas of enquiry were explored.

- How is the relationship between school staff and health services enacted in the current primary school setting in New Zealand?
- What are school staff views and experiences of health services in schools?
- What are the enablers and barriers to school staff accessing health care for children in New Zealand primary schools?

Researching this topic is important, as currently, there is no formal requirement for the education and health sectors to work together in New Zealand. Instead, relationships rely on individuals' and groups' willingness to collaborate intersectorally, interprofessionally, and interpersonally. Without a formal infrastructure or directive to work together, the competing demands both sectors experience in their day-to-day practice can influence their ability and willingness to work collaboratively. This lack of collaboration means that children's health and learning needs are not addressed quickly and effectively. In my experience as a nurse working with primary school staff, their support of students with health issues seemed to benefit from timely and appropriate health service provision. However, having witnessed first-hand the challenges that school staff face in accessing health service support for their students, I was motivated to understand possible reasons.

Sustained collaboration between the education and health sectors has implications for effective support of children's learning and health needs in New Zealand. Education is known to have a positive association with health behaviours, life expectancy, and morbidity (Feinstein et al., 2006; Haycock, 2010; Silles, 2009); and is an established social determinant of health (Braveman et al., 2011; Braveman & Gottlieb, 2014; World Health Organization, 2011a). For optimal learning to occur, children need to be in good health and be ready and able to participate. All too frequently, ill-health and disability hinder learning and school attendance leading to long-term negative social

and health consequences (Case & Paxson, 2011; Costante, 2002; Michael et al., 2015). Having access to health services through schools is an effective way to support children who suffer ill-health or are experiencing health or disability-related barriers to their learning (Lear, 2007; Leroy, 2017).

Schools are key stakeholders in the provision of school-based health services. It is essential to understand the experiences of educational practitioners in accessing and working with health service providers. This understanding will serve to inform future service delivery models and practices. Although the focus of this study was to address and inform health service delivery models and practices, the study also provided helpful information for the education sector concerning the benefits of, and challenges to, upholding relationships with health providers. Improved understanding of stakeholder perspectives can inform improvements in practice, a guiding principle in health and education research (Bate & Glenn, 2006; Bird et al., 2021; Mutch, 2013; Newby, 2014).

Philosophical Orientation

In this study, four primary philosophical assumptions provide the foundation for situating the research: ontology (the nature of reality); epistemology (ways of knowing); axiology (what is valued) and methodology (how research is conducted) (Creswell & Poth, 2018; Clark et al., 2021). The following section discusses these four assumptions in the context of social constructivism.

Ontological perspective

Ontology is the study of being and the nature of reality (Daniel & Harland, 2017; Scotland, 2012). The ontological perspective of researchers differs, directly influencing the type of questions a researcher is interested in and the preferred design of individual research studies. The ontological position in this study is based on a constructivist worldview that takes the interpretivist and relativist view of 'truth' as socially constructed and relative to an individual's subjective experience. This viewpoint maintains that people actively construct their own identities, reality, and knowledge through their experiences (Crotty, 1998; Guba & Lincoln, 1994; Mackenzie, 2006). Constructivist research is typically inductive, building from individual

experiences, extending to broader patterns or concepts and eventually to a broader understanding of an area of interest (Creswell & Plano Clark, 2011; Lauckner et al., 2012; Lincoln & Guba, 2013). In this study, the constructivist paradigm enabled me to generate meaning from the understanding expressed by participant school staff on their relationship with health services. Constructivism also enables and fosters an appreciation for the differences between the participants, their views, and their contexts, eliciting multiple perspectives.

Epistemological stance

Epistemology is the theory of knowing; how it is possible to know things through the use of techniques, approaches, and tools (Daniel & Harland, 2017; Scotland, 2012). From an epistemological viewpoint, in constructivism, reality is co-constructed by the researcher and the study participants, with the researcher prioritising close interaction with the subject or case (Creswell & Poth, 2018). Epistemological positioning is embedded into how people make sense of their world, and in this study, aligning with the constructivist paradigm, subjectivism was significant. Epistemological subjectivism proposes that knowledge is always influenced by factors such as gender, language, culture, and social experiences (Levers, 2013). Epistemologically, subjectivist research positions the world as unknowable, including research participants' psychological world. Accordingly, the role of the researcher is to construct an understanding of the world as the participants express their experience of it (Ratner, 2008).

In this study, in adopting the lens of epistemological subjectivism, I saw myself co-producing knowledge through my understanding, interpretation, and communication in the process of exploring the research question(s). Throughout this process, I was influenced subconsciously by my existing viewpoints, beliefs, and meanings (Daniel & Harland, 2017; Grix, 2002; Lincoln & Guba, 1985). In line with subjectivist epistemology, I sought multiple user perspectives by interviewing individuals to fully understand participant school staff's relationship with health services. I attempted to locate, view, and understand these perspectives from their different contexts, both individual and situational. To do this, I drew on the data collected through observing and interacting with the research participants in their school environments.

Axiological position

Axiology is the study of values and refers to what is valued and what role values play in research (Hart, 1971; Hiles, 2008). More recently, Biedenbach and Jacobsson (2016) claimed that axiology assists in addressing what is beneficial and desirable for people and society as a whole. Each researcher brings their subjectivity and values underpinning what constitutes research to their research approach and design. This begins with selecting the research focus and questions, through research design considerations, data collection and analysis, to the interpretation of research findings. From an axiological perspective, in a qualitative study such as this, the researcher must acknowledge the role their experiences play in shaping the research and openly state their objective, interpretations and biases (Creswell & Plano Clark, 2011).

My personal axiological position relates to a desire to reduce health service access inequities for children living in low socioeconomic communities in New Zealand. Currently, inequities exist in health *and* education outcomes for the most disadvantaged children (Bolton, 2017; Simpson et al., 2017a, 2017b).

From this axiological stance, I view one way of addressing this inequity is through positioning health services in schools and promoting education-health collaboration to support and uphold these services. Creating better access to health services through schools would allow health professionals to support children with existing health conditions and provide opportunities for collaboration with school staff where children's health needs are directly impacting their learning and educational attainment. Equally, from my axiological stance, I advocate for effective education-health sector collaboration as being a beneficial and desirable thing to do. However, the intention was not for my experiences and ideals to steer this research but to be acknowledged as part of it. Context is important in the constructivist paradigm, with researchers readily acknowledging and recognising their life experience's role in interpreting the data (Creswell & Plano Clark, 2011; Creswell & Poth, 2018; Guba & Lincoln, 1994).

The overall aim of this study and the research question, required conversation with school staff about their experiences of working with health services thus participant interviewing was an appropriate data collection method. In addition, employing non-

participant researcher observation of a special educational needs (SEN) meeting allowed me to be close to the participants in a real-life context and to better understand the influences on the relationship between school staff and health services through their interactions. In addition to these two data collection methods, a pre-interview questionnaire, school profile form and review of professional development offered to school staff provided additional data to help inform the research question and to understand more about the contextual influences on the perceived relationship.

Choice of Methodology

Crotty (1998) suggests that the chosen methodology is guided by the researcher's theoretical perspective and the epistemology informing this perspective. Using a methodology provides the researcher with a strategy or plan of action that links the choice of methods used to the intended outcome of the research study (Clough & Nutbrown, 2012; Crotty, 1998; Green, 2014; Mackenzie, 2006). A constructivist perspective underpins this study; as such, an important consideration is to capture the participants' experiences. As well as being guided by a constructivist worldview, the study was also guided by my understanding of the relationship between school staff and health services. These understandings were set against experiences originating from my time working as a health professional in schools. These understandings also assumed that the perceptions of school staff in working with health services would be closely connected to their personal beliefs and values and their situational context, including the ethos of their work environment.

A methodological approach was needed that could consider all of these aspects as they were essentially intertwined. In addition, the methodological choice had to be guided by how best to explore the research question, be flexible and accommodating, and generate understanding from participants' experiences in conjunction with data from other sources. In choosing a methodology for understanding the current relationship between school staff and health services, opportunities were needed to interact with school staff and spend time in a school setting. Thus, the choice of methodology depended on how best to generate an understanding of the participant and researcher's experience situated within a particular context. The selected

methodology also needed to attend to both common experiences and the unique, as both had the potential to build on an understanding of the particular nuances of the current school-health service relationship in New Zealand.

As a health professional and researcher, my knowledge of the relationship between school staff and health services has built over time. I observed the positive effects on children's learning and health outcomes through effective education-health collaboration and, conversely, the negative outcomes in the absence of such collaboration. I had come to understand good health as being essential for helping optimise a child's learning. Based on my theoretical and practical knowledge, I also believe that the visibility of health services in schools influences the relationship between school staff and providers of school health services. However, neither the literature nor my experience sheds adequate light on the perspectives of school staff within this relationship or how they perceived health providers in their work environment and their experiences accessing health support for children.

Qualitative research

Qualitative study is a discipline in its own right. Philipsen and Vernooij-Dassen (2007) define qualitative research as "the study of the nature of phenomena, [including] their quality, different manifestations, the context in which they appear or the perspectives from which they can be perceived" (as cited in Busetto et al., 2020, p. 1). Whilst qualitative research is not based on an integrative theoretical and methodological concept, theoretical approaches and associated research methods tend to inform the research practice (Denzin & Lincoln, 2008; Flick, 2018; Stake, 2010). In terms of research inquiry, qualitative research can intersect different disciplines, topics, and specialisations (Denzin & Lincoln, 2005; Grbich, 2007; Stake, 2010).

Qualitative research differs from quantitative research in its philosophical assumptions and strategies, and the methods employed are consistent with these strategies (Creswell, 2014; Grbich, 2007). As previously mentioned, quantitative research is predominantly informed by positivism and postpositivism and underpinned by specific assumptions. These assumptions include objectivity, deduction and the belief in a single truth or reality (Bloomfield & Fisher, 2019). Researchers in this paradigm focus on gathering empirical evidence directly or indirectly through sense data. Empirical

evidence is gathered using structured instruments and usually consists of numeric data obtained through measurement and analysis. Quantitative researchers are less interested in the *why* of a particular issue and instead focus on cause-and-effect associations (Bloomfield & Fisher, 2019; Burns et al., 2015; Davies & Fisher, 2018).

Contrastingly, adopting a qualitative approach in research provides a means to explore and understand a particular phenomenon through the experiences of individuals or groups and their perceptions and interpretations of it (Creswell & Porth, 2018). Many researchers use a qualitative approach because they want to improve how things work and gather data not to measure but to gain insight, explain and understand. It is this explanation, understanding, and portrayal of the complexity of a situation that assists in finding ways of improvement (Creswell & Porth, 2018; Flick, 2018); this notion was central to the aim of my study.

Stake (2010) outlined four particular characteristics of qualitative study: interpretive, personalistic, experiential, and situational. From an interpretive and personalistic perspective, a qualitative study focuses on the meanings of human actions as seen from different perspectives and is empathic in its attempt to understand them. Qualitative study is also experiential and situational in its approach, aiming to collect and convey contextual data in a naturalistic and vicarious way. These profiles align well with the aim of this study which attempts to understand, within a specified context, the relationship that school staff have with providers of health services and to interpret the current influences on this relationship.

Exploring some of the different theoretical and philosophical worldviews that help shape a research study makes it clear that the researcher should consider carefully how these approaches might be drawn upon to answer the specific research question. As a starting point for all research, Grix (2002) suggested that the researcher must begin at the level of ontology and follow a logical lead into epistemological and methodological positioning. Guba (1990) included methodological premises in this categorisation and collectively referred to the alignment of ontology, epistemology, axiology, and methodology as the researcher's paradigmatic lens and interpretive framework.

As a constructivist perspective underpinned this study, it was important that the experience of individuals was captured through the course of the study. Three qualitative methodological approaches were considered potentially fitting for this study but were eventually discarded. The first was phenomenology, broadly defined as the body of discourse of the study of a phenomenon (Smith, 2018). Phenomenology focuses on the *what* and *how* of an experience; this contrasts opinions or interpretations about the experience (Creswell & Poth, 2018; Grbich, 2007; Smith, 2018). In phenomenological studies, attention is paid to the structure of meaning, how individuals experience and understand the world around them. Discovering the common meaning of the same lived experience for multiple people is the key focus, and interviews are typically the primary data collection method. Whilst the constructivist worldview does manifest in phenomenological studies, the focus is on an individual's experiences of a phenomenon as opposed to the context of a phenomenon, as in case study research. In this study, there is a shift from wanting to make sense of the individual experience to focusing on how individuals construct their sense of place, identity and relation within a particular context. Thus, if phenomenology is used as the chosen methodological approach to this study, an opportunity to provide relevant contextual layering to the phenomenon of relationships (the focus of this study) could be lost.

Grounded theory was another possible approach to conducting this study. Like phenomenology, grounded theory also aligns with a constructivist worldview in so far as it uses participants' experiences of a phenomenon or process to generate a theory (Charmaz, 2014; Levers, 2013). Grounded theory is best used to study a research problem when a theory is not available to explain or understand the phenomenon or process. One of the disadvantages of grounded theory is that it fails to recognise the researcher's positionality as part of the research process, obscuring what they bring to the interpretation and construction of the data (Charmaz, 2014; Creswell & Poth, 2018). In addition, grounded theory does not allow enough for contextual information; context is considered important in the constructivist worldview, as is recognising the role of the researcher's experience. Considering these factors and the overall intent of grounded theory, it was clear that the study aim did not fundamentally align with this approach.

The final methodological approach considered was narrative enquiry. As a method, narrative inquiry draws on individual experiences as lived and told through stories of a particular event(s) (Creswell & Poth, 2018; Grbich, 2007). The fundamental purpose of narrative inquiry is to create meaning of past experiences to reveal how life events affect people and how individuals ascribe meaning to such events (Creswell, 2014). In narrative inquiry, the object of investigation is the story itself rather than the information contained within the story (Riessman, 2012). With respect to this study, the aim was not to focus on any particular event or occurrence but rather to harness an understanding of an individual's experience in relation to a phenomenon of interest. The focus of this study was on the essence of context-specific experience, not how the experience was expressed. Narrative inquiry, therefore, did not support the study's aim and focus.

Methodological approach: Case study

Having considered and rejected other methodological approaches, case study was considered as a better fit with the study aim and research question for a number of reasons. Bhatta (2018) claimed that a case study is well suited to qualitative research due to its capacity to study complex issues in depth. Bhatta also upholds case studies as appropriate for theory building by using an inductive approach guided by a qualitative research paradigm. In conjunction with working within a qualitative paradigm, using a case study approach as a research methodology afforded an opportunity to study in-depth the relationship between school staff and health services within different school contexts.

Definitions of case studies and associated applications vary throughout the research literature. There is often discussion about whether a case study is best viewed as a methodology, design, or method. Much of the available literature refers to case study as both a methodology *and* a method (Anthony & Jack, 2009; Boblin et al., 2013; Flyvbjerg, 2006). The philosophical positioning of case study research relates to the different paradigms adopted in social science research and is fundamental to the overall research design (Bhatta, 2018; Flyvbjerg, 2006).

Case study supports the exploration of complex situations, enabling multiple perspectives to be gathered through various sources, including contextual information

(Stake, 1995; 2000; Yin, 2014). The strength of case study is that it allows the phenomenon (in this study - the relationship between school staff and health services) to be examined within a real-life context. This is particularly appropriate where context is considered relevant to the phenomenon (Baxter & Jack, 2008; Stake, 1995; Yin, 2014). In terms of the outcome of case studies, they provide a comprehensive understanding of a bounded unit and help the reader also to examine the case so they can learn from it. Another characteristic of case studies is that they tend to focus on the *why* or *how* types of research questions which are directed at exploring and understanding a phenomenon in depth (Yin, 2014). The collective attributes of case study oriented well to this study's questions and overall research aims.

The key purpose of undertaking case study research is to explore the uniqueness of a single case (Simons, 2009; Stake, 1995a) and to understand the dynamics and nuances that shape the case. Case study research is not specifically associated with qualitative or quantitative methods, although its descriptive nature aligns more closely with a qualitative research approach (Creswell, 2013; Jones & Lyons, 2004; Simons, 2009; Stake, 1995a; Yin, 2009). Neale et al. (2006) describe case study research as "a story about something special, unique or interesting" (p. 3). Stake (1995a, 2006) and Yin (2003, 2009) preferred to describe case studies as in-depth investigations of an individual or several different entities used to unearth the essence of an issue or phenomenon. With respect to this study, both of these descriptions are fitting - I wished to offer an account of the relationship between school staff and health services; this would be achieved by conducting an in-depth study of three different schools to reveal some of the influences and peculiarities of this relationship.

As previously stated, it is possible to employ case study in both positivist (quantitative) and non-positivist (constructivist and interpretivist) research paradigms. Bhatta (2018) and Harrison et al. (2017) maintained that it is essential for the case study researcher to decide between the two paradigms when choosing a particular case study approach. However, the choice of case study by many authors is made without consistently making their epistemological position clear (Bhatta, 2018; Boblin et al., 2013; Flyvbjerg, 2006; Harrison et al., 2017). This lack of clarity means different authors hold different views depending on their preference of research paradigm. This

can sometimes make the philosophical positioning of case study appear rather vague (Bhatta, 2018; Harrison et al., 2017; Jones & Lyons, 2004).

Robert Stake and Robert Yin are two of the leading proponents of case study research. Both Stake (1995a) and Yin (2014) agreed that case studies are in-depth investigations of an individual or several different entities to reveal the essence of an issue. Furthermore, both authors emphasise that an overarching methodology shapes the way a case study is conducted and that multiple methods and data sources can be used. However, these two proponents approach case studies differently through their philosophical assumptions and their chosen methods (Baxter, 2008). Yazan (2015) and Harrison et al. (2017) claimed Yin's structured case study methodology limits innovation and flexibility and presupposes a more positivist leaning.

In contrast to Yin, Stake's epistemological stance is constructivist and, as such, is strongly motivated toward discovering meaning and understanding through studying experiences in context (Boblin et al., 2013; Stake, 1995a; Yazan, 2015). Consideration of these different perspectives assisted in choosing the most appropriate approach for this study. What follows is a brief overview of the differences in definitions and applications of case study, beginning with Yin and transitioning through to Stake.

Approaches to case study

Yin (2014) is a strong proponent of case study being considered a method, emphasising the procedures used. As previously mentioned, Yin adopts a positivist leaning (Bhatta, 2018; Harrison et al., 2017; Yazan, 2015), conceptualising case study as "a form of empirical enquiry" (Yin, 2014, p. 16) used to investigate a case in depth and within its own context. However, Yin (2009, 2014) acknowledged that the use of case study method can apply to a range of epistemological orientations, including relativism or interpretivism. Reality, to Yin, is objective and predictable; and in conducting research, the researcher is detached and independent of what is being researched. Research is cause and effect orientated, and Yin advocated for using a formal, conceptual framework to portray the cause-and-effect relationship. Yin's approach does not concur with my philosophical or epistemological positioning, making it unsuitable for this study.

Gillham (2000), in his positivist account of case study, concurred with Yin's view suggesting that a case study is a primary method. Different sub-methods are used to gather evidence, such as interviews, observations and document analysis. Gillham referred to case study as the investigation of an entity to answer specific research questions, stressing the case study researcher must keep an open mind looking for data until what they have is comprehensive and, even then, not stop completely. Furthermore, Gillham emphasised that case study research is not exclusively concerned with qualitative methods, but these are usually dominant. As with Yin, Gillham's positivistic view did not align with my philosophical or epistemological position.

Seated part way between upholding case study as a method or methodology, Merriam (1998) adopted a pragmatic, constructivist approach to case study, suggesting that the researcher upholds reality as being constructed through understandings and meanings that have developed socially and experientially. Like Yin, Merriam emphasised the importance of having structured and rigorous processes that aid the researcher in managing gathered information. However, Merriam is pragmatic, suggesting that the processes used must assist in providing clarity and applicability to the findings. The aim, Merriam proposed, is to provide a rich and holistic description that highlights an understanding of the research topic. Structure and rigour are not usually associated with qualitative case study and have the potential to limit flexibility and responsiveness in the research process. For this reason, whilst Merriam's approach to case study aligns with a constructivist paradigm, it was not ideal for remaining open to the unique and particular, which was essential to consider in a study focused on understanding relationships.

Simons (2009) preferred to describe case study as an 'approach' to offer a different perspective. This approach is not specifically qualitative or quantitative. It aims to generate an in-depth understanding of a specific topic to produce knowledge that will help inform policy and practice. Consistent with Gillham, Simons emphasised that, in case study, exploration should be inclusive of different methods and be research-based and evidence-led. Simons reserved the term 'methods' for the techniques used to gather data, such as interviewing and observing.

Distinct from Yin and Gillam's positivistic views, but with some similarities to Merriam and Simons, Robert Stake (1995a) approached case study from an ontological perspective of constructivism; reality is subjective, and subjectivity is an essential aspect of understanding (Boblin et al., 2013; Harrison et al., 2017; Stake, 1995a, 2000; Yazan, 2015). Stake upholds the belief that individuals build their understanding of the world from their personal experience and "not by discovering it whirling there untouched by human experience" (p. 100). Stake maintained that case study is neither a method nor a methodology but a choice of what is to be studied, the unique case we seek to understand.

In relation to undertaking case study research, Stake differs from Yin in an epistemological sense, considering that the role of the researcher is central. When adopting Stake's approach, the researcher interacts with the phenomenon - the intent being to close the gap between self and who or what is being researched. Stake also acknowledged that the researcher may hold an insider perspective and envisaged qualitative case study researchers as both gatherers and interpreters. In going through the research process, the researcher should report on how they are constructing knowledge and building theory as they progress (Stake, 1995a, 2006; Yazan, 2015). In addition, Stake maintained that the research methods used should be flexible and inductive; the search is for 'happenings' rather than causes. The goal is to understand the phenomenon of interest; this is exactly what the current study aimed to do.

Reading about case study research suggests that although there are differences in approaches, epistemological and philosophical underpinnings, and considerations of its use as a method or methodology, the theoretical assumptions bear some similarities. All of the authors of case study research previously mentioned uphold case studies as appropriate to use when the researcher wishes to define a topic broadly, cover complex or contextual phenomena or is relying on multiple sources of evidence (Creswell, 2013; Creswell & Porth, 2018; Gillham, 2000; Merriam, 1998; Simons, 2009; Stake, 1995a; Yin, 2003, 2014). In addition, all authors support using a qualitative or mixed-method data collection approach. Further theoretical agreement lies in the characteristics of case study methodology, namely the need to define a unit of inquiry (case), the production of an output in the form of a case report, the use of a diverse range of research strategies and processes, and an aim to produce new insight and

understanding (Baxter, 2008; Harrison et al., 2017; Tellis, 1997). Having read and considered the various perspectives on case study and how they might align best with the current research topic and philosophical positioning, Stake's constructivist approach was chosen as the most appropriate theoretical and methodological lens to guide the current study. Stake's constructivist approach aligns with my previously identified philosophical orientation and acknowledges that my professional experience will add depth to the study.

Research Strategy

Connecting the philosophical and methodological orientation of the researcher to research activity requires careful consideration of how theory and practice will align. Using a constructivist orientation, a case study approach provided a strategy to gain insight into the relationship between school staff and health services in context (Stake, 1995; Yin, 2014). Constructivism assumes that human beings construct their social reality (Lincoln et al., 2011; Mackenzie, 2006; Polit & Beck, 2008). In the research milieu, constructivism recognises that the researcher's understanding and context influence the data and its interpretation.

Robert Stake's constructivist approach to case study

Stake's approach to case study actively seeks the different perspectives held by those involved in the case and aims to equally gather similar and dissimilar perspectives (Lauckner et al., 2012). Stake (1995a, 2006) maintained that an additional layer of knowledge construction occurs when *readers* of the case study report interpret what is written from their own perspective. Stake explained that "there are multiple perspectives or views of the case that need to be represented, but there is no way to establish, beyond contention, the best view" (Stake, 1995a, p. 99). To explain this notion further, Stake (1995a) imagines three realities: external, experiential, and rational. On the one hand, experiential and rational reality blend into each other, with every individual having versions of these that are ever-changing. On the other hand, external reality exists, and the aim of research is not to discover it but instead to construct a clearer and more sophisticated understanding of reality to help build on a universal understanding. However, Stake clarified that this understanding will remain unique to the individual, despite much being held in common with others. Despite this,

Stake (1995a) upholds that a qualitative case study informed through a constructivist epistemological lens does not necessarily require the researcher to avoid generalising; however, the emphasis should be on "thick description" (p. 102) from the people most knowledgeable about the case.

Utilising Stake's approach as the methodology for this study offered many advantages. First, it allowed flexibility in how meaning was extrapolated across the data sources and how the different data sources were interpreted when positioned beside one another. Second, through Stake's approach, the researcher is encouraged to capture and reflect on their own experiences, simultaneous to capturing those of their participants. Stake emphasised that both researcher and participant experiences act as data, and considering both, adds depth to the study and promotes contextual understanding. Third, Stake described the methodological implementation of a qualitative case study in detail, providing a structured approach using worksheets to assist the researcher in applying a research procedure/framework, including the data analysis process.

As the sole researcher, I came to this study with an understanding from a health service provider perspective of the enablers and barriers to delivering health services in schools. However, I had little idea of how school staff perceived the service. I believed that for school-based health providers to work more effectively alongside school staff, health service providers need to better understand how these services are perceived and contextualised by schools. Drawing on Stake's constructivist approach to case study allowed the consideration of multiple different perspectives and acknowledged these would vary according to participants' worldviews, occupational roles, and life experiences. If these multiple perspectives could be verified, Stake (1995a, 2006) maintained it is acceptable to make some generalisations.

Types of case study

Stake (1995a) characterises three main types of case studies according to their purpose: intrinsic, instrumental, and collective. An intrinsic case study involves exploring one particular case for its own sake and interest. In contrast, an instrumental case study sets out to gain insights into a particular phenomenon using a specific case or collection of cases, to inductively generalise or develop a theory. Stake described an

instrumental case study as contributing to something other than understanding a particular case; in using an instrumental approach, the case becomes *instrumental* in helping to gain a greater understanding of the research issue (Hancock & Algozzine, 2017; Simons, 2009; Stake, 1995a; Yin, 2014). In this study, using schools as cases aimed to broaden understandings of the relationship schools have with health services by providing insights into specific school processes and practices that might help promote or unintentionally undermine this relationship.

Case studies become 'collective' when using multiple instrumental case studies to compare a particular phenomenon or issue; the issue is considered dominant to the case (Stake, 1995a, 2006). Herriott and Firestone (1983) suggested that the inclusion of multisite case studies enables the researcher to undertake a collective cross-case analysis and interpretation relevant to more than one case. Therefore, the findings would have greater significance to readers interested in the issues within the focus topic. In this study, that interest may relate to the barriers and enablers to the relationship schools have with health services across several education contexts. Herriott and Firestone argued that multisite case studies provide better descriptions than single case studies. Jacobsen (2002) concurred, claiming multisite case studies offer an ideal balance between generalisability and data–relevancy. However, Stake (2006) emphasised the importance of referencing and contextualising the uniqueness of the *individual* cases in the reporting through "show[ing] how the program or phenomenon appears in different contexts" (p. 27).

To summarise, this study used an instrumental, multicase study approach embracing a constructivist paradigm or worldview. In embracing this constructivist worldview, the study adopts interpretivistic ontological assumptions, subjectivist epistemological assumptions, and case study methodological assumptions as guided by Stake (1995; 2006). The case study approach allowed the exploration of unique instances within each case that could offer valuable insights in response to the research question whilst simultaneously revealing consistent issues across the cases in relation to the research question and focus. Recruiting several cases allowed scope for generating a broader understanding of the research phenomenon (Firestone, 1993; Stake, 1995a, 2006; Yin, 2009).

Ethical Considerations

Ethical approval for this study was gained through the Auckland University of Technology Ethics Committee (AUTEC) #17/359 (Appendix C). A consultation was held with the Auckland University of Technology (AUT) Mātauranga Māori Committee to obtain guidance on increasing and supporting Māori participation in the study (Appendix D). Recommendations from the Mātauranga Māori Committee included offering Māori school staff participants the opportunity to be interviewed in their own culturally safe place, having a Māori support person in the interview, specifically to help interpret some of the participant responses, and the giving of a koha (gift) in acknowledgement of the participant's contribution. In adherence with the feedback provided by the Mātauranga Māori Committee, the support of a Māori researcher was enlisted, who provided advice in interpreting the two interviews undertaken with Māori school staff.

Confidentiality

Wallace (2012) observed that anonymity and confidentiality are closely linked in case study research. Anonymity was desired to protect participants' identities and that of the schools. Therefore, demographic details pertaining to individual participants and the three schools were adjusted to ensure anonymity. This was achieved by replacing all names with pseudonyms following the completion of data collection.

Maintaining the anonymity of each case and its participants and preserving confidential information shared by participants was challenging. Given the uniqueness of each case site, the removal of identifying information meant also removing from the reports some contextual information that was interesting and potentially valuable to the study. Upholding anonymity was further complicated because of the potential for other participants from the same site to recognise collegial experiences and locations.

Another confidentiality challenge lay in the school and education network within the geographical area where the study occurred. Networking is prevalent among schools and teachers (Ministry of Education, 2018). There is a great sense of collegiality, and this created a potential risk that someone familiar with the area and the schools within it would be able to identify one or more of the cases and individual participants in the

study. Lindsay and Goldring (2012) suggested three stages for anonymising data for secondary use. The first stage involves removing or renaming. The second involves removing indirect identifiers such as age by bracketing them into age categories. At the third stage, the researcher needs to decide if the data are too sensitive to be made available to the public and therefore not to use it. All three of these stages were relevant to this study.

Abiding by AUTEC ethical standards and procedures, the participating schools (cases) and individual participants in this study were given pseudonyms. The interview transcripts, school profiles, pre-interview questionnaires, observation data, and details of participant pseudonyms were kept secure throughout and after completion of the study and were only accessible to the researcher. To ensure accuracy prior to commencing the data analysis, individual participants were invited to read their transcribed interviews for accuracy and to add or remove content from the text. The transcriptionist of the individual interviews signed a transcriber confidentiality agreement (Appendix E).

The Study: Defining the Case

There are many definitions of the term 'case' in relation to case study research. Yin (2009, 2014) is not overly definitive, referring to a case as an individual, group, programme, or other such entity, but stressing that the definition of the case relates to the way the initial research question is defined. Although not set on one clear definition, Stake (2006) defines a case as "a noun, a thing, an entity" (p. 1), bound by time and place. As such, a case can be an individual, a group, a community, an institution or anything that is a specific, functioning, complex unit (Simons, 2009; Stake, 1995a; Yin, 2014).

Bounding by place was achieved in this study through the physical location of each case. Each case was situated in a different area in a metropolitan region of New Zealand and within diverse communities with respect to ethnic mix, socioeconomic status, and community demographics. However, the cases were located in defined geographical locations within the region. Bounding by time in a literal sense was governed by when it was convenient to visit schools and interview participants. Coupled with this was the permitted time frame of the doctoral

programme balanced with the time spent gathering data. Time also provides a boundary when considered in a historical and political context. Chapter Two provided an overview of this context as it relates to the current historical, political, sociocultural and geographical environment.

Consistent with the terms of the overarching research question, the individual cases were defined and bounded as:

- A state-funded Full or Contributing primary school in a metropolitan region of New Zealand
- Data collection occurring during an 18-month timeframe between mid-2018 and the end of 2019.

To provide further definition, a state-funded school in New Zealand is a school that receives government funding to support its operations; education for children in New Zealand is free. A 'Contributing School' in New Zealand is defined as a school that caters for children in school years 1 to 6, equivalent to ages 5 to 10 years; most primary schools in New Zealand are in this category. A 'Full Primary School' caters for students from years 1 to 8, equivalent to ages 5 to 12 years (New Zealand Immigration, 2020). Three individual cases were recruited for the study.

The conceptual structure of the case

Case studies are contained within a conceptual structure that builds from the research question and are based on existing experiential and theoretical knowledge about the issue in focus (Simons, 2009; Stake, 1995a, 2010; Yin, 2014). This knowledge defines the boundaries of the case and helps identify the types and sources of data needed to answer the research question. Stake (1995a) described the conceptual structure as central to a case study and builds this structure around issue statements or questions. These issue statements are dominant in an instrumental case study, and the research begins and ends with these (Stake, 1995a). However, the issue statements may be redefined based on emerging data throughout the study. Yin (2009) referred to issue statements as study propositions, with each proposition directing the researcher's attention to something that should be examined. To Yin, issue statements are not as dominant as Stake suggests; they serve more as a guide than a structure. Similarly,

Simons (2009) and Smith (1978) referred to issue statements as foreshadowed issues or problems, with the idea that a researcher rarely enters into a domain of study without a pre-existing idea of potential problems, issues, and debates in which the phenomenon under study is situated. These foreshadowed issues guide the researcher.

The case study researcher identifies issue statements early in the study. They may reflect theoretical understandings but are based mainly on experiential knowledge; the researcher brings in the issues from the outside, having had no previous experience with the particular case itself. Stake (1995a) referred to these issues as "etic" issues. As the study progresses, "emic" issues begin to emerge; these issues are those that evolve and derive from 'inside' the case. Table 1 on page 96, identifies the issue statements and sub-issues that I brought to the study. These issue statements and sub-issues were drawn from my professional practice experiences, a review of the associated literature, and framed by the overarching research question. Five etic issue statements were identified at the start of this study. Whilst these issue statements are proposed at the start, Stake (1995a) reminded the researcher that they are open to redefinition as the study progresses.

Stake's approach acknowledges that the existing experiences and ideas researchers bring to the study shape the research process. However, the researcher's impartiality plays a significant role if participants' lives and values are prioritised. Stake's holistic stance pays attention to reciprocal links between the research phenomenon and its contexts; in reference to this study, understanding how the relationship between school staff and health services are represented in each of the three schools was key to answering the research question.

Table 1. Issue Statements and identified sub-issues

Issue Statement	Sub-issues
1. Good health is necessary for effective learning through:	• *Attendance* • *Physical and psychological wellness* (Basch, 2011a) • *Absence of feelings of illness or illness that prevents learning* • *Ability to engage in learning activities* (Case & Paxson, 2011; Fleming et al., 2019)
2. Individual experiences shape teachers' perceptions of health services both professionally and personally	• *Length of teaching experience will influence teachers' experiences of interfacing with health services* • *Teachers' professional development will influence their knowledge about health-related learning difficulties* (Elek et al., 2017) • *Teachers' experiences of and perceptions about nurses and their services in the school will affect relationships* (Biag et al., 2015; Cook & Rice, 2003; Reich & Hershcovis, 2011) • *Teachers' knowledge of health services will influence the relationship between health and education*
3. Organisational and individual culture will shape school staff's perception of health	• *Māori and Pacific teachers may have unique perceptions of health* (Health Navigator New Zealand, 2020; Ministry of Health, 2015) • *There may be a specific culture of the school concerning understandings about health* (Warwick et al., 2005) • *Teachers' perception of their role in supporting the health and well-being of their students*
4. Accessibility of health services will shape relationships between school staff and health services through:	• *Visibility of health services in schools* (Lightfoot & Bines, 2000) • *Families' ability to access health services, including physical accessibility – location, time, cost, cultural make-up/appropriateness of services* (Bidwell, 2013; Denny et al., 2012) • *Schools with a more significant number of students and staff will afford fewer opportunities for one-on-one interaction between the health provider and individual teachers* (Helleve et al., 2020) • *Decile of school – the decile affects the availability of a regular nursing presence which will impact the ability to build a relationship* (Buckley et al., 2012; Vester, 2018)
5. The opportunities for collaboration between the health service providers and school staff influence the quality of the relationship	• *The presence and skill of education staff with a specific role in managing special educational needs will influence the involvement of health professionals in schools* (Ministry of Education, 2006; NZEI Te Riu Roa, 2018) • *Provision of formal opportunities for collaboration between health and education will influence the relationship* (King et al., 2014)

Drawing from the work of Jones and Hocking (2015), a matrix was derived from the issue statements and identified sub-issues to help guide data collection. The issue statements identified topics to help focus but not restrict data collection. Table 2 (p.99) presents the compiled matrix. The top row of the matrix lists the five issue statements. The second row lists the developed topics related to these issue statements and of which further information was desirable. Next, the data sources that could contribute to each topic were identified. The ticks indicate a match between the information sought and the relevant data source.

Selecting the cases

To maximise what can be learned in case study research, Stake (1995a) emphasised the importance of selecting cases that are likely to promote understanding of the researcher's line of enquiry. Stake (2006) outlined three main criteria for selecting cases:

- Is the case relevant to the focus of the study?
- Do the cases offer diversity?
- Do the cases provide enough opportunity to learn about complexity and contexts?

Stake (1995a, 2006) also advised the researcher to choose cases that are easy to get to geographically and willing to collaborate and interested in the research topic. Stake suggested this for practical reasons, cautioning the researcher that their time in the field is usually time-bound, as is access to the case itself. With this in mind, three schools were selected as cases for inclusion in the study. The number of cases chosen was deemed realistic given the amount of time required to be on-site at each school gathering data and the applied time constraints of completing a doctoral programme of study.

The criteria for including a school as a case were aligned with the case definition, a state-funded Contributing or Full Primary school. Exclusion criteria applied to schools beyond Year 8 and categorised as private or integrated. This exclusion was because private and integrated schools in New Zealand frequently employ their own nurse or health providers rather than utilise publicly funded services. Cases were sought that could maximise understandings related to the research question. Drawing from my practice experiences and responding to Issue Statement 4, the selected schools were representative of different socio-economic deciles.

Deciles are a measure of socio-economic status in education and are primarily used to target funding to support schools serving lower SES neighbourhoods (Ministry of

Education, 2022b)[1]. Public health service providers have also utilised the decile ranking to target the intensity of service provision in schools. Schools classified as decile 1 have the highest proportion of students from low socioeconomic backgrounds, while those classified as decile 10 have the lowest. Correspondingly, low decile schools tend to be allocated more publicly funded school-based health services, usually in the form of a regular visiting nurse and, in some cases, an allocated social worker. Schools of different deciles could offer diversity to this study; nonetheless, my clinical practice observations were that schools, regardless of their decile ranking, differ in culture, leadership, and school ethos. This observation aligns with Stake's emphasis on valuing and acknowledging the uniqueness of each case when conducting case study research.

[1] The decile system is currently under review by the MoE with a new *equity index* proposed to replace it.(https://www.beehive.govt.nz/release/school-deciles-gone-two-years-says-education-minister)

Table 2. Conceptual Structure: Matrix to Guide Data Collection for Case Studies

Issue Statements:

1. Good health is necessary for effective learning
2. Individual experiences shape teachers' perceptions of health services both professionally and personally
3. Organisational and individual culture will shape school staffs' perception of health
4. Accessibility of health services will shape relationships between school staff and health services
5. Opportunities for collaboration between school staff and health service providers influence the quality of the relationship

TOPICS: Information sought	Individual experiences and understandings about health	Observed linkages between health and education	Naming and describing the current relationship with health services - frequency, availability, effectiveness	Barriers to accessing health services: what and why?	Opportunities for formal collaboration: What?	Barriers for formal collaboration: What and how?	School Staff knowledge and experience of working with health services	Staff attributes- age, gender, position held	School Profile - decile, role, ethnic mix, SENCO co-coordinator, PD	Teachers' perception of their role in relation to supporting the health and well-being of their students	Visibility of health services in schools
Related to Issue Statements:	1,2,3,4	1,4,5	4,5	2,3,4,5	1,4,5	1,4,5	1,2,3,5	3	3,4	1, 2,3,	4, 5
Data Source and Perspectives											
School Profile			√	√	√	√			√		√
Individual Pre-interview Questionnaire							√	√			
Staff Interview	√		√	√	√	√	√	√		√	√
SENCO Meeting Observation	√	√	√		√	√	√		√	√	√
Programme (PD) Review		√			√				√		

Recruiting the cases

Recruiting the first case school in the study was uncomplicated; the principal of this school was very familiar with partaking in research and had previously contributed to another study run by members of the District Health Board (DHB), by whom I was employed. A work colleague forwarded the principal's contact details, and I duly met with the principal at the school to further discuss and explain the study. Interested in the study focus, the principal immediately agreed to the school's participation. Subsequent cases proved less easy to recruit. Working alphabetically through a service list of schools situated in the DHB that matched the selection criteria, a further eight school principals and deputy principals were emailed; no response was received from any of these. I used my network of teacher colleagues and contacts to 'spread the word', providing copies of the study information guide for them to disseminate. The teacher contacts had suggested that emailing principals was probably not the best approach as they received many emails in one day and many requests from post-graduate researchers. Namageyo-Funa et al. (2014) and Porter and Lanes (2000) maintained that the response rate greatly improves when researchers utilise a more personal approach via known intermediaries. These authors also emphasise the importance of the researcher understanding their target population and being prepared to modify and flex their approach to support the recruitment process. Within six weeks, two other schools were enlisted as cases for the study. Both met the criteria for selection, offered diversity and would assist in maximising understanding of the research phenomenon.

Participants

Recruitment

Purposive recruitment was used to select the participants within the cases. It is usual for qualitative researchers to select participants for a study based on the area of interest (Bassett, 2004; Holloway & Wheeler, 2009; Schofield, 2004). For this study, adult participants who were qualified teachers and individuals who provided direct support to the classroom teacher and could convey diverse views and experiences about their relationship with health services were invited to participate. No less than five participants would be interviewed at each school to ensure adequate depth of

data and analysis. These numbers were achieved with ease, with many members of the school communities keen to be included. Participants were selected in order of application, and there was no need to turn anyone away. The participants encompassed school principals, Special Education Needs Co-ordinators (SENCOs), class teachers, teacher aides, and one school secretary.

Once each case school had been recruited, and the consent form signed by the school Principal, recruitment of interview participants commenced. In each case, this began with a brief 10-minute oral presentation of the research study to the school staff during their morning tea break. I left participant information sheets (Appendix F) and my contact details in the school staff room. To support anonymity amongst staff and management, I requested that anyone interested make contact with me directly via email. When they did so, I reiterated that there was no compulsion to be involved in the study and reassured them regarding their anonymity and confidentiality.

The original aim was to recruit approximately 15 study participants, five from each of the three cases; however, this was exceeded. The final number of recruited participants was 19 across the three case schools.

The information sheet (Appendix F) was offered again before each individual interview, and confirmation sought that the participants had understood the content. For Māori and Pacific participants, the offer of cultural support during the interviews was made but declined by all three participants. Before the interview, the participants were requested to sign a consent form (Appendix G) acknowledging that they understood the information provided and were willing to be interviewed. An interview question guide (Appendix H) helped focus the interviews.

All three schools held SENCO meetings, but one was not doing so currently as their SENCO had recently left and they had not yet found a replacement. Having established the contact for coordinating the SENCO meeting in the two schools, I introduced the study and explained the purpose of observing the meeting. In this introduction, I provided copies of the study information sheet to give to potential SENCO meeting participants (Appendix I) and copies of the associated consent form (Appendix J). Providing the information sheet and consent form beforehand enabled the meeting

coordinators to discuss the research and potential involvement with the meeting attendees and gain an indication of an agreement to participate; the coordinators then updated me accordingly. In both cases, all meeting attendees were willing to have the meeting observed as part of the study.

Before starting the scheduled observation, all attendees were offered an opportunity to ask questions about the study and about me observing the meeting. Further copies of the information sheet and consent forms were provided for those who did not have one. It was reiterated that there must be a consensus agreement, plus an individual signed consent form provided from all meeting participants for the observation to proceed. All members of both SENCO meetings agreed to an observation of their meeting. Copies of the meeting interpretation notes were made available to participants on request.

In the school without a SENCO, the study information was emailed by the school to the ex-SENCO, who agreed to be interviewed. Although not in keeping with the intended research design, interviewing this participant would offer some insight into how meetings at the school were run previously, who attended and the types of concerns discussed. The same individual interview consent form (Appendix G) as the other interview participants was used to gain a record of consent.

Each school principal was requested to provide a retrospective overview of the professional learning development (PLD) opportunities provided in-house to staff during the previous two years. Although not comprehensive in its detail, this information supported an understanding of the types of topics and focus for PLD made available to school staff. None of the three schools held formal records. However, all were able to provide an email or written list of professional learning activities offered to staff over the stipulated time frame.

No individual teacher's professional learning and development information was gathered for this study. The focus was on gathering general information about in-service PLD offered to all staff over a specified period. In consenting to provide access to school staff as potential participants for the study, the principals of each of the three school cases consented to me accessing the school PLD records (Appendix K).

Data Collection

Stake (1995a) and Yin (2009) both recommended that the researcher develops a data-gathering plan or guide before commencing data collection; this is further supported by Simons (2009). Stake suggested that this plan primarily saves the researcher time and serves as a reminder of the research focus. A simple but effective conceptual structure and data collection guide were developed for this study, as outlined previously in Table 2. This guide, depicted as a matrix, greatly assisted in anchoring the research topic. The data collection guide outlines the specific data collection methods adopted for this study. The methods included a mix of field study (participant interviewing and meeting observation) and data collected outside the participants' experience (such as reviewing PLD records, school profile forms, and pre-interview questionnaires). The data collected outside of the individual experience added necessary contextual layers to consider during the data triangulation.

School profile

The school profile questionnaire (Appendix L) was supplemented by information obtained through the New Zealand Education Review Office|Te Tari Arotake Mātauranga website (ero.govt.nz). Each principal completed the profile questionnaire to ascertain each school's general demographic details, such as school roll, ethnic mix, and decile. In addition, information about what health services were available to the school and any barriers to accessing these services was elicited through the questionnaire response. This simple questionnaire provided information on at least four topics outlined as needing more information in the data collection guide (Table 2, page 99). School locations and names were later anonymised. The assembled school profile provides a context to situate and analyse the data. Providing context aids researcher and reader understanding (Gillham, 2000; Simons, 2009; Stake, 1995b) and enabled consideration of the varied participant experiences relative to the research question.

Pre-interview questionnaire

Before commencing the full semi-structured interview with the selected participants, a pre-interview participant questionnaire (Appendix M) was administered. The purpose of the pre-interview questionnaire was to gather information about individual staff

attributes such as age, gender, and position at the school and their knowledge of current health services available to the school. Additionally, the questionnaire asked whether or not participants attended professional learning and development (PLD) sessions and Special Educational Needs Coordinator (SENCO) meetings. The data collected helped guide some of the questions posed in the individual interviews and provided additional data to inform the analysis and findings. Each participant was assigned an individual identifier in the form of a pseudonym, which was used throughout the study to protect anonymity.

Individual interviews

Individual semi-structured interviews with participants provided the primary data source for this study. It is common for interviews to be used in qualitative research as they offer an opportunity to explore in-depth experiences and associated meanings of research participants (Adams, 2010; Britten, 2006). Merriam (2009) and Patton (2002) suggested that in asking relevant questions and actively listening to the participant's responses, the researcher is afforded an opportunity to enter into the participant's perspective for a time and, in doing so, become closer to their lived experience.

Interview participants were offered the choice of where they would prefer to be interviewed. Except for one, all chose to be interviewed in the school setting during school hours, either during their usual teacher release time, at school intervals or after school hours. One participant was interviewed at their home.

The interviews were guided by questions drawn from the conceptual structure and the data collection guide; these were contained within an interview guide (Appendix H). Stake (1995a) referred to these questions as "topical information questions" (p. 25); they are distinct from the issue statements and focus on information needed to better describe and understand the case. Consistent with the premise of semi-structured interviewing, these questions, although guided, remained flexible, responding to relevant topics and thoughts raised by the participant (Adams, 2010; Creswell, 2013; Grbich, 2007), and allowing further exploration of any unexpected perceptions and experiences related to the study question. Some of the questions were reframed throughout the study (Appendix N) to respond to new ideas that were emerging about the topic. I sought to add clarity and depth to my questioning as my understandings

evolved in line with what I was told. In case study research, the importance of remaining flexible in questions posed in the interview is primarily to allow emergent issues to be followed and understood (Merriam, 1998; Simons, 2009; Stake, 2000; Yin, 2009).

The interviews were recorded on digital voice recorders and, to protect against device failure, were captured on two devices. The recordings were transcribed by a transcriptionist, and the completed transcriptions were then verified against the audio recordings, and corrections were made where necessary. The transcriptions were returned to participants to confirm and check that they were happy for the content to be used. No participants requested any changes to their transcript.

While verifying the transcriptions against the audio recording, changes in voice tone that reflected a particular emotion, for example, anger, sadness, or frustration, were captured manually in pencil onto the physical transcript. Researcher reflection notes were made after each interview, including the length of the interview and particulars relating to body language displayed, including gestures, were noted. Undertaking this process helped to name the emotion more specifically.

At the end of the interview, a koha was offered to each interview participant, acknowledging their involvement and time.

Observation of the SENCO meetings

Participant observation is a valuable tool for collecting qualitative data enabling the researcher to get close to events and actions in real-time (Creswell & Porth, 2018; Grbich, 2007; Stake, 1995a). The purpose of observing the SENCO meetings in each school was to further inform 9 of the 11 pre-identified topics needing further information to assist in answering the research question (as outlined in Table 2, p. 95). These topics included observing where there were links to students' education and health, opportunities and barriers to collaboration, and teachers' perceptions of their role in supporting their students' health and wellbeing. The meeting observations afforded an opportunity to develop a better understanding of the individual cases. In each case, the meetings' structure and character varied, as did those invited to attend. The observation paid attention to understanding how health was contextualised and

considered by the meeting participants when there was an identified learning need. When health issues were identified, who identified them and did the participants know where and how to access support?

Constructivist qualitative research studies emphasise using observation (and interviewing) for generating data as the researcher aims to understand the research phenomenon from the perspective of those experiencing it (Given, 2008). Observation complements other data by elaborating on how individuals interact with each other and potentially influence the cultural norms of their shared environment. In this study, observing the SENCO meetings made it possible to highlight context-specific practices and consider their relevance to this study's research question and aim.

When undertaking participant observation as part of a research study, a researcher can adopt different roles, including specific participant and non-participant positions (Creswell, 2014; Grbich,2007; Bowling, 2014). In this study, I assumed a 'non-participant' or 'complete observer' role. As its name suggests, assuming this position required me to observe without participating. The process was overt, with everyone in the meeting fully informed about my presence and intent (Appendix I). Non-participant observation allows the researcher to observe the participants' behaviour and interactions, which in this study helped to level out researcher bias in the other methods used, specifically the interviews, to reveal differences in what the participants say and what they do. Triangulation allowed me to cross-check the findings between these other methods and is discussed in more detail in the data analysis section of this chapter.

From a constructivist perspective, there is no possibility of an objective world; opinions, beliefs and theories shape how an individual views the world. Thus, reflection is considered an essential element in the research process, as is researcher awareness of the role of self (Mortari, 2015). After each SENCO meeting observation, I engaged in the process of reflection through journalling; this assisted me in remaining in touch with my own lived experience and how this might influence my construction of new knowledge and understandings from my observations. Reflection also allowed me to pause and sort through my observations and experiences of the meetings to

consider possible interpretations and create meaning. This meaning then became learning which helped inform my actions and perspectives about the research topic.

Stake maintains that in case study observations, the researcher must focus on those relevant to the issues. In addition, good record-keeping at the time of the observation is essential to enable the researcher to reflect further, analyse, and report on the findings accurately (Stake, 1995a). In line with this idea, an observation data collection sheet was developed to help focus and collate the observations (Appendix O). Observation of a SENCO meeting was achieved in two of the three cases. In the interview of the third (ex-)SENCO, the researcher learned how this participant had operated SENCO meetings at the school, gaining further insight into the challenges and nuances of the SENCO role within this particular school and in general.

In the two SENCO meetings attended and observed, the observation was guided by an observation protocol (Appendix P). Attention focused on the dialogue between the meeting participants, as previously mentioned, the purpose being to gain insight into how health was considered and contextualised by the meeting participants when a student case was discussed. The observation notes did not record details identifying the children under discussion. These field notes and reflections formed the data for analysis (a sample of these are Appendices Q & R).

Review of professional learning and development records

A retrospective review of the in-service PLD provided by the school for staff over two years was undertaken. The purpose of reviewing the PLD was to determine if any linkages between education and health had been profiled and relevant health-related learning opportunities afforded to staff. In addition, the review highlighted if any interprofessional education between school and health staff had occurred at any time. Permission was gained from each of the school principals (Appendix K) to access the school's PLD records and record the number of professional development opportunities related to students' health and well-being. However, none of the cases held a formal record book or spread sheet from which information could be drawn. The principals supplied either a handwritten or emailed list which lacked detail. Despite this lack of detail, I gained a sense of the types of education offered across the

three cases. Through the individual interviews, I was able to clarify missing detail and confirm my understanding.

A summary of how the methods adopted aligned with the research question and aims are outlined in Table 3 below.

Table 3. Methods used to inform research question and aims

Overarching Research Question: *What is the perceived relationship between primary school staff and health services in New Zealand, and how is this relationship influenced?*	
Specific areas of enquiry	**Methods selected to inform the research question and related areas of enquiry**
How is the relationship between school staff and health services enacted in the current primary school setting in New Zealand?	• SENCO meeting observation } *field study* • Semi-structured interviewing } *field study* • School profile questionnaire
What are school staff views and experiences of health services in schools?	• Semi-structured interviewing • SENCO meeting observation
What are the enablers and barriers to school staff accessing health care for children in New Zealand primary schools?	• Semi-structured interviewing • Review of the historical, socio-political context of the provision of health services in schools (past and present) – literature review • SENCO meeting observation • Review of PLD records • Participant Pre-interview Questionnaire • School profile questionnaire

Data Analysis

The data analysis process in qualitative research is not explicitly prescribed; the choices are aligned with the research question and each data set (Miles & Huberman, 1994; Creswell & Poth, 2018). The process is iterative rather than linear. The data analysis framework for this study was guided by Stake (1995a), who asserted that

there is no particular moment when data analysis begins. Simons (2009) argued for starting analysis and interpretation early, proposing an element of this is already occurring when the researcher selects the research questions and designs the study. Consistent with both of these authors, my analysis began during the initial stages of data collection within the individual cases. My understandings were iterative and evolved throughout all stages of the study.

I selected a set of analytical strategies and tools to support the generation of patterns and themes across the data set and enable a more thorough exploration of the issues and influences of the research phenomenon. I regularly revisited the research question to draw out directly relatable and valuable themes. Ayres et al. (2003) emphasised the importance of researchers developing an interpretation of qualitative data that reflects the individual participant experience. They stress the need for researchers to distinguish between information that is exclusive to particular participants and information that is relevant to all. Beginning the analysis sooner led to modifying some of the interview questions as some of the emerging data topics held significance in informing the research question. Stake referred to this flexibility in approach as 'progressive focusing', a concept introduced by Parlett and Hamilton (1976). Progressive focusing is based on the idea that as the research study unfolds, the transition from one stage to another occurs "as the problem areas become progressively clarified and re-defined" (Parlett & Hamilton, 1976, p. 148). The different stages of data analysis are described in the following sections.

Individual case analysis

The individual cases were analysed first. Stake's approach to analysis incorporates direct interpretation (reported as narrative description) and coded data, which draws on categorical aggregation. The latter relies on aggregating or considering the frequency in which ideas or events occur in the data. Stake (2006) also pointed out that, at times, the particulars and uniqueness of the cases may be important to interpret and convey to the reader.

As previously emphasised, Stake maintained that consistent with a constructivist approach to knowledge, qualitative research is also underpinned by participants' and researchers' interpretations and focuses on the researcher thoroughly understanding

the phenomenon under investigation. The participant and researcher's perceptions enable the reader to experience the situation or scenario vicariously and to learn from this experience. This process is known as naturalistic generalisation (Stake, 1995a, 2010; Wikfeldt, 2017). In this process, the reader compares the case study findings to their own experiences and knowledge and determines whether they apply to their own situations (Stake, 2002).

A total of five different types and sources of data required analysis, as outlined in Table 4. The analysis was led by an inductive approach that involved an iterative process of repeatedly revisiting the data to sort and order it into meaningful themes, patterns, and categories (Creswell & Porth, 2018; Merriam, 1998; Srivastava & Hopwood, 2009). Specific analytic strategies that drew on thematic and content analysis as well as simple description and categorisation were used to respond to the variation in the different types of data and data sources

Table 4. Data Sources and Analysis

Data Source	Approach to Analysis	Description
1. Pre-interview questionnaire	Coding (Braun et al., 2018; Thomas, 2006)	Coding involves converting data into meaningful categories
2. Individual semi-structured interviews with school staff	Thematic analysis – General inductive approach (Thomas, 2006)	Thematic analysis involves drawing out themes that are essential to the research topic
3. SENCO meeting observation	Inductive content analysis (Elo & Kyngas, 2008)	Allows the researcher to make sense of the data and gain insight into what is happening, the emphasis being on the why and how of contextual interpretation
4. School profile form	Categorisation (Chenail, 2008; Lincoln & Guba, 1985) and simple description	Grouping patterns in the data into meaningful units that relate back to the research question
5. Review of Professional Development	Categorisation and Simple Description (Stake, 1995a)	Simple description tells things how they are, without analysis or interpretation, and communicates this to the reader

One of the great benefits of thematic analysis is its flexibility and applicability, which stems from it being an analytic method rather than a methodology (Braun et al., 2018). This flexibility helped deal with a large amount of interview data I had gathered and enabled a seamless interface using NVivo software (www.qsrinternational.com/nvivo-qualitative-data-analysis-software) as a storage, search, and retrieval tool. One of NVivo's many assets is its use of a coding system in which the researcher can create and identify themes, ideas, keywords, and topics (referred to as 'nodes'). Specific interview excerpts are then exported to relevant nodes (Edhlund, 2011; Richards, 1999). Using NVivo software aligned well with conducting a thematic analysis and proved an invaluable tool for managing the analysis and easy retrieval of the interview data.

There are several ways of conducting a thematic analysis, but all stem from the same underlying principle (Ayres, 2012; Braun et al., 2018; Nowell et al., 2017; Terry et al., 2017; Thomas, 2006). I chose to use Thomas' (2006) approach as it offered a straightforward and logical way of deriving themes from a large amount of textual data. In addition, Thomas's inductive approach aligned well with a constructivist perspective. Thomas suggested the primary purpose of an inductive analysis is "to allow research findings to emerge from the frequent, dominant or significant themes inherent in the raw data without constraints imposed by structured methodologies" (p. 238). Thomas' analysis process utilises detailed data readings to derive concepts or themes through the researcher's interpretations.

Analysing the interview data

Utilising Thomas's inductive thematic approach, all 19 individual transcribed interviews were first analysed manually. This process allowed me to reconnect with the participants through their transcripts and re-familiarise myself with the emergent data. I repeatedly read the interview transcripts and searched for core meanings relevant to the research question and topic. Whilst doing this, I was also coding, identifying segments of text that contained relevant meaning relating to the research question (Gibbs, 2007; Lincoln & Guba, 1985; Stake, 1995a; Thomas, 2006).

When the first coding round was completed, I assessed the codes as a collective, looking for overlap and reassessing for relevancy. Initially, I arranged codes into themes using a basic Word table, again checking for possible overlap and integration,

which I may have discounted initially. I then grouped the themes into categories. On further review of data significance and its relevance to answering my research question, I rationalised the initial number of codes; Stake (1995a) characterised this process as: “analysis and synthesis in direct interpretation” (p. 75).

I uploaded the interview data into the NVivo programme after completing the first round of manual coding for each interview transcript. Although arguably a lengthier process than coding directly in NVivo, doing this provided an opportunity to revisit the individual interviews and confirm previous coding and resulting themes. After completing the data entry and final coding, an NVivo Code Book was produced for each case (Appendix S); this provided a printed summary of the resulting themes and sub-themes generated from the codes. These Code Books proved invaluable when undertaking the cross-case analysis.

Cultural guidance

Consultation with a Māori cultural advisor occurred as I analysed interview data obtained from the participants identifying as Māori. The advisor provided feedback on how I might interpret some of the points raised in the interviews from a Māori perspective, particularly how Māori view health from a holistic perspective and why there may be barriers to accessing support. The advisor introduced me to Māori concepts and words that both explained and described feelings alluded to by the participants, but where there was no exact equivalent in the English language or Western culture. An example was when I asked one Māori participant, ‘Mary, what might prevent parents from engaging with health services at the school?’ The response was:

> They may be too embarrassed or too closed to be open to the health workers here in the school. (Mary)

The advisor explained that Mary was likely to be alluding to whakamā, a psychosocial and behavioural construct in New Zealand Māori, akin to feelings of inadequacy, shame, inferiority, or embarrassment. Sachdev (1990) stated that whakamā is an essential construct in understanding Māori behaviour in cross-cultural settings and with each other.

This process of consultation supported me, as the sole researcher, to have greater insight and understanding of the Māori participants' experiences and, in doing so, weave these into the more extensive data collective. I initially thought some of the issues that participants raised were the same, but a slightly different interpretation was revealed when viewed through a cultural lens.

Analysing data from other sources

Inductive content analysis is recommended if there is not enough former knowledge about the research topic or if the knowledge is fragmented (Elo & Kyngas, 2008; Hsieh & Shannon, 2005). I used inductive content analysis with the observational data gathered during the SENCO and interagency meetings. Inductive content analysis moves the data from the specific to the general through categorisation. This process occurs in such a way that the observed information is then combined into a larger whole, making it an ideal approach for managing data used as part of a case study. There are no systemic rules for analysing the data; however, three primary phases form the basis of the process: preparation, organising, and reporting (Elo & Kyngas, 2008).

The data that arose from conducting the meeting observations were prepared and organised by analysing the obvious and latent content; the latent content aims to notice things like body language, pauses, and expressed emotion (Elo & Kyngas, 2008). Much of the latent content had been captured in my post-meeting reflections. I considered these reflections essential to the analysis process. They helped me re-examine my judgements and beliefs and how these might affect my interpretation of the data, and were used to understand what was existent concerning the research question. The data from the meeting observations were entered into the Observation Data Collection sheet (Appendix O); this sheet was used to code and categorise emerging themes. These themes were then prepared and organised in order of relatedness and relevance to the research question.

After analysing the remaining data sources using the methods outlined in Table 4, I organised the resulting summaries in different, table-like formats, enabling quick access to the data ready for amalgamation with findings from the interviews and meeting observations into the final case reports. Summary tables outlining the

participants in each school and their responses to the pre-interview questionnaire and tables outlining the professional development offered at each school were used to compare, contextualise, confirm, and further inform the data emerging from the individual interviews. Examples of these are contained within the individual case reports. Figure 2 summarises the data analysis process for the individual cases.

Figure 2. Summary of Individual Case Data Analysis Process

Cross-case analysis

After the three individual cases had been analysed and the reports completed, a cross-case analysis was undertaken. While the individual cases provided valuable insights into three unique situations, undertaking a cross-case analysis enabled the further mobilisation of this knowledge. The process of mobilising knowledge from individual cases occurs when the researcher accumulates the collective case findings, comparing and contrasting and, in doing so, produces new knowledge (Khan & VanWynsberghe, 2008)

Stake (1995a, 2006) cautioned that multicase study is not a design for comparing cases but instead draws from the cases studied to understand better the overall phenomenon or what Stake referred to as the *quintain*. For example, in this study, the quintain (phenomenon) is the relationship between New Zealand primary schools and health services. Three individual case schools were studied to learn about the features and variations of this phenomenon. Undertaking a cross-case analysis required me to take a deliberate shift away from understanding the individual cases to understanding the phenomenon (Stake, 2006). The emphasis thus shifts from the particular and the situational to the phenomenon; the cases themselves become instruments for understanding the whole. In analysing the data, the researcher must repeatedly determine what is more important for understanding the phenomenon - the differences in the cases or what is common to all cases (Stake, 2006).

Conducting the analysis

I reviewed the case reports to draw differences and similarities; this formed the basis for a crude cross-case, merged findings list. This process enabled me to separate unique individual case data. Tesch (2013) referred to this cross-case comparison as a process of "de-contextualization and re-contextualisation" (p. 123). Losing some contextual detail is consistent with the overall goal of identifying themes across cases (Ayres et al., 2003). Having completed this preliminary process, I applied the same thematic analysis approach used in the individual case analysis to draw out similar themes across the cases. This process resulted in seven initial cross-case findings. In addition, an online mind mapping software programme (XMind ZEN[2]) was used to

[2] https://www.xmind.net/about/

assist in early interpretations. Mapping the data visually helped provide additional clarity as the analysis advanced (Appendix T).

This preliminary analysis was followed by a more formal process that drew on Stake's (2006) approach to multicase analysis. Stake employed a series of seven detailed worksheets to assist in the cross-case analysis process. In addition, he proposed three different tracks the analyst can take according to their overall objective. Track II focuses on merging findings across the cases and not necessarily preserving the particular situation of the findings. Adopting this structured approach to conducting the analysis is particularly helpful when dealing with an abundance of data from across cases and from more than one source, as in this study. Figure 3 summarises the cross-case analysis process using the Track II approach (examples of completed worksheets are in Appendices U & V). Figure 4 provides an example of how I manually organised the findings.

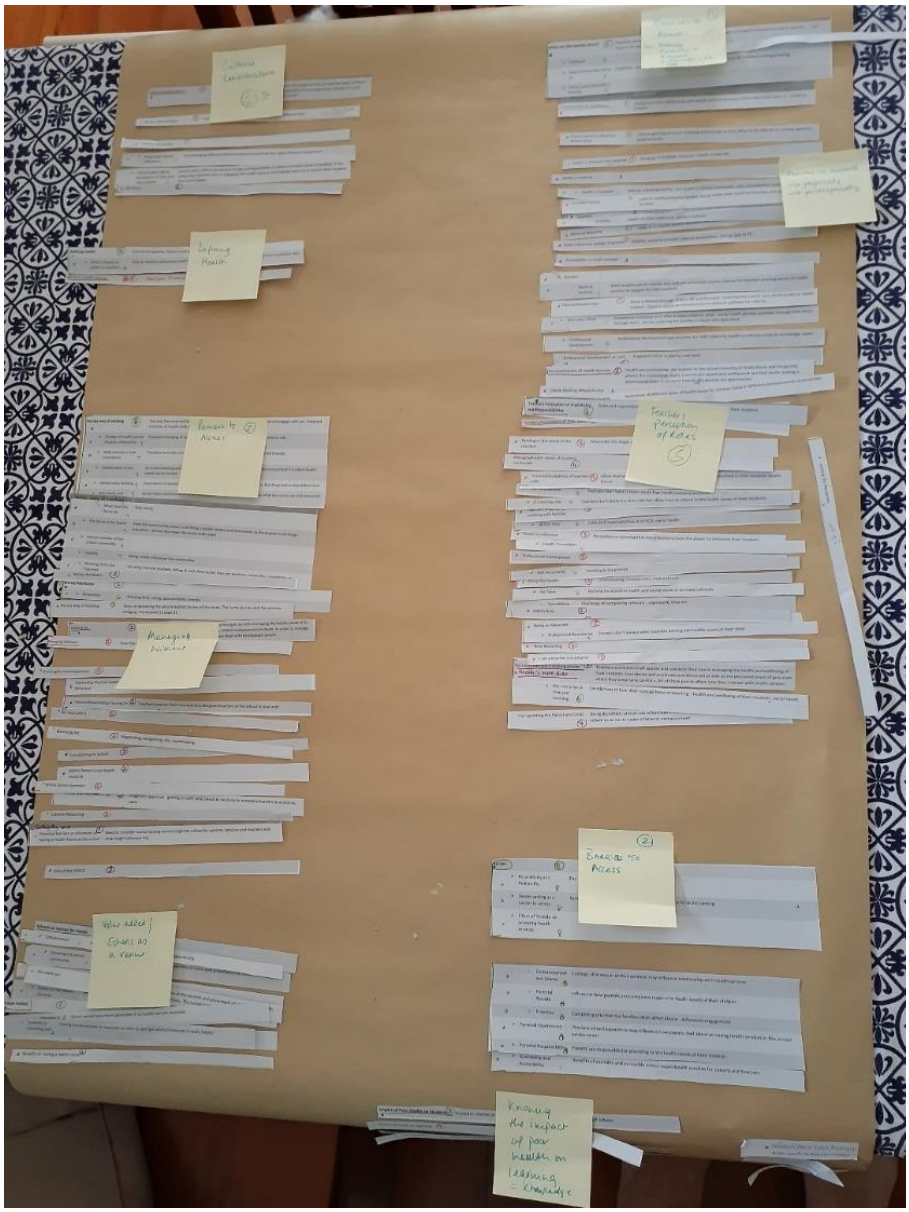
Applying steps 3 and 7 (Figure 3) of Stake's (2006) process proved particularly challenging. Step 3 involved applying ratings of utility against each case concerning the research questions. In this study, I considered all the cases had high utility, the only difference being why they had. In addition, although all cases may have utility, the ranking of *how much* utility was essential to consider, as was the uniqueness of a case's situation. The challenge is knowing whether and to what extent a local and particular finding is relevant when analysing the data from across multiple cases. Stake acknowledged that balancing valuing the particular and the generalisable is a constant dilemma in multicase research.

Step 7 involved ranking the utility of the *finding* against the research question instead of the case. This required more in-depth consideration as I examined the how and the why and attempted to tease out the unique and atypical. Stake suggested that the connection between the cases and the merged findings will be less strong in Track II. However, if a merged finding comes mainly from a single case, this should be identified clearly on worksheet 5b (Stake, 2006). Entries such as these require more thought when generating assertions as they could potentially extend or limit generalisability. An example was in the merged finding related to perceived barriers in accessing health services; Case 1 was identified as atypical because the school had high visibility and

regular access to health services by comparison with the other two cases; nonetheless, there were still barriers identified.

Figure 3. Summary Cross-Case Analysis

Figure 4. Cross-Case Analysis – Merging Findings – Step 4.



Research Credibility

Qualitative case study has been subject to much debate surrounding its reliability, validity, and generalisability (Crowe et al., 2011; Gibbs, 2007; Leung, 2015; Yin, 2014). These issues can be considered concerns confined to the quantitative research sphere, not qualitative. However, many researchers do not share this view and propose there is no need to set new criteria or adopt new terminology but instead adopt different means to address these from a qualitative perspective (Leung, 2015; Long & Johnson, 2000; Noble & Smith, 2015; Patton, 1999). From the perspective of Stake (1995a), validity in case study research is about providing accurate case representation for the reader of the report; this, Stake believes, provides the basis for the reader's learning

and future action. Validity for Stake is entwined with an ability to bring about generalisation of the knowledge.

A common critique of qualitative case study is the lack of rigour and the limitation for generalisation (Jones & Lyons, 2004; Leung, 2015; Wikfeldt, 1993, 2017; Yazan, 2015). Crowe et al. (2011) suggested addressing these concerns by ensuring the following:

- Preparing a conceptual framework
- Ensuring member checking of findings
- Maintaining transparency throughout the research process

The emergence of 'emic' issues (internal to each case), as referred to earlier, was highly relevant to this study. Although there was a conceptual framework and identified issue statements, I needed to remain open to emergent, emic issues relevant to the research question and which the participants might bring to the fore, such as the impact of school ethos on each school's relationship with health services.

Triangulation

Triangulation was used as a method to help support the validity of this study. The concept of triangulation derives from quantitative methodology. The use of triangulation in qualitative research was first advocated for by Denzin (1970) and refers to using multiple reference points or sources of evidence to establish and verify meaning (Carter et al., 2014; Gibbs, 2007; Patton, 1999, 2002; Seale, 1999). Using this approach, the researcher actively seeks out different perspectives on the case study topic to check interpretation and reveal alternative meanings. Denzin (1978, 1984) described various triangulation approaches: investigator, theoretical and methodological triangulation. *Methodological* triangulation involves using more than one method to gather data to increase the researcher's confidence in their interpretations (Denzin, 1984; Fusch et al., 2018; Heesen et al., 2019). I achieved this with data collected through interviews, observations, and questionnaires. It might be argued that in this study, the methods used were not always targeting the same issues; for example, the participant interviews focused on school staff experiences working with health services. The observations looked for examples of how health was considered when a student had a learning need. This, however, is the essence of

methodological triangulation—the rich collection of data drawn from different sources assisted in unpacking the nuances, drivers, and influences on the relationship between schools and health services. Having a broader data set provided a greater depth of understanding and reinforced my overall findings.

Moran-Ellis et al. (2006) developed an approach called 'following a thread' to support the methodological triangulation process, which involves conceptually placing the various datasets alongside each other and analysing each to identify themes and raise questions that might need further clarification. A theme is then chosen from a dataset and followed across the others to create a collection of findings that can be used to generate a deeper understanding of the phenomenon. This practical tactic for dealing with an extensive data set was helpful for this study and applicable to the chosen philosophical and methodological approach.

Although methodological triangulation was the primary approach to supporting the validity of this study, for each case, I had gathered interview data from a cross-section of staff that included teachers, principals, SENCOs, office staff, and teacher aides to obtain different perspectives from the different roles. This is referred to as data source triangulation (Denzin, 1984; Stake, 1995a). I noted and captured how the relationship between school staff and health services enacts itself in different circumstances and between people and contexts.

Mindful of the time triangulation of the data can take, Stake (1995a) suggested only spending time triangulating *important* data and claims; the importance is measured by the degree of understanding and clarification this data will bring to answering the research question. Linking back to the chosen analysis methods described previously, the process of coding manually and then again in NVivo, helped to withdraw data that, although interesting and relatable, did not directly contribute to answering the research question.

Generalisability

Regarding qualitative case study, generalisability is the most criticised aspect alongside validity (Firestone, 1993; Gerring, 2007; Wikfeldt, 1993; Woodside, 2010). This perspective seems to centre on case study being considered a study of the singular,

the particular and the unique (Simons, 2009). However, Herriott and Firestone (1983) argued that multicase studies offer the opportunity for better description and generalisability than single case studies do. This view is supported by Jacobsen (2002), who considered multicase studies offer a perfect balance between generalisability and data relevance. Wikfeldt (1993) stated that it is inappropriate to generalise case studies to a population, but it is appropriate to generalise to a theory, which is further acknowledged by Yin (2014).

Similarly, Stake (1995a) acknowledged that a single case study is not suitable for making broad generalisations, though the single case offers more *petite* generalisations that can assist the researcher in refining a greater generalisation. To this end, the case studies contained within this research contribute to theoretical understanding of the relationship between schools and health services. In addition, the case studies contribute to organisational theory, and to understandings about organisational relationships as applied to education and health settings.

Stake (1995a) recognised two types of generalisation - naturalistic and propositional - that are associated with case study research. The former are understandings derived from an individual's engagement in everyday life or acquired vicariously. Propositional generalisation refers to understandings acquired primarily through didactic means (Stake, 2005). Stake claimed that naturalistic and propositional generalisation are not entirely separate, given that understandings gained through experience can translate into more formal, propositional understandings when they are communicated in other learning situations.

Stake (2006) reasoned that making generalisations should be balanced in favour of the reader responsibility rather than the writer. However, the researcher must assist in this process by providing high-quality analyses and interpretations for the reader to consider. Stake suggested that the researcher needs to provide an opportunity for vicarious experience through a detailed, narrative description of the findings, including the physical context (Stake, 1995c). This notion was considered when outlining the findings in the final individual and multicase reports. Table 4 summarises how validity and generalisability were supported throughout this study, from initial study planning through to the analysis phase.

Table 5. Strategies for Enhancing Credibility of the Research Study

Strategy	Description and Example
Truth Value *(Validity)*	**Reflexivity and reflection on researcher's own perspectives** ✓ Maintained reflective journal with ideas and decisions documented as well as challenges and issues (Jootun et al., 2009; Lincoln & Guba, 1985; Simons, 2009; Stake, 1995a) ✓ Peer debriefing: regular sessions with supervisors who provided guidance on coding decisions, interpretations and methods (Houghton et al., 2013) ✓ Cultural consultation to aid understanding and interpretation of interview data from Māori participants ✓ Prolonged contact with key participants: Maintained relationships with the three school principals and some interview participants throughout the 3-year research process (Dikko, 2016; Houghton et al., 2013)
	Representativeness of findings in relation to research topic/question ✓ 19 individual semi-structured interviews with school staff enabled prompts and follow-up questions in addition to ongoing clarification of findings (Dikko, 2016) ✓ Member checking – interview participants given opportunity to review their transcripts (Houghton et al., 2013; Stake, 1995a) ✓ Audiotapes and transcriptions of interviews assisted revisiting of data ✓ Use of participant quotes from transcripts to support the reader to judge whether final themes are consistent with participants accounts ✓ Observation data contributed to contextual understanding ✓ Use of illustrative methods such as mind maps and Wordles to assist reader to reflect on validity of the interpretations drawn from the analysis ✓ Triangulation: the use of multiple data methods plus participants perspectives allowed me to explore several facets of my research phenomenon (Bekhet et al., 2012; Fusch et al., 2018; Houghton et al., 2013; Simons, 2009; Stake, 1995a, 2006)
Consistency/ Neutrality *(Reliability)*	**Achieving auditability** ✓ Provided overview and clear description of entire research process; including development of methods, analysis and reporting of findings (Yin, 2003, 2009) ✓ Peer debriefing: emerging themes discussed with study supervisors who hold expertise in both case study methodology and community child health (Houghton et al., 2013) ✓ Iterative process: using methods of analysis suitable to the type of data collected, enabled me to stay receptive to refining my decisions and interpretations in light of what was emerging. I reflected and refocused, making changes to my conceptual framework, questions and interpretations where necessary (Kekeya, 2016; Simons, 2009; Srivastava & Hopwood, 2009; Stake, 1995a)
Applicability *(Generalisability)*	**Application of findings to other contexts** ✓ Rich detail of the case context was provided in the individual case reports ✓ The process of conducting a cross-case analysis supported generalisability by enabling me to mobilise the knowledge I had gained from studying the individual cases. In doing so I enhanced my capacity to understand what was happening in relation to the research question and to generate new knowledge as a result (Herriott & Firestone, 1983; Jacobsen, 2002; Jenkins et al., 2018; Khan & VanWynsberghe, 2008)

Reflexivity

Reflexivity refers to the researcher examining their belief system throughout the research process and understanding how these may influence the study. Reflexivity recognises that research outputs inevitably reflect these beliefs, judgements and practices and acknowledges the researcher as part of the research (Finlay, 1998; Gibbs, 2007; Simons, 2009). Finlay (1998) maintained that reflexivity enables richer understandings through its involvement of continued self-reflection and questioning and evaluating the research process as it unfolds.

Reflection is a key element in qualitative research (Mortari, 2015). To maintain reflexivity throughout this study, I kept a reflection journal which helped me to tease out what was evolving in the data. After the interviews and meetings, I voice-recorded my reflections, and transcribed these, and then applied a basic thematic analysis process. I balanced this analysis with my previously held assumptions and positionality. Questioning myself helped keep me grounded, well-positioned, and better able to maintain reflexiveness (Kekeya, 2016; Srivastava & Hopwood, 2009). Appendix R offers excerpts of some of my reflections.

Summary

This chapter has outlined the research methodology used to explore the relationship between primary school staff and health services in New Zealand and determine the influences on this relationship. The rationale for choosing case study as a research strategy and the methodological and theoretical positioning of Robert Stake is discussed. Also described in this chapter were the chosen methods for data collection and how these methods helped anchor the research design and process of analysis. The methods used enabled exploration of the various complexities and experiences of the schools in their relationship with health services. The process used to analyse the data of the individual cases and the cross-case analysis have also been conveyed. The research findings and resultant themes are presented and discussed in the following chapters.

Chapter 4 Findings

This multicase study aimed to understand the relationship between school staff and health services in primary schools and what the influences are on this relationship. The overarching research question to which answers were sought was: **What is the perceived relationship between primary school staff and health services in New Zealand, and how is this relationship influenced**? The objective of gaining a better understanding of this relationship is to inform the advancement of health service provision in New Zealand primary schools as new opportunities arise. A qualitative, instrumental multicase study approach, guided by case study theorist Robert Stake, was used to gather and analyse data relevant to the research question and aim. The data provides a deeper, more contextualised and considered understanding of this complex relationship.

This chapter presents the individual case findings of the study and a brief indication of the cross-case findings prior to full consideration and discussion in Chapter Five. The chapter provides an overview of the findings from each of the three individual school cases. Towards the end, the cross-case findings as they relate to the research question and aim are introduced. Consistent with the situational nature of qualitative research findings and with qualitative study not being considered conclusion orientated, the cross-case findings are presented as assertions (Erickson, 2012; Nolen & Talbert, 2011). The use of assertions in this multicase study report is consistent with Stake's (1995a, 2006) constructivist approach.

The research findings reported in this chapter are based on an analysis of the following data sources; semi-structured interviews, observation of a SENCO meeting and a review of the PLD offered to school staff over two years. The three individual case study reports are presented in full in the Appendices (Appendices Y, Z & AA). Readers are invited to study these for the deep insights they offer into each case.

Case Study Reporting

In writing the complete case reports, I was guided by Stake (1995c), who emphasised the importance of providing context for the reader to understand the case more

thoroughly. The researcher should select only the data required to illustrate the issue or scenario directly related to the research question. In addition, researchers are encouraged to include their reflections and thoughts, which keeps the researcher connected and grounded in the case and during interpretation, whereby "the case and the researcher interact is presumed unique, and not necessarily reproducible for other cases and researchers" (Stake, 1995a, p. 135).

In each case, an introduction to the interview participants is presented in a tabulated format, including demographic information, participants' experience, their knowledge of health services available through the school, and their participation in PLD. Each case is contextualised, and participant quotes and descriptive examples support the narrative of the findings.

In the following abridged reports, the name and location of the school in each case study have been altered to ensure confidentiality. All participant names have also been changed to ensure their privacy and prevent their identities from being known.

Case One: Pūkeko Valley School

Pūkeko Valley school was the first case included in the study. As such, it paved the way for developing an overall understanding of the relationship between primary schools and health services as perceived by teachers and other school staff members.

Pūkeko Valley school is a fully-funded state primary school situated within a low-socioeconomic suburb in a large New Zealand city. At the time of this study, the school had over 200 students; approximately 25% were Māori, 30% Tongan and Samoan, and the remainder identified as Asian, Middle Eastern, and Other. The local population is ethnically and culturally diverse, with just over a third born overseas and just under half of these having lived in New Zealand for less than ten years. Many of the local population live in state-funded housing or private rental accommodation.

Pūkeko Valley school is classified as a decile 1 school by the Ministry of Education based on census data. As previously noted, school deciles indicate the socioeconomic status of the community from which a school draws their students. Decile 1 schools have the highest proportion of students from low-socioeconomic communities. In contrast, decile 10 schools are those with the lowest proportion of these students

(Ministry of Education, 2022b). As a decile 1 category school, health services are prioritised by the local District Health Board in providing an assigned community nurse and cultural worker who visit Pūkeko Valley school two or more days per week. The majority of health concerns relate to skin infections, respiratory ailments, and Group A streptococcal throat infections, the causative organism for Acute Rheumatic Fever, and a significant health issue for New Zealand children, particularly those living in poverty (Baker et al., 2019).

The school had chosen to employ a SENCO for four days per week. As discussed in Chapter One, this role has responsibility for helping students with learning difficulties and ensuring that they have access to the learning programmes and support they need to achieve at school. The SENCO role was funded by the school out of staff resource funds, with the school running larger class sizes to compensate. The school also had an onsite social worker employed part-time by the Ministry of Social Development (MSD).

Observation of the SENCO meeting

The SENCO, Angela (pseudonym), was responsible for actioning teacher requests for health and education services referrals. In addition, Angela facilitated a once-a-term SENCO meeting, where attendance was by invitation, with class teachers only attending if they were specifically requested. The workload of the SENCO role at Pūkeko Valley was high, and evidence suggests that the processes for eliciting support were often lengthy and frustrating.

At the time of observing the SENCO meeting, the school social worker was present but no class teachers or teacher aides. Also present was the assigned school nurse, a school attendance officer, a Resource Teacher of Learning and Behaviour (RTLB), and a Speech-Language therapist (SLT). The meeting was held in the morning. A list was provided to meeting attendees of children currently on the SENCO register, those experiencing difficulty engaging or progressing with their learning. Typically, the students had been referred by their class teacher or had known education or health needs on enrolment at the school. There were 42 existing children on the register and three new ‘cases’ listed on the register that day. The list was compiled and maintained by the school SENCO, Angela and contained information that she deemed important or necessary for attendees to know.

As SENCO, Angela led the observed meeting, which ran for 75 minutes. Due to time constraints and many children on the SENCO register that day, the meeting ran as an update opportunity for attendees rather than as a case review opportunity. Health was only on the agenda if a child on the SENCO register was known to have a health concern. It was not bought into the conversations as a standing agenda item; instead, it remained as a separate matter. Angela spoke most, leading and directing the meeting throughout its duration. Angela posed no specific questions to the meeting to any of the professional attendees in relation to the children on the register.

When providing the updates of some children on the list, Angela commented on the time and effort taken to complete referrals to various outside agencies, including health services; this was despite having a nurse assigned to the school. If Angela did go to the effort of making a referral, she would balance doing so with how likely the child was to meet the referral criteria or how soon they would be seen. The way Angela described her experiences in making referrals gave the impression that she often found the processes frustrating.

Angela spoke about her workload after the meeting; her weariness and frustration in managing some of the cases were evident in her examples and body language. She expressed feeling burdened at times with the responsibility, but at the same time felt committed to helping the students: “A lot of the children’s problems are left for me to sort out”. This statement was undoubtedly true; the SENCO at Pūkeko Valley school was responsible for referring students to health and other services; a responsibility that sat almost exclusively with her role.

Review of professional learning and development

At Pūkeko Valley, school staff are offered professional development as needed but usually as part of the regular staff meetings. The school principal decides on the content or topics for PLD, usually based on need in response to issues arising or changes in policy or legislation. A review of the PLD offered to staff over the previous 18 months revealed that the content focused on pedagogical practices that supported learning and achievement. During the individual interviews, when the participants discussed what PLD they had received explicitly related to health topics, they stated that there had been very little concerning health or behaviour issues that might impact

learning. The participants reflected that although it could be helpful to have more education on health topics than they currently had, they were less likely to draw on that knowledge unless they had a child in their class with that particular condition or issue.

> In all honesty, from my point of view, I've learned some stuff earlier in my teaching career, and I haven't used it, which you don't unless you have a child in your class that's specifically got that same issue…. It's always worthwhile to know stuff, I'm not discounting that, but again if you don't use the information what's the point? (Greg)

The interview participants did not appear to be motivated to want to know or understand more than they needed to know.

Individual interview participants

Eight participants from Pūkeko Valley school engaged in the semi-structured, individual interviews, the largest number interviewed across the three school cases. The pre-interview questionnaire and the interviews provided rich information about how the participants viewed health services available in the school and the benefits and challenges that sat alongside them. The participants included males and females who held a range of experience and roles. Table 6 provides an overview of the participants drawn from the pre-interview questionnaire.

Table 6. Interview Participants Pūkeko Valley Primary School

Name	**Age Bracket (years)**	**Ethnicity**	**Position**	**Teaching Experience (years)**
Rachel	45-50	NZ European	Class Teacher	25
Moira	45-50	Other European	Class Teacher	6
Angela	55-60	NZ European	SENCO	10
Greg	30-35	NZ European	Class Teacher	10
Karen	40-45	NZ European	Deputy Principal	20
Kirsty	55-60	Māori/ NZ European	Relief Teacher	18
Mary	Not disclosed	Māori	Teacher Aide	10
Rob	55-60	NZ European	Principal	30

Identified themes

Four main themes were identified from the data collected across the individual interviews, SENCO meeting observation, and review of PLD offered to staff in the previous 18-months. These four themes informed all of the five issue statements and sub-issues identified in the conceptual structure of this study (Table 1, page 96). Reference to the overarching issue statements is provided again in Table 7 to assist the reader.

Table 7. Issue Statements

	Issue Statements
1	Good health is necessary for effective learning
2	Individual experiences shape teachers' perceptions of health services both professionally and personally
3	Organisational and individual culture will shape school staff's perception of health
4	Accessibility of health services will shape relationships between school staff and health services
5	Opportunities for collaboration between school staff and health service providers influence the quality of the relationship

Theme One: Health is separate from education

The first theme centres on the perception that education was considered separate conceptually and logistically from health, despite staff and students having access to an assigned school nurse. Although participants could name some health services and supports available to the school, both were viewed as separate operating entities and external to the school and its community. References were made to the *bringing in* of health services as if to *fix* or *repair* students in preparation for learning.

> They're [health personnel] not permanent features of schools you know, they come in caravans, and they come into school, but they're not actually viewed as part of the school community. (Rob)

Participants appeared to understand the impact of poor health on learning but did not always integrate this understanding in their day-to-day teaching practice.

> I have had a lot of children whom I have eventually found out have hearing issues. When I got the results I thought - oh yeah, that's no surprise because they [the students] haven't really been following instructions or progressed very well in their reading. (Kirsty)

Some acknowledged that there were students who would need access to health care support to achieve learning, but despite recognising this, they perceived that delivering health care in the school setting could impact learning through interruption.

> It is always when you're in the mid-flight that you know the announcement would come over the speaker that the nurse is here, and she would come in and say, "right, anybody to see the nurse?" and you're just like, ahhhh! So, it's [the school nursing service] more of an inconvenience than anything else. (Greg)

Balancing learning against health needs was a dilemma for class teachers, particularly because learning outcomes are often used to measure school and teacher performance.

> There's always tension about what is the school's purpose. You know, so what is it? What is to be educated? And, how do we do that? And we've had some regimes in education that have been saying, "well, just teach them to read, write and get them through to national standards; this is your priority". (Karen)

The participants were conflicted; they were aware they needed to emphasise student literacy and deliver the curriculum as specified by the MoE and overseen by the principal, but were also aware of the impact health had on learning outcomes for their students.

Contrary to the participants' awareness of the impact of poor health on learning outcomes for students, they were divided in their perceptions of their professional role in supporting their students' health and wellbeing. Some participants were adamant that it was not their role to be involved in following up on health concerns, while others felt obliged, believing that ethically they could not teach a child who was showing apparent symptoms of ill-health and not follow up on this. Karen was adamant that she did not consider it her role to follow up on health-related needs, yet, she pondered whose role it should be.

> It shouldn't be my job; I shouldn't have to make it happen! But, at the end of the day, this kid's in front of me; I'm going to do everything I can to help this kid, but it's not my job. It shouldn't be my job. I'm there to teach them, but you do what you have to do, right? (Karen)

Rob was more definite, suggesting that those with expertise in these areas were best to deal with students' health and education needs.

> You know we're education, you are health. You know, I know more about reading than you do. (Rob)

Theme Two: A filtered and mediated relationship

The second theme focused on teachers' use of the SENCO as an intermediary to access health support for their students. Teachers and the principal were happy with this arrangement as it allowed them to focus on teaching. In addition, they felt protected from becoming too involved with the health needs of their students. However, although teachers wanted to be included in any feedback about their student's health needs, they were often not updated. The school principal, Rob, stated that he tried to look after his teachers by not putting the responsibility on them for following through on students' health issues. Instead, he chose to employ a full-time SENCO for this purpose, drawing from his school funds for the past 10 years to do so. Doing so served a functional purpose by relieving the teachers of the responsibility and time taken to attend to student health concerns and enabling them to devote their time and energy to teaching.

For Mary, a teacher aide, having access to the SENCO went further; it was about providing role clarity and boundaries. In attending to the health needs of students, Mary believed that this was not within the permitted scope of a teacher aide role.

> In that kind of area [attending to health issues] I don't feel it's my territory to do anything with the child, I just send the child to the class teacher…. I know my role and what to do as a teacher aide. I am *just* a teacher aide, so I just know what I need to do. (Mary)

The SENCO at Pūkeko Valley school viewed herself as the key student support person and the school's health and learning support services coordinator. She receives referrals from teachers and other school staff for students needing support relating to

health issues and then decides on a course of action or selects the appropriate service with whom to engage. The SENCO sensed that health issues needed to be dealt with in a time-effective way.

Theme Three: The nurse is our conduit to health services

The third theme relates to the school staff's association with their school nurse. Participants viewed the assigned school nurse favourably and as their direct relationship with health services. The importance of the nurse working and collaborating in ways that built a partnership and trust was essential to sustaining the teacher-nurse relationship.

> The more we consult and collaborate together, the easier it is for all of us to do our job and for the children because we're all here for the children, you know. And if you can work together to get an outcome, that's what it's all about isn't it? (Angela)

Teachers emphasised the importance of the nurse having positive personal attributes, such as being warm and friendly over being brusque and task-focused, which directly influenced their willingness to interact with her. Teachers were not immediately willing to be parted from their students if they were unsure of the benefits of doing so or if their students would be treated with care and compassion.

> When you've got somebody who's a nice gentle, friendly face coming to the classroom and saying, 'come on my darling, you come with me', you feel confident letting the children go, but not with someone that stands at the classroom door saying 'Joe Bloggs you need to come, so and so, you need to come'. (Rachel)

The teachers preferred that the nurse be flexible and work cooperatively to ensure that students' learning opportunities were not impacted by being pulled out of the class to see the nurse when perhaps this could wait. Having a more regimented approach that suited the needs of the nurse rather than the student or teacher was counterproductive to the teacher-nurse relationship. Despite having direct access to nursing services, staff at Pūkeko Valley still made referrals to the service via the SENCO.

Information sharing between the nurse and the teachers about students' health needs was a topic deliberated on during the individual interviews. Teachers wanted to be

informed enough to observe their students, pre-empt issues, and accommodate any needs. There was often tension over the lack of feedback to the class teacher following a referral via the SENCO. Consequently, many of the teachers felt that they were often left uninformed about health issues relating to their students.

> If we don't physically get that feedback, we can't act on it. I don't know what to look for - I've got one child that's going out of my class for regular counselling, I never know when she's going, I don't know why, and I don't know the strategy I'm meant to use to support her in class. (Rachel)

Theme Four: Cultural perspectives differ

The fourth theme draws attention to understanding different cultural perspectives when considering health needs alongside learning and delivering health services in schools.

Two interview participants at Pūkeko Valley school identified as Māori or Māori and Pākehā on the pre-questionnaire and in conversation. Mary and Kirsty offered valuable insight into the cultural influences on the relationships between schools, families, and health services. This insight included the importance of building and maintaining relationships and the perceived barriers to accessing health care for Māori and other cultural groups. In their interviews, it was evident that they viewed health in a holistic way, thus reflecting Te ao Māori, a Māori worldview. They drew on their own lived experience/mātau a wheako to provide examples of how these perspectives influenced their expectations of teaching practices. Mary described her concerns for students who appeared unusually quiet or withdrawn at school. For Mary, this was an alert to student wellbeing, and she would go out of her way to discern the cause for these behaviours. Mary also discussed the importance of teachers adopting a broader lens on health rather than only a physical perspective, particularly where a child might struggle with their learning.

> The staff might put pressure on the child without realising that this child has something going on at home, that's why they are not learning…it could be a lot of things, could be fatigue, it could be hunger. If the student is not doing right, for whatever reason, yeah, it could be things at home. (Mary)

The Māori concept of 'Taha Whānau' is a concept that involves taking a holistic view to wellbeing and including those individuals that the child shares their life with, not just immediate family, when considering why the child may not be accessing or receiving health care as advised. Concerning some Māori families delaying accessing health care, Mary cautioned that this may not always be down to a relationship or resource issue; it could be that Māori simply view health differently. Te ao Māori, Mary advised, includes the view that if a child is happy, eating, and playing, for example, everything must be all right. As a result, health concerns may be left longer before being addressed if the child appears otherwise well.

Mary spoke specifically about the Māori concept of 'whakamā', meaning shame, embarrassment or shyness, and how this could influence the relationship between families, teachers and health providers at the school, particularly when language and financial resources were an issue.

> They [caregivers] could be embarrassed, they could be too shy to come in…it could also be the language; we've got our Māori people, we've got our Pacific Islanders and all that…and we might have other cultures, different ethnic groups that could be too shy, they might be too embarrassed to ask for help, so they don't get the help they need. (Mary)

In discussing the concept of whakamā and Māori specifically, Mary alluded to the struggles many Māori families face and their reluctance to reach out for help.

> For Māori people, there are some families that are suffering, but they're a bit too shy to talk to anyone about it. They'd rather treat their own children, their own family, in their own way. They avoid buying prescriptions and all that because it is a struggle. Although, I would say that the children are treated more with medication, and it's the older ones that often miss out, or sometimes they just share because of the cost. They will share to help another one that is in need of it [the medication]. (Mary)

With respect to teachers and families engaging with health services, both Mary and Kirsty felt it was important to draw everyone in together, upholding the Māori practice of whanaungatanga - that of building relationships, connections and kinship. In Māori culture, whanaungatanga is created through shared experiences and working together and aims to provide people with a sense of unity and belonging.

At the time of this study, Pūkeko Valley primary school's relationship with health services appeared positive and functional. How the school staff interfaced with health services was influenced by what they perceived as the relationship between learning and health. A filtered internal referral pathway for children experiencing health issues, teachers' perceptions of their role and responsibility concerning health, and how they related to their assigned school nurse influenced the school's overall relationship with health services. The school's pragmatic approach to engaging with health services stemmed from the school's desire for its teachers to first and foremost, be able to get on and teach the children.

Case Two: Tarāpuka Beach School

Tarāpuka Beach school is a decile 4 school located in a residential metropolitan suburb in the North Island of New Zealand. The school hosts a Special School satellite class[3]; students from this class are integrated into the school activities. When conducting this study, Tarāpuka Beach school had approximately 340 enrolled students. The largest groups of student representation drew from Samoan, New Zealand European, Māori, and Indian ethnicities in comparatively equal proportions. Ethnic groups, including Tongan, Cook Island, Filipino and Chinese, were represented in smaller numbers.

Tarāpuka Beach school promotes a culture of inclusivity and diversity, reflected through the various design features, colours, artwork, and sculptures throughout the school and school grounds. These representations celebrated the many different cultures at the school and individual diversity and uniqueness. The principal (Neil) was strongly committed to both the students and staff aiming high and achieving to the best of their ability. The principal was receptive to my research, and six school staff members volunteered as participants, including the principal, Neil. Conscious of the need to minimise disruptions to school functioning and teachers' ability to have their usual breaks, Neil paid for a relief teacher to cover the staff members who wanted to take part during a single day of interviewing. There was no obligation to be

[3] Special schools support high needs students, either in day schools or residential schools across New Zealand.
https://www.education.govt.nz/school/student-support/special-education/day-special-schools-for-students-with-high-needs/

interviewed on this day; instead, it was an option for staff. All of the participants took up this offer.

Observation of the SENCO meeting

On the day of the SENCO meeting, I was introduced to the meeting attendees by the designated school SENCO Cushla. The meeting did not progress as I expected a SENCO meeting might, based on my professional experience. At the end of the meeting, Cushla confirmed what I had supposed and explained that the school did not have a meeting entitled SENCO meeting, but instead they held a fortnightly *Interagency* meeting plus a *New Referrals* meeting twice a term. The meeting I observed was the *Interagency* meeting. The five participants present at this meeting were the Deputy Principal, a behavioural psychologist from the MoE, the Tarāpuka Beach school SWiS, the school SENCO and a RTLB.[4] There were no MoH representatives; the school had requested that a Public Health Nurse from the local health service provider have a regular presence at these meetings, but this had not yet eventuated. Absent on the day was the SLT assigned to the school by the MoE.

This meeting served as an update between the professionals present on where each attendee was at with the student with whom they were working rather than a formal opportunity for review and future planning. The meeting was collegial in the sense that the participants offered each other time to give feedback on their work and progress with the students; however, no collective decisions were made, nor were meeting minutes recorded. Each participant remained siloed within their professional discipline as they spoke and shared student-related information. No participants in the meeting sought advice or feedback from another, although ideas were shared amongst the group and challenges were discussed, but without future-focused solutions being offered.

Review of professional learning and development

The PLD programme offered to teaching staff at Tarāpuka Beach school was planned and facilitated by the principal and a senior teacher from the school's curriculum planning team. Together, they were responsible for deciding on the programme

[4] An RTLB is funded by the Ministry of Education to work with teachers to support the learning and achievement of students with learning and/or behavioural difficulties. https://rtlb.tki.org.nz/The-RTLB-service/What-RTLB-do

content. Over the preceding 18-months, the content had focused mainly on pedagogy and managing challenging behaviour. An outside charitable agency had offered one session on supporting children diagnosed with Autistic Spectrum Disorder (ASD). After the interagency meeting observation, the principal, Neil, asked if I knew anyone who could present some education on Attention Deficit Disorder (ADD) and Attention Deficit Hyperactive Disorder (ADHD). Despite uncertainty about how to source relevant PLD, there was an awareness amongst all of the study participants that they would benefit from more health-related content, particularly about behaviour and mental health disorders.

> I've had a lot of autistic kids now, but my first autistic child I remember was years ago, I really knew nothing about autism, and I'd had no professional development, so I just kind of stumbled through. It was my own reading that gave me information, I can't remember having any PD. (Fran)

A holistic understanding of health and wellbeing related to learning and teaching practices was not discernible from my observations and interactions with school staff at Tarāpuka Beach school. It was evident that the school was actively pursuing PLD opportunities specifically related to health conditions but, in part, wanted this knowledge so they could categorise health issues pragmatically by diagnosis. Having a health diagnosis played a pivotal role in securing health support and additional resources for many of the children that attended Tarāpuka Beach school.

Individual interview participants

Other than the school principal, Neil, the remaining teaching and support staff employed at Tarāpuka Beach school were female. When Neil spoke, I learned how committed he was to the students and staff at the school and to them achieving to the best of their ability. Neil's commitment to celebrating diversity, reducing inequity, and going the extra mile was tangible; he spoke passionately about children's rights and what he perceived as failures in the New Zealand education and health systems.

Table 8 provides an overview of the interview participants from Tarāpuka Beach school based on the data collected from the individual pre-interview questionnaires. Initially, six participants consented to be interviewed; however, one withdrew due to ill health. The participants ranged in age and included four females and one male. The

participants had experience ranging from a first-year graduate to over 40 years of teaching experience. Except for the school principal, the remaining participants were all classroom teachers at the school.

Table 8. Interview Participants Tarāpuka Beach School

Name	**Age Bracket (years)**	**Ethnicity**	**Position**	**Teaching Experience (years)**
Neil	60-65	NZ European	Principal	42 years
Kate	30-35	NZ European	Class Teacher	1 year
Jennifer	55-60	Other European	Senior Teacher	22 years
Cassie	30-35	Cook Island Māori	Class Teacher	7 years
Fran	50-55	NZ European	Senior Teacher	30+ years

The data collected from the participants were highly informative, with interviews ranging from 35 to 45 minutes in length. Each participant provided their accounts of working with children who had experienced health-related issues that impacted their learning and the accompanying challenges.

Tarāpuka Beach school is culturally diverse and promotes inclusivity. The principal, Neil, leads by example, and there is a strong sense from the school staff that the student is at the heart of decision-making. Classified as decile 4, Tarāpuka Beach received minimal visible health service resources from the local DHB; however, the school went to considerable lengths to ensure that no child was disadvantaged because of this. The expectation of staff concerning the relationship between schools and health services was shaped by their experiences of working with the local public health nursing service.

Identified themes

Five prevailing themes were identified from the data collected across the individual interviews, interagency meeting observation, and review of PLD offered to staff in the previous 18-months. These themes informed all of the five issue statements (Table 1) and sub-issues identified in the conceptual structure of this study.

Theme One: Reduced visibility of health services

This first theme relates specifically to issue statements two, four, and five; the findings reveal the minimal health service support offered to the school and suggest that health services are invisible, accessible only through invitation or referral.

Although the participants at Tarāpuka Beach school knew about *some* of the health services available to the school, particularly nursing, the visibility of such resources was low or non-existent. Fran, a more experienced teacher at the school, commented: "I don't currently know who the public health nurse is. I don't know if there is one, and I'm not sure if they ever come". Jennifer shared Fran's sentiment:

> We used to have a public health nurse who would regularly come on a weekly basis. But I think the services must be too stretched now and they don't come. We used to always know who the public health nurse was, but now I wouldn't have a clue. (Jennifer)

The interview participants referred to nurses more often than any other health professional. Most had encountered nurses in the school setting and had more experience working alongside nurses than other health professionals. They often described the nurse as the health 'expert'. Although the nursing service was once highly visible, Neil confirmed that access to it had dwindled over the years and was now almost non-existent. In addition, no representative from the health sector attended the interagency or referral meetings at the school.

> Sometimes in a meeting where we've got concerns about a child's learning or their care or whatever, the representative of health isn't there. We might have our social worker and related parties, but the health piece isn't present. We have had that presence at different times over the years where, depending on the nurse, a nurse will attend when and where possible. Now, a nurse is invited to come but doesn't come. (Neil)

Some teachers were unaware that particular health service supports were accessible to them, especially those with fewer years of teaching experience. One participant, Kate, a first-year teacher, had no personal experience working with health service providers in schools. Health services available in schools had not been discussed with her in her undergraduate training or as a new to practice teacher; these services

simply did not exist for Kate. About her undergraduate training programme content, Kate commented:

> We didn't have much training about health stuff, even at a basic level, more from a historical perspective and definitely not on an individual child level or psychology based…I think it would have been helpful…I don't think I know enough yet to know how to ask the right questions or to know what I'm looking for. (Kate)

Theme Two: Filtering of teacher referrals

At Tarāpuka Beach school, teachers refer children who have health or behavioural issues of concern to another person to formally activate the necessary help and support.

> I go through my team leader who then, once we've filled out application forms for RTLB support, gives it to the SENCO. So, we I don't have any interaction with the nurse or social worker directly; the referral just goes to the SENCO. (Kate)

This seemingly *filtered* referral system meant that frequently it was the designated SENCO, team leader, principal or deputy principal, who acted as the conduit between the school, the health service provider, and the family. This appeared to be a practical approach because these persons were perceived as more readily able to do so as they did not have classroom teaching responsibilities. Some teachers articulated that they wanted to be able to access health services themselves, not necessarily via another person or system. This desired access included having face-to-face contact with health professionals so they could share nuanced information about the needs of their students with respect to their learning, information that was best received first-hand rather than via an intermediary.

Sometimes, those responsible for completing health referrals were reluctant to do so, either because they lacked the knowledge or found the process too complex and lengthy. Neil, the principal, demonstrated the most knowledge about what health service support was available to the school. Neil described himself as the "*interface"* between the teachers, the family, and health services; and did so with an air of resignation tinged with frustration.

> There's not much to say, I can't say much because there is very little [health service] provision. If there is, it's siloed, and they operate independently from everybody else. They [health service providers] don't have that understanding or interest in communicating or actively going out and promoting their service within the schools to be more effective. (Neil)

To Neil, access to health services was one issue; another was the separation of services *within* the health sector. Navigating different departments and specialist resources such as developmental paediatrics and mental health services required tenacity and time.

Theme Three: Supporting student health and wellbeing

The third theme focuses on the often-conflicting tensions when teachers reflect on their role in supporting their student's health and wellbeing. The interview participants responded consistently to what they perceived their role to be in relation to supporting the health and wellbeing of their students. They described their role in this process as mainly educational, involving health promotion activities and improving health literacy. Most felt that it was an integral part of their responsibility as teachers, but not necessarily from a hands-on provision of care perspective.

Teachers saw their role in addressing immediate health issues at school as similar to that of a parent. This perception was coupled with a dilemma: If the teacher did not intervene in a similar way that a parent might in a given scenario, they would be questioned as to why not; but if they did intervene, they put themselves at risk of being deemed by parents as overstepping the boundaries of their professional role:

> We're on alert, I guess, trying to be aware of that health thing and trying to remember to catch up with parents after school, to notify them in a way that's not going to embarrass the child or the parent. There's all those kinds of levels of alertness and awareness that you have to have. You've got to be diplomatic and not make anybody feel ashamed. (Jennifer)

When it came to supporting their student's health and wellbeing, there was an ill-defined boundary between what the study participants at Tarāpuka Beach school felt they could and should do or not do. This was further complicated by a sense of obligation and duty of care some teachers expressed for their students.

Theme Four: Managing without

In the fourth theme, the practical stance that the school takes in dealing with health-related issues in the absence of any other external support is highlighted. In the absence of a visible and sustained interface with health services at the school, the staff at Tarāpuka Beach school worked cohesively and conscientiously to meet their students' health needs. Working together included engaging families and the wider school community. The staff indicated their willingness to talk with families about health concerns; however, this was often clouded by their perception that they were not the 'experts' and that a health professional was likely to have more authority and influence to speak on health matters. It was not uncommon at Tarāpuka Beach school for the principal or deputy principal to visit parents and caregivers at home when concerned about the health and wellbeing of a student.

In the individual interviews and during the meeting observation, there were references made to the lack of funding and learning support resources available to run programmes that support small groups of students or to invest in intensive one-on-one interventions. One example of this at the interdisciplinary meeting was when participants spoke about a particular child who was not eligible for individually targeted funding for his specific and significant learning needs. I detected a sense of frustration primarily through the experiences and rhetoric shared by the meeting participants. Additional learning resources for students who did not meet a required funding threshold were perceived as overly challenging to secure and inequitable.

> It's [additional learning support] not flexible. They're [funders]trying to operate it rigidly and fairly, but it's not fair. It needs to be equitable. It needs to be delivered in a more differentiated way. (Neil)

There was a sense from the interview participants that anything was better than nothing, and the school would always find another way to meet a student's needs should a particular resource become unavailable. However, this way of allocating resources was frustratingly piecemeal and unreliable for everyone involved; plus, there was no opportunity to plan long-term goals for the student. In light of this, meeting attendees often had to think creatively and allocate leftover funding from specific individualised student care packages (which included the allocation of learning and

health-related support) to students who had not reached the threshold for securing funding.

Theme Five: Cultural perspectives

The fifth and final theme was identified through valuable insights provided in the interview data about the need to consider different cultural perspectives when engaging with children and their families. As the only non-New Zealand European interview participant, Cassie offered valuable insights into how Pasifika[5] families relate to education staff and consider teachers as leaders. In doing so, families are often reluctant to question teachers. Cassie commented that it was similar to the health profession. Cassie went on to explain that this somewhat hierarchical way of thinking was part of the day-to-day Pasifika family functioning too:

> The Mums are usually frontline. You see them, but behind them are the Dads, and the father at home will have the final say. Mum may come home and say, I am getting medicine, and Dad will say no. (Cassie)

Kate, a first-year teacher, offered insights on her practice and how she needed to carefully consider how she communicated any concerns about a student's health and wellbeing with their family, particularly with those from another culture than her own. Drawing on previous experiences in another non-teaching role, Kate was careful that her conversations were not misinterpreted as blaming the family or being seen as superior. This was difficult in regard to Pasifika families, who hold teachers in high regard in terms of superiority, and it created a level of unease for Kate:

> I feel it as a tension, I have to navigate it, but I find it a good challenge because I really enjoy working with Pasifika families. I understand how some organisations or people can come across; it can be very accusatory or very derogatory. I think it stops people from engaging, and so, I'm very, very sensitive to that. (Kate)

Based on her own experiences and cultural background, Cassie emphasised the importance of teaching staff to understand how families from different cultures function and openly acknowledge different cultural perspectives, language barriers and any potential resulting power imbalances.

[5] Pasifika is a term used by the MoE and MoH to describe people living in New Zealand who have migrated from the Pacific Islands or who identify with the Pacific Islands because of their heritage.

Tarāpuka Beach school case findings highlight those certain barriers to accessibility, such as the referral system, were sometimes considered lengthy and complex, impeding teachers from engaging and sustaining a relationship with health providers. Likewise, there were fewer opportunities for engagement with health services due to a lack of visibility. The findings also provided new insights on engaging and working more effectively with Pasifika families, particularly how culture can potentially influence Pasifika people's direct relationship with teachers. In addition, from the perspective of the interview participants, there was minimal content on health conditions that commonly interrupt or impact learning in the undergraduate teacher education programmes they had individually completed. Whilst the teacher training syllabus is directly influenced by the New Zealand curriculum, it is worth highlighting that the overall content varies from provider to provider. The perceived lack of content on health conditions in some training programmes could potentially bear influence on early teachers' understanding of health-related barriers to learning.

Case Three: Ranguru Cove School

Ranguru Cove primary school was the third and final case in this study. A large decile 10 school, Ranguru Cove has a school roll of over 600 students. The school is located in an affluent, cosmopolitan residential suburb adjacent to the inner city. It has a Māori medium education[6] unit where students who attend are taught in Te Reo Māori for many of their subjects. The school environment was well-maintained and ordered.

Almost one-quarter of the students at Ranguru Cove school identify as Māori and learn in either the mainstream setting or the Māori medium education unit. A further sixty percent of students identify as New Zealand European, and the remaining identify as Samoan, Cook Island, Other European, and Other. The school usually employed a designated SENCO; however, the position had recently been vacated at the time of this study.

The principal, new to the school, granted me an opportunity to present information about the study at a staff morning tea. Six registrations of interest to participate in the study were received and confirmed through further email contact.

[6] Māori medium education is where students are taught all or some curriculum subjects in the Māori language for at least 51 percent of the time (Māori Language Immersion Levels 1-2). https://www.educationcounts.govt.nz/data-services/directories/maori-medium-schools

Observation of the SENCO meeting

At the time of the study, the designated full-time SENCO, Saskia, had recently resigned from the role, and a new person had yet to be appointed. As a result, the principal advised that SENCO meetings were not currently taking place. The senior management team and teachers were doing some of the SENCO work informally between themselves, with one teacher assigned to most of the behavioural concerns and pastoral care responsibilities. The principal agreed to forward the study information sheet to Saskia, the previous SENCO, to see if she was interested in participating. Saskia subsequently made contact, and I engaged her as an interview participant. A suite of questions (Appendix W) based on the original SENCO meeting observation tool was constructed to elicit how the SENCO meetings had been run in the past and to gain an insider perspective.

Saskia provided valuable insights into the SENCO role and functioning at Ranguru Cove school. Saskia alluded to the heavy workload and stressors of the SENCO role and described there being no access to health service support at Ranguru Cove school; it was something in her role that she had to "fight for". Saskia also reminisced about how she perceived students' health and wellbeing needs had changed over recent years and how, nowadays, accessing the right kind of help was increasingly challenging.

When Saskia was in the role, weekly SENCO meetings were run at Ranguru Cove. They included the principal, two deputy principals, a senior teacher (designated responsibility for children with behavioural and pastoral care needs), and the SENCO. The meeting was run as part of the Senior Management meeting, not solely as a SENCO meeting. No external health or education representatives were present, and class teachers were invited only if a particular student of theirs was being discussed. Saskia regularly met with the allocated RTLB to discuss resources available to support individual students with their learning. Even though health issues were frequently discussed, the school had no standard interface with health services at these meetings.

Class teachers at Ranguru Cove school escalated any significant health or learning concerns they had to Saskia for her to action and undertake the necessary referrals. Teachers did not always feel comfortable with doing this, sometimes feeling excluded from the referral stage of the process; they implied that there was a degree of

ownership held by management and the person holding the SENCO role over actioning external referrals:

> We, as classroom teachers, are expected to hand it over to the SENCO and the senior management. We refer it to senior management; one of them said that she was looking after it, it was under her umbrella and to kind of, as a classroom teacher, step back, and they were going to deal with it. We have to assume that they will follow up and do stuff. (Suzie)

A senior teacher at the school had the assigned role of behaviour support and pastoral care, and Saskia, as the SENCO, had the role of learning support. From Saskia's perspective, the two functions were separated for practical reasons, based on the senior teacher having established relationships with families and the wider school community. These relationships had been developed over the senior teacher's long tenure at the school. The teacher would coordinate getting children and families to health appointments if needed and do a home visit if concerns about a student's physical health or behaviour existed.

Saskia described the SENCO meeting as occurring "around a table", with all members of the meeting contributing freely. The meetings lasted for up to an hour, with, on average, seven cases discussed in some depth. The dialogue centred on resources, time frames, and who might oversee an intervention if Saskia felt she did not have time. Collaborative discussions occurred around possible strategies and solutions for supporting students. When concerns or queries about students' health were raised, Saskia explained that she took on the responsibility of following up with external health providers describing this as often challenging and needing to be persistent and tenacious. As Saskia described these challenges, she spoke with emotion and exasperation.

Review of professional learning and development

PLD opportunities were offered to staff weekly at Ranguru Cove school and lasted approximately an hour and a half. The senior leadership team at the school was responsible for planning and choosing the education offered. Over the previous 12 months, the focus for staff had been on student or learner agency[7]. Opportunities to

[7] Student or Learner Agency is having the power or capacity to act and make choices.

learn about health conditions that might impact educational outcomes for children have been minimal.

In addition, PLD was offered on an "as needs" basis for teachers who had a child in their class with a long-term health condition. The SENCO's role was to ascertain where that support and education might come from and arrange for the teacher to be released from their class to attend. I explored the targeted PLD approach to health with Tanya, the principal. She explained that the cost of providing PLD to all staff on health issues that may only pertain to one or two students, a minority, was prohibitive. There was also a notion that teachers who were not interacting with that particular student would not consider attending such PLD a good use of their time. It was expected that whoever was released to attend targeted PLD would feed back to their teaching colleagues.

Nonetheless, the participants communicated that they would have liked more health-related topics included in their PLD programme, particularly mental health. Many alluded to the increasing number of students who started at the school with existing anxiety and other mental health and behavioural issues. Many participants perceived mental health as an issue that significantly impacted learning, but finding help and support was challenging. Although identified as impacting learning, the participants did not consistently link mental health and behaviour to physical health and vice versa.

Individual interview participants

An overview of the interview participants from Ranguru Cove School based on the information gathered in the pre-interview questionnaire is included in Table 9. Six participants took part in the individual interviews. They included the principal, three classroom teachers, the previous SENCO, and one of the school secretaries responsible for the sick bay and interfacing with families when students had health-related issues. The information gathered from the interviews spanned an array of topics and views, and provided an abundance of rich, informative data. The length of each interview ranged from 35 to 45 minutes.

In a learner-centred environment, learners have agency over their learning and classroom systems serve the needs and interests of the learner. http://elearning.tki.org.nz/Teaching/Learner-agency

Table 9. Interview Participants Ranguru Cove School

Name	Age Bracket (years)	Ethnicity	Position	Teaching Experience (years)
Kate	40-45	NZ European	Senior Teacher	20 years
Suzie	50-55	NZ European	Part-time Class Teacher	25+ years
Tanya	45-50	Other European	Principal	30 years
Jodie	60-65	NZ European	Class Teacher – Māori Medium Unit	20 years
Saskia	45-50	NZ European	SENCO	28 years teaching, 1-year SENCO role
Kendra	50-55	NZ European	Administration staff	9 years

Identified themes

Four main themes were identified from the data drawn via the different data collection methods. Collectively these closely aligned and informed issue statements two, three, four, and five (Table 7).

Theme One: Invisible school health services

Health services were not visible to staff at Ranguru Cove school. There was a perception that previous services had been withdrawn from the school based on their decile ranking, which impacted the school's ability to access health support promptly. Participants nostalgically recalled the past when health services were more visible to them and how much they had valued this, particularly nursing services. Suzie and Tanya acknowledged that a higher decile school might not need as much health support as a lower decile. However, they spoke about the challenges of accessing support for a cohort of Ranguru Cove students and their families struggling to manage long-term health conditions, economic hardship, and social problems.

> I'm sure a decile 10 school doesn't need quite as much as the lower decile schools, but there's still a real need for a small percentage of our kids. We are decile 10, but there are still kids in social welfare, there are refugee families, and there are kids with high anxiety levels. (Suzie)

The nursing service was the most referenced health service, with all participants having an understanding and knowledge of this service despite it being regarded as invisible or inaccessible to them. Much of this knowledge was gained through previous experience working in schools where the nursing service had been more readily available. The participants who had been at the school for a longer time reminisced about when they had access to the service and its perceived value for the staff and students, including knowing and understanding the school community's needs.

> It was a really lovely environment to work in, to have a health person supporting us. It's just another helping hand because basically health needs are huge in schools. It's another person that can bring expertise; you don't have to constantly upskill yourself or try to make contact with somebody who knows. (Saskia)

The participants reflected on desirable attributes for a nurse working in the school; these included the nurse being approachable, caring, and understanding, and being visible and accessible. Having a *portal* to health in the form of a nurse was seen as beneficial, potentially streamlining decision-making and enabling timely access to the proper support for the student.

Securing the necessary funding was a barrier to staff requiring health support for students with complex needs. This task was the responsibility of the SENCO to navigate, and it took a considerable amount of her time. The amount of paperwork involved in completing some types of funding applications was considered prohibitive and not worth doing unless one was confident of a positive outcome. As a result, the school often self-funded initiatives to assist students with learning and health needs.

Theme Two: Teacher's perceptions of their role

Throughout the individual interviews, the participants discussed, deliberated, and questioned their roles and responsibilities in managing the health and wellbeing of the students at the school. Many viewed managing the health needs of their students as an additional burden but, at the same time, acknowledging the interrelatedness of health and learning. This was considered within the context of existing workload and perceived boundaries of responsibility and expertise between themselves, the families, and the health sector.

> You can't teach a kid [sic] that's not at school through truancy or is unwell or unhappy. You've kind of got to look at the holistic nature of the child. They can't learn if they can't hear or if they can't see properly. They can't learn if they're in pain, so you are always having to look out for that. (Suzie)

Some participants likened their role to being a parent, needing to set behavioural expectations and boundaries. In addition, tending to basic physical needs, such as reminding the child to wear a warm jersey, change wet clothing, drink more water, or go to the toilet, was seen as something a parent or caregiver might do. Participants spoke about taking care to foster good relationships with families so that conversations around the health and wellbeing of the child were received in the way that was intended. Maintaining an open and positive relationship with families was considered necessary in supporting student health and wellbeing both at school and at home. In addition to having a pseudo parental role, those interviewed also saw themselves as role models to the children in promoting the school values and behavioural expectations.

> I definitely liken my role to that of a parent, especially in teaching about behavioural expectations, boundaries, how to relate to other children and how to relate to adults. You are modelling the whole time the type of behaviours you would expect. (Jodie)

Theme Three: Getting by without access to school health services

Being a large, busy school influenced how Ranguru Cove interfaced with health services and led them to develop their systems for reasons of efficiency and consistency. Managing without health service support involved utilising the office staff, the wider school and local community, national health lines and websites, in-house referral systems and allocating specific roles and responsibilities across senior staff members.

Kate, a class teacher, spoke about how it was usual practice to escalate minor health concerns to the school office staff, who then dealt with the issue via liaison with the appropriate external service and the parent/caregiver. This functional approach sat comfortably with most of the class teachers interviewed, who perceived they had limited time to deal with their student's health concerns and were confident in the office staff's relationship with the families.

Kendra, the school secretary, explained that her ever-increasing role in supporting the health needs of students at the school was born mainly out of necessity following the withdrawal of the nursing service six years prior. Kendra described her role:

> I'm the enrolments officer and receptionist, plus I am number one in the sick bay. Some of the children call me the doctor at the school! I actually deal with that side of it, plus the health and safety side of things; you know I follow up after injuries. I also have a lot of children that do just come in and just need to have a chat. So, you know, I'm that sort of in-between person between parents and pupils. (Kendra)

It became clear that Kendra was the main default for the teachers in supporting the everyday health needs of students at the school. In addition, she was often regarded as a substitute parent during school hours by many of the students. When asked what training and resources Kendra had received to support her in this role, she stated that she attended first aid training every two years and utilised the national 0800 Health Line[8] and a local GP practice to access additional guidance and support. Kendra also alluded to spending time on the internet updating herself on common conditions such as asthma, allergy, and skin infections. She reminisced about when there was a visiting nursing service and how they had provided this level of knowledge and expertise.

> Having the health nurse was great, I could just pick her brains with things, and she would just feed me lots of information. I'm not a professional you know, and that's first and foremost. I'm not a professional. I've had basic first aid training, that's it. As much as the kids call me the doctor at the school, I'm not a doctor, and I'm not a nurse. (Kendra)

Theme Four: Culture matters

During the data collection phase, it became evident that culture from both an ethnic and ethos perspective influenced how Ranguru Cove school and its community related to and interacted with health services. Participants expressed their belief that the school was unique. This uniqueness lay in the types of health needs experienced by the children attending the school, the belief that they are ineligible for external health service support and the school having a Māori Medium unit operating within it. This belief had manifested over time and was related to the school's current decile ranking.

[8] Healthline is funded by the Ministry of Health and provides free health advice and information to the public 24 hours a day, 7 days a week. https://www.health.govt.nz/your-health/services-and-support/health-care-services/healthline

The staff valued the known in-house referral and support system for children with health needs. The current system was viewed as effective, and there was an assumption that the school would not be eligible for any additional external assistance because of its decile ranking. This deemed ineligibility was not ideal from the school's perspective, but participants were at a loss to know how to change things and were resigned to accepting the status quo. Consistent with this, an ethos of school self-responsibility had emerged:

> In my time here, we haven't accessed health services; my experience is that there is a culture at the school that we are decile 10, so we should not expect help and support. I'm trying to change that culture to say that actually there is help and support out there, and our children are as entitled to it as anybody else. (Tanya)

Jodie was sceptical about the benefit of a visiting health service to the school and students. In her view, the school staff already had some knowledge and knew how to access help to address the most common physical health concerns.

> You know we know what the services are out there…. We know how to use an epi-pen. We know where the epi-pens are; we know what to do when we go on trips. We know the children who are diabetic and what they require. We know what to do with asthmatic children and that you have to be considering them all the time when you're doing physical activities blah de blah… We have all that information, and we know what to do. (Jodie)

In contrast, Kendra believed there was a benefit to the school working with external agencies, including health, to address various issues ranging from attendance, social needs, physical ill health, and behavioural concerns. Kendra perceived that a visiting health service could assist in accessing a variety of specialist supports, such as developmental and behavioural assessments for children and their families.

Most of the interview participants considered the school unique in relation to its health needs, with some students and their families coping very well while others (a minority) struggled on both poverty and emotional health fronts. However, the perception that visiting health services were not available to the school further reinforced the culture of managing alone. When it came to accessing external help and support specifically for Māori children attending the unit, Jodie lamented that there

were few if any, Māori health providers operating locally. It was challenging to access wraparound support services specifically for Māori children and their whānau. Jodie also expressed caution in utilising mainstream health service providers; in her view, some clinicians' degree of cultural competence could negatively impact both initial and sustained engagement. Staff knowing what to do and the custom of being self-sufficient was a strong sentiment across all of the interviews, often described in a way that suggested they did not want to be told what to do by an outsider.

In summary, the staff at Ranguru Cove wanted to be able to connect with health service providers, both mainstream and Māori. However, the school staff did not believe that they were eligible to receive visiting health services due to their high decile ranking. The lack of visible health service support prompted the school to develop ways of working to address the health needs of their students in a way they considered best. An example was implementing a referral system whereby teachers passed on their concerns to a designated individual at the school. This person was allocated a specific and individual responsibility relating to either behaviour, pastoral care, learning, or physical health.

It was evident that individual and organisational culture and experience at Ranguru Cove school have helped shape and influence interactions with health services over time. In addition, decreased visibility of health services at the school and the consequent lack of opportunity to work alongside health service providers have directly influenced the quality of the relationship.

This third case report is the final one to be presented and concludes the reporting of the individual case findings. The findings across all three school cases align with and have further informed all five of the issue and sub-issue statements presented at the outset of this study to a lesser or greater extent (Refer Table 1, page 96).

Cross-Case Findings

As outlined in Chapter Three, after the individual case reports were developed, a cross-case analysis was undertaken using Stake's (2006) cross-case Track II procedure. Before commencing the cross-case analysis process, the key findings of the individual case studies were collated into a tabulated format (Appendix X) that served as a

reference point for the key themes that had been identified in the individual case studies. After the cross-case analysis was completed, the cross-case merged findings were added to this table. Assertions relating to the interpretation of the cross-case findings were then created (Erickson, 2012; Nolen & Talbert, 2011; Stake, 2006; Weaver-Hightower, 2019). These assertions respond specifically to the study's overarching research question.

Qualitative research is not usually considered conclusion oriented in that it captures life as it was at that point and acknowledges that findings may alter with time and with changes among participant informants (Creswell & Porth, 2018; Erickson, 2012). Creating assertions that draw from the situational nature of qualitative findings rather than formulating conclusions is considered more appropriate (Freeman et al., 2007; Nolen & Talbert, 2011). An assertion in a qualitative study consists of information 'bits' drawn from the data collected and confirmed through triangulation; assertions arise from the findings and are generated based on sufficient and varied evidence (Erickson, 2012; Nolen & Talbert, 2011). According to Stake (1995a), arriving at an assertion involves a process of "vigorous interpretation" (p. 8) during data collection and analysis; this process draws on understandings from a combination of a researcher's personal experience, scholarship, and assertions of other researchers (Erickson, 2012; Stake, 1995c). The newly created assertions provide a platform for further discussion and exploration.

It is customary for qualitative research to feature one or several assertions about key issues relating to the research question (Stake, 2010; Weaver-Hightower, 2019). In this study, and remaining consistent with Stake's (2006) identified approach when compiling the assertion statements, the focus was on what was similar across the three cases and what was different, though not necessarily unique. Sustaining focus in this way assisted in extending my understanding of the overarching research phenomenon. The cross-case assertion statements are presented in Table 10 below and form the basis for interpretation and discussion in Chapter Five.

Table 10. Cross-Case Assertions Relating the Research Question

Research Question: What is the perceived relationship between primary school staff and health services in New Zealand, and how is this influenced?	
Related Assertions	
Assertion One	The relationship between primary school staff and health services is one of referral
Assertion Two	Visibility of health services in schools influences the relationship between school staff and health providers
Assertion Three	How school staff perceive their professional role influences how they relate to health services
Assertion Four	Onerous processes in gaining access to health services influenced school staff's relationship with health providers
Assertion Five	Higher decile schools have a weakened relationship with health services due to less visible health service support
Assertion Six	School staff perceive health and health services as separated logistically and conceptually from education and learning
Assertion Seven	A shared understanding of the interrelatedness of learning and health reinforces the working relationship between school staff and health service providers
Assertion Eight	The relationship between education and health services can be facilitated through a nurse
Assertion Nine	It is common for classroom teachers not to have a direct relationship with health service providers due to schools' allocating this role to an intermediary
Assertion Ten	School staff perceptions of their role in supporting the health and wellbeing of their students sit on a spectrum

Summary

This chapter has presented an overview of the three individual case findings and introduced the 10 overarching understandings in the form of assertions that were identified from the cross-case analysis. The study findings have revealed challenges relating to the actual and perceived conceptual and logistical separateness of the education and health sectors in New Zealand. These challenges present in the form of accessibility issues, understandings of the interdependence of learning and health, visibility of health services in schools, and differing perceptions of school staff roles and responsibilities in supporting the health and wellbeing of students. The separate operating structures of the education and health sectors hinder the ability to work collaboratively; further compounded by no current directive to work together further

compounds this. Instead, diverse school and health service governance structures exist, with different service-driven priorities and agendas, making it challenging for school staff and health providers to sustain effective working relationships.

The following chapter offers an interpretation of the assertions arising from the cross-case analysis and provides a discussion of the study findings and their implications for the relationship between education and health sectors in New Zealand moving forward.

Chapter 5 Discussion

In New Zealand, health service delivery in schools has existed for over 100 years. In the early years, the collaboration of teachers and nurses was standard practice. This relationship has changed, with several significant health and education reforms since the 1950s contributing to this change. The adoption, over the past 40 years, of neoliberal ideology (Barnett & Bagshaw, 2020; Springer et al., 2016), and the effects of the decentralisation and privatisation associated with this ideology, have increased the variance in health service delivery models and the availability of health resources to schools (Denny et al., 2012; Hansen et al., 2007; Voyle, 2000). In addition, the development of siloed working practices between and within both sectors due to the influence of NPM practices, such as agencification, has affected the ability of health and education services to form and maintain collaborative working relationships that benefit all parties (Hawke, 2002; Overman & van Thiel, 2016; Pollitt et al., 2001).

The overarching theme of inquiry in this study was to explore participant primary school staff perceptions of their relationship with health services and how this relationship is enacted and influenced. Appreciating the historical, contextual, and everyday practice influences on these perceptions is critical to understanding this relationship. Considering the current relationship from the perspectives of the study participants has contributed new knowledge about potential strategies to improve this relationship moving forward. The overarching research question forming the backbone for this enquiry was: **What is the perceived relationship between primary school staff and health services in New Zealand, and how is this relationship influenced?** The primary aim was to understand better where this relationship needs to be advanced, strengthened, and supported to benefit children's education and health in New Zealand. To address this aim, interviews with school staff, field observation, questionnaires and a review of professional learning and development offered to school staff were completed. Various approaches to analysis were adopted for the different data sets (refer Table 3), resulting in an in-depth description of the relationship school staff have with health services. The findings contribute to the existing knowledge about schools and their relationship with health services. The

knowledge gained also tends to the existing literature gap specific to primary schools and New Zealand.

This study has shown that the relationship between school staff and health services in New Zealand is complex. The relationship is unique to school staff as individuals and to individual primary schools as functioning systems in New Zealand. The history of school health service provision clearly shows that system structures, plus the effects of decades of neoliberal-influenced reform across the education and health sectors, have affected the current working relationship from intersector, interprofessional and interpersonal perspectives (Dow, 1995; Hansen et al., 2007; Larner, 1997; Overman & van Thiel, 2016). It is evident that the visibility of health service providers in schools directly influences the relationship between school staff and health services. The current study found that this visibility is considerably greater in low decile than in high decile schools. Increased visibility creates more opportunities for engagement and collaboration of health services and schools. Collaboration depends on what school staff believe their professional and assigned role to be in this relationship.

Equally, this study shows that the current logistical separation of the two systems has resulted in the relationship becoming one of referral only. Schools refer *out* to health providers to bring *in* the service they require. Increased years of teaching experience, plus an understanding of the importance of the interrelatedness of learning and health, increases the likelihood that a teacher will complete a referral or seek consultation with a health provider. Sharing a conceptual understanding of the interrelatedness of learning and health reinforces the working relationship between school staff and health providers. Unfortunately, overly complex referral processes frequently create barriers to accessing health support for students, meaning they may miss out.

Achieving sustainable and collaborative cross-sector relationships between complex systems such as education and health is challenging (Burgess et al., 2015; Keshavarz et al., 2010; Tooher, 2017). Given the acknowledged interdependency of education and health (Basch, 2011a; Costante, 2002; Michael et al., 2015), fostering cross-sector relationships and joint understanding supports positive learning and health outcomes for children and young people (Allensworth, 2011; Kolbe et al., 2015). Findings from

my study identified influences that shape the current relationship between schools and health services in New Zealand and, in doing so, has enabled me to identify potential strategies to strengthen and advance this relationship. The data collected across the different sources considers the influences on the school-health relationship from different standpoints; thus providing a comprehensive and holistic understanding of the relational influences between the education and health sectors.

The Assertions

The assertions respond to the research question by providing answers to a single focus or orientation for understanding the relationship between school staff and health services. Developing each assertion was iterative and required frequent revisiting of the findings. I preface the discussion section of this chapter by offering an interpretation of the assertion statements (Table 10, page 155). These interpretations provide the foundation and conduit for the ensuing discussion piece.

The ten assertion statements interconnect to varying degrees (Appendix T). Assertions one, six, and seven were findings related to the separation of education and health as systems and of conceptual understandings of their interdependence. Assertions two, four, eight and five relate to accessing health services in the school setting and how the visibility of health providers, plus onerous referral processes, influenced engagement. Accessing health services was often time-consuming and challenging, with no guarantee of success. However, teachers' experiences of working with nurses verified them to be a valuable conduit to health due to their increased visibility compared to other health professionals. Assertions three, nine and ten relate to school staff roles in the context of role expectation and responsibility at the school and teachers' perceptions of their professional role in supporting their students' health and wellbeing.

The following discussion provides an interpretation for each assertion. Although presented separately, it is essential to acknowledge the overlap and association between the ideas that are communicated. Consistent with an instrumental case study approach, and the emergent nature of qualitative research, the assertion statements convey a broad understanding of the relationship between primary school staff and

health services in New Zealand. Each school case and its participants have been instrumental in developing these understandings.

Interpretation of the assertions

The assertion statements are interpreted in light of Stake's (1995a) three realities, external, experiential and rational (as described in Chapter Three, p. 89). The interpretation uses material extracted from the individual interviews to help illustrate key points related to the assertion and research question. The order of the assertions reflects their prominence across and within the individual cases.

Assertion One: The relationship between primary school staff and health services is one of referral

The action of making a referral was fundamental to the schools' relationship with health services; this was how they elicit support from health providers, referring *out* to bring *in* the assistance required.

> As soon as there is an issue with a child or like dental, sores, or even with eyes or anything like that, I just put a referral through. (Angela, Pūkeko Valley)

Making a referral was not always straightforward or efficient; it relied upon schools developing a system that worked for them and the service to which they were referring. Jennifer, from Tarāpuka Beach school, spoke about the length of time it took to do a written referral in between her teaching hours. She preferred, instead, to have a named contact she could email or telephone.

After sending a health referral, there were often delays in hearing whether the provider accepted the referral. The time delay varied between services. For example, the Hearing and Vision testers scheduled their school visits annually; if the referral did not coincide with a pending visit or that visit had been and gone, a further referral to an outpatient clinic was required. Time taken to complete a written referral and get a response from a health provider was an issue that echoed across the interview participants. They articulated concern that a delay could negatively impact the child and their ability to engage in learning activities.

Some participants also referenced the current complex and lengthy process involved in accessing support for children with significantly high health and disability needs:

> The referral form is a 20-page document and takes over 100 hours to complete one of those, you can get turned down, and if you get turned down three times, you can never apply again… It's highly scrutinised, and it is highly competitive because it is capped across the country. It's assessed by a team of people that will never even see the child. (Rob, Pūkeko Valley)

Lengthy referrals for children with complex health and associated learning needs were perceived as unnecessary. Many participants felt that complex needs referrals could be managed differently to optimise opportunities for early intervention.

In-house referral systems varied significantly between the three cases depending on the internal operating systems of each school. One or two staff members were usually designated to manage the referral processes and liaise with health services. All systems involved degrees of filtering or delegating, explained further in Assertion Nine.

Assertion Two: Visibility of health services in schools influences the relationship between school staff and health providers

The degree of visibility of health services in the school cases was directly related to the uptake of services. High visibility correlated with high uptake of services and improved relationships. Low visibility could reduce uptake and cause schools to believe they have to manage alone.

> What we lack here is visibility. So, we're stuck with a child, and we don't know where to go next because we don't have a link or a person or a contact. (Tanya, Ranguru Cove)

> If there was a person or if it [school nursing service] was more visible, we'd definitely make more use of it. (Jennifer, Tarāpuka Beach)

Visibility was related to health services having an increased physical presence and profile in schools. Some schools were unaware of what services were available to them and how to access help. Reduced visibility of the publicly funded school health service often resulted in schools drawing on their wider school and local community to elicit help and support for students; this included teachers, parents, or other community members, such as the local GP or optometrist.

A lack of visibility and contact from funded school health providers directly influenced how often schools made referrals and utilised services. With no visible support or interface, schools would sometimes utilise their staff to take children to medical appointments and visit homes to follow up with caregivers.

> If there are serious health issues within the school, we [school staff] deal with it…we ring a doctor. We do things like that because we know that they [the students] have to be looked at. We tend to take on that responsibility because there is no one else. If I see a child that we know has got a clinic appointment, we'll sometimes take them with the parent to advocate for the parent because many of our families don't feel comfortable. (Neil, Tarāpuka Beach)

Atypically, Pūkeko Valley, a decile 1 school, had an assigned public health nurse who regularly visited. Despite this, visibility was still raised as a potential barrier to access and engagement. School staff perceived that in visiting the school intermittently, there was less access to and opportunity for staff and students to get to know the assigned nurse. The nurse being present and visible for part of *each* school day was preferable to having set visiting times and days. Participants considered that integrating with school staff during morning tea and lunch breaks was pivotal to the nurse being considered part of the school community. Some of the interview participants also proposed a benefit to having the school nurse visible outside of school hours during set activities such as parent-teacher interview evenings. Hence, families had an opportunity to engage and familiarise themselves with the nurse.

Assertion Three: How school staff perceive their professional role influences how they relate to health services

How school staff related to health services was influenced by how they perceived their role from a functional perspective. As in any other workplace, individuals working in schools usually have a particular focus to their role. For example, teachers assist students with their learning, school administration staff focus on administrative tasks, and the school principal concentrates on the bigger operational picture. How these varied positions interfaced and worked alongside health services was determined by what the individual perceived their role to be in this relationship. This perception was shaped further by the expectations of peers and those in designated senior roles.

Kendra's role as the office receptionist also included working in the sick bay, a combination she did not always find easy.

> It's in my job description that I do the sick bay; that's basically how it's written, that I'm the sick bay person. I do sort of struggle with that because I sometimes wonder what people think I actually do here. You know, people know I'm the sick bay person, people know I do enrolments, but I don't think they actually realise quite how involved it [the sick bay work] is, and quite how much work is involved in it. (Kendra, Ranguru Cove)

Kendra's colleagues at the school expected that she would deal with the less serious health concerns and, if necessary, liaise with parents and local health providers to meet the students' needs.

The staff who held designated SENCO positions were expected to work with education and health providers to support student learning. However, this role was often exclusive and limited the opportunity for class teachers to have direct contact with members of health teams. Classroom teachers spoke about being busy, often juggling many pedagogical demands and expectations which frequently impacted their ability to follow through with seeking help from health providers. Not over-involving the class teacher was done with good intent and primarily to relieve them of additional work.

> You're so damn busy trying to get the educational side of things done and just doing the classroom, running of the classroom and looking after the kids and, and teaching them as well as the normal meetings and PD and everything, that you run out of time to search for healthcare. (Suzie, Ranguru Cove)

The participants who were not qualified teachers or worked in part-time teaching roles often lacked confidence in making direct referrals to health providers, believing that it was either not permitted in their role to do so or not their responsibility.

> The hardest thing in my position at the moment is that I am a relief teacher. I don't think I can just go ahead and do a referral or fill in a book, you know, I have to go through the classroom teacher, then it's up to the classroom teacher to then make her own judgement of the situation and if she doesn't think it's important enough then maybe the problem doesn't get seen to. (Kirsty, Pūkeko Valley)

Given the demanding nature of their teaching roles, there was tension for teachers over just how much they should and could be involved in working with health providers.

> The problem now is that there are even more expectations upon us as teachers for the administrative and bureaucratic, and professional requirements too. You know there is lots of extra paperwork, and there are all sorts of stuff that we have to do on top of all of that. (Jodie, Ranguru Cove)

Assertion Four: Onerous processes in gaining access to health services influenced school staff's relationship with health providers

Accessing health support can be a complex process for teachers working in schools. Many are either unaware of the services available to them or impacted negatively by the lengthy and sometimes convoluted process of gaining access.

> We feel that we've got to go through a lot of steps before we get to an actual medical professional. (Jennifer, Tarāpuka Beach)

Achieving access to support and resources often involved the teacher collating additional data and supporting evidence, which was time-consuming and did not guarantee success.

> Paperwork, data gathering, you've got to get qualitative and quantitative data. You've got to have observations; you've got to have everything. (Saskia, Ranguru Cove)

Time was considered a precious resource to the classroom teachers. Many perceived they had insufficient time to pursue the health support they needed for their students due to the processes involved; this was particularly relevant in the higher decile schools with less visible health service support or interface.

Teachers deliberating whether or not to make a referral to a health provider was not uncommon and was directly related to the perceived success rate.

> There are so many forms and things that you are constantly weighing up if it's worth it or not…. you can spend so many hours just ticking boxes and filling in paperwork that you do wonder if it is all really necessary. (Suzie, Ranguru Cove)

> By the time you've made a proper referral, and they [health provider] have decided they can come in or they can't come in, it's really not worth your time and effort. (Saskia, Ranguru Cove)

Teachers having a positive experience with the process of accessing health support equated with an increased likelihood that they would refer again. Conversely, a negative experience increased the likelihood that the teacher would defer to balancing needs against the effort required.

> I've had positive experiences. We've made referrals to the local [Mental Health Service[9]]; you can ring them and have a talk, and they can help by giving you some suggestions if their wait list is too long. So, they're great. (Angela, Pūkeko Valley)

Assertion Five: Higher decile schools have a weakened relationship with health services due to less visible health service support

The two higher decile primary schools received less health service support, particularly from visiting health professionals. Staff in the higher decile schools were unaware of the full range of health service support available for their students. The decreased visibility of health services prompted some participants to believe access to some services was not possible because of the school's higher decile ranking.

> My understanding is that it's [health service support] decile based, and that if you're from a high decile, you have limited access… (Saskia, Ranguru Cove)

The prolonged impact of reduced visibility of health service support in the higher decile school cases, in this study, resulted in the schools believing they had to manage alone. The staff did not want to do this but perceived no other option.

> You just get by; you do your best. You get by with whatever's there, but it's not the model we want. We don't want to just get by; we want everyone to thrive. That is what we want. (Saskia, Ranguru Cove)

Whilst participants in the higher decile cases acknowledged the need for comprehensive and integrated health supports in lower decile schools, they were also keen to emphasise that children in higher decile schools were not immune to experiencing health and social issues.

[9] Name removed to support anonymity

> Whilst we are a decile 10 school, we've got families who are not necessarily a typical decile 10 family and who would probably benefit from having a nurse onsite one day a week. I think some families find it really hard to take their children to the doctor. Our admin team have taken children to get their eyes tested and things like that to support families. (Kate, Ranguru Cove)

> While you might say that we're a decile 10 school, we do actually have a breakfast club, and we have children who sometimes don't have lunch, and so we do feed them at school. (Jodie, Ranguru Cove)

The consequence of not having visible health service support in higher decile schools has resulted in a weakened and distanced relationship between school staff and health service providers. This weakened relationship impeded timely access to health support for students.

Assertion Six: School staff perceive health and health services as separated logistically and conceptually from education and learning

Participants perceived health service provision in schools as an entirely separate operating entity in all three cases. Health support was bought into schools through referral instead of operating from within schools whereby "They [health services] sort of come in and out. They pop in and out" (Rob, Pūkeko Valley).

There were no obligatory, formal interactions between the health and education systems, although opportunities to collaborate existed through SENCO meetings and interprofessional meetings. However, health professionals were not always invited or present at these meetings. Informal opportunities for health professionals to integrate were afforded through a presence in the staff room during lunch or morning tea breaks. School staff valued their presence.

Not all teachers identified a conceptual interrelation between student health and learning. In those that did, it was not always implicit in teachers' recall of their day-to-day teaching practice, particularly in the absence of any physical signs of ill-health. Whether this was conscious or unconscious, influenced by current systems and structures, or by teachers' knowledge and experience, was not entirely discernible through the study. However, there were strong indications that it was likely to be a mix of all three.

> We do kind of know that [health impacts on learning], but we try and get on with it ourselves rather than thinking of it as a health problem. (Suzie, Ranguru Cove)

> I am working with a beginning teacher at the moment…giving her quite a lot of support… her priority probably at the moment is getting her class going the way she wants it, and maybe the health of some of these children wouldn't be, a priority. (Kirsty, Pūkeko Valley)

> I feel like there's a knowledge gap, where teachers don't quite know where to go because they're not sure if the problem is learning or health. (Tanya, Pūkeko Valley)

Despite perceptions of education and health being separated systems, school staff did not necessarily think this was a good thing but held a realistic perspective based on the existing status quo. When opportunities were afforded to work alongside health professionals to support student learning, staff welcomed this.

> They say it takes a village to raise a child, and I guess that's the thing; if health support was not available, I think a lot of our children would not be in a good engaging learning space. I think it would be massively detrimental you know, if we didn't have that support. (Greg, Pūkeko Valley)

> It's another person that can bring the expertise so that you don't have to constantly upskill yourself, or try to make contact with somebody who knows. (Saskia, Ranguru Cove)

Assertion Seven: A shared understanding of the interrelatedness of learning and health reinforces the working relationship between school staff and health service providers

Having an awareness and understanding of the interrelatedness of education and health strengthens the working relationship between both parties. In this study, participants who had more years of classroom teaching experience drew on this understanding and, in doing so, articulated the benefits of working together spontaneously.

> At my last school, having health work alongside us was awesome. It helped me understand my learners and how to help them with their learning. It helped the learners with their learning. It helped the family support the learner. (Cassie, Tarāpuka Beach)

When questioned on what health services were accessible to the school, participants with less teaching experience tended to list the individual health services offered and, predictably, provided fewer practice examples. Those participants with more teaching experience provided specific examples of working together with health professionals to support student learning and school attendance. Teachers' positive experiences working alongside health professionals equated to them being more likely to use their services again.

The more teaching experience, the better the understanding was of the interconnectedness between student learning and their health. Newly graduated and junior teachers did not have the benefit of this experience. Feedback from participants implied that there are currently limited opportunities in both undergraduate training and in-school professional development programmes to understand more about non-academic barriers to learning. Kate shared her experience as a recent undergraduate teaching student:

> We had a major paper on health and physical education. It was more about sex education and physical education, and sort of a lot of emotional things as well. It wasn't necessarily about physical or mental health. Autism was quite a thing that I was mystified about and other conditions like that. I've had two, maybe three boys, in my class whom I'd say would be on the spectrum, but I've only learned to notice the signs since I've been on the job; all things like that I've learned on the job. (Kate, Tarāpuka Beach)

Assertion Eight: Nurses commonly facilitate a relationship between schools and health services

All study participants spoke, unprompted, about their experience working with nurses in the school setting. Most conceived that health services in schools were represented by a nurse, with some reference to other visiting health services such as hearing and vision, dental, and social work. Nursing services were consistently at the forefront of discussion across the three cases, even when nursing was not visible as a service to them. Participants' experience working with health providers was mainly with a nurse; few examples of working with other health professionals were provided.

In the three cases, the participants perceived nurses as a trusted, effective, and appropriate workforce to have working in schools. However, participants commented

that the nurses' attributes and ways of working could influence how school staff and students engaged with them: positive attributes and ways of working centred on being approachable, knowledgeable, flexible, and kind. Negative attributes revolved more around being task-focused than child-focused, inflexible, and brusque.

> They've [the nurse] got to be seen as approachable, and I always think they've got to be seen as fairly neutral…If the nurse gets the relationship right, because that's what it's all about, relationships, then I think you get more progress on issues. (Rob, Pūkeko Valley)

> They need to have an air of authority, know what they're talking about but also be able to listen and be very approachable. But, be able to say look, this is rubbish you know, you've got to sort this, and I'm going to help you. (Fran, Tarāpuka Beach)

> The nurse who was giving the immunisation talk had a go at me in front of my class when I went to hand the forms out; she pulled me up in front of my class and told me that I wasn't to say anything to them about the injection and that I didn't know what I was talking about. I've now said to the principal that I don't wish to work with her. (Rachel, Pūkeko Valley)

The participants perceived nursing services as a valuable conduit to health support in schools. Only one case, Pūkeko Valley school, had a designated nurse assigned to them who was visible and accessible most of the time. Tarāpuka Beach school had a named nurse assigned, but the nurse was not visible regularly and only came to the school to action referrals she had received from them. Ranguru Cove school had no assigned nurse; nursing support was perceived as invisible and inaccessible to them. They did not want this to be the case.

> Three or four years ago, when the nurse I'm thinking of left here, you know you could rely on that person, you knew that they were coming in, and if you had a concern or a query, you could raise it. Now, you might have to address it with the parent yourself, but you're not really quite sure because you might think it's a sore, but maybe it's something really minor like a mozzy bite that's got infected? I don't know, but I did feel that having that expertise was really helpful for teachers. (Fran, Tarāpuka Beach)

Nursing services had been more accessible to Ranguru Cove and Tarāpuka Beach schools in the past, but had reduced considerably over time. Examples provided by participants in these two schools were based primarily on historical interactions with a

nurse at the school or in schools where the teacher was previously employed. Despite the varying extent of interaction with nursing, all participants espoused the value of having nurses in schools regularly.

> At my previous school, I dealt with the PHN on a weekly basis because I had students that were with her. But even when I had no students in my class working with her, she would still walk through the classes, walk around, and she'd be visible within the school, and I guess that's because she had more time to be at our school. There were dedicated days that she was in. She was available through email at any time, whereas here, I haven't had any email contact either. (Cassie, Tarāpuka Beach)

The variance in assigned nursing support in primary schools at the time of this study was because nursing service provision was apportioned according to the school's decile ranking. The lower the decile the more nursing resource was assigned; conversely, the higher the school decile, the less resource was allocated. The premise behind this apportioning was to try and reduce inequities by improving access to health services for children living and attending school in disadvantaged communities (Ministry of Health, 2021b)

Assertion Nine: It is common for classroom teachers not to have a direct relationship with health service providers due to schools' allocating this role to an intermediary

All three cases in this study had chosen to employ a SENCO, whose role was to ensure the coordination of support and resources for learners with special educational needs (SENs). SENCOs frequently provided the interface between the school and outside services, including health. It was usual for a class teacher to refer students with health concerns to the SENCO or another designated person in the school to pursue.

> Every week in our syndicate meeting, we [class teachers] write down the children causing concern, it could be health or behaviour; those minutes are then shared with the SENCO, the Principal and the DP to action. (Jennifer, Tarāpuka Beach school)

It was not uncommon for students' health and behaviour issues to be addressed independently in the three individual school cases. Referrals for physical health and learning issues were typically passed on to the SENCO; whereas problematic behaviour might be designated to a different person, often a deputy or associate principal.

Minor, day-to-day accidents and health problems were usually referred to the school office staff or designated first aiders to attend.

Transferring students' health concerns to an intermediary was usual practice for teachers in all three cases. This system of delegating health referrals was done with good intent and often for wholly practical reasons. It revolved around keeping teachers free to teach rather than becoming involved in issues that might draw them away.

> The SENCO plays a very key role. It was created here by me, because I think teachers can't do it well enough on top of what they're doing. (Rob, Pūkeko Valley)

Not being able to talk directly to a health provider at the point of referral often meant that the opportunity to give nuanced information about the child was lost. Overall, the teachers welcomed this filtering of access to support; however, most verbalised wanting to be involved and to receive direct feedback.

> I would like the opportunity for a bit of input. Sometimes it is taken away from us, and often, there is no feedback. It's like, what's happening with this child? You are not telling me anything. Are they having breakfast? Who is in the house at the moment? What's going on? We really don't know the big picture because it has been taken away and removed so much from us. There needs to be a two-way relationship, a balance, so we, as class teachers, know what's going on. (Suzie, Ranguru Cove)

Assertion Ten: School staff perceptions of their role in supporting the health and wellbeing of their students sit on a spectrum

When asked directly what role the participants thought they had in supporting the health and wellbeing of their students, their answers lay on a continuum. The responses ranged from low to high responsibility, irrespective of the participants' teaching experience. Instead, their perceptions seemed to align with how they interpreted the concept of health and wellbeing, and whether or not they held a holistic view of their professional role.

Some participants perceived that being involved in supporting health and wellbeing was not and should not be their responsibility. In contrast, others shared the notion that they could not teach a child if health and wellbeing were an issue and therefore were willing to be involved.

> How long is a piece of string? That's how it can be, you know. Primarily I'm supposed to care about their learning. To care just about their learning well, if they're not in a physical or emotional state to learn, it's a bit of a waste of time. (Jodie, Ranguru Cove)

> My job as a teacher is to be aware of the needs of that child part of that is knowing their wellbeing and health. So, you know I would never let a kid sit in my class for a week with sores on their legs and not do something about it. (Neil, Tarāpuka Beach)

When participants spoke about an accident or injury occurring at school, their understanding of their role and responsibility was clearer. This clearer understanding may have been due to their familiarity with the Health and Safety policy and legislation requirements that are provided to schools by the MoE. Their responses were consistent with each other instead of sitting on a spectrum.

> We can be held liable; there are some real legal issues there, too, in some ways. You have to be conscious of that child's needs. If they've had a bang on the head, you have to deal with that immediately. You can't leave it. You have to make sure that the parents know that that child fell on their head. Parents are going to get really, really angry with you if they've not been advised of a child having an accident at school. (Jodie, Ranguru Cove)

Discussion of the Three Convergent Themes

As previously stated, the 10 dominant cross-case assertions are interconnected (Appendix T). In the following section, to convey this interconnection more explicitly and offer further interpretation and discussion related to broader ideas and other research, the assertions are grouped inside three overarching convergent themes. These three convergent themes and the associated assertion statements are outlined in Table 11 on the following page.

The first theme, *Separate and Siloed Systems,* relates to the separation in functioning of the education and health sectors in New Zealand. In particular, the siloed working practices and variances in conceptual understandings of the interdependence between learning and health are described here. Assertion statements one, four, six, and seven are within this theme.

Table 11. Overarching Themes and Contributing Assertion Statements

Overarching Themes	Contributing Assertion Statements
Separate and Siloed Systems	A1. The relationship between primary school staff and health services is one of referral A4. Onerous processes in gaining access to health services influenced school staff's relationship with health providers A6. School staff perceive health and health services as separated logistically and conceptually from education and learning A7. A shared understanding of the interrelatedness of learning and health reinforces the working relationship between school staff and health service providers
Developing and Managing Intersector Collaboration	A2. Visibility of health services in schools influences the relationship between school staff and health providers A5. Higher decile schools have a weakened relationship with health services due to less visible health service support A8. The relationship between education and health services can be facilitated through a nurse
Teachers' Role in Supporting Student Health and Wellbeing	A3. How school staff perceive their professional role influences how they relate to health services A9. It is common for classroom teachers not to have a direct relationship with health service providers due to schools' allocating this role to an intermediary A10. School staff perceptions of their role in supporting the health and wellbeing of their students sit on a spectrum

The second theme, *Developing and Managing Intersector Collaboration,* considers schools' access to health services and how the visibility of health providers, plus onerous processes of referral, influences engagement. Accessing health services was often perceived as time-consuming and challenging, with no guarantee of success. However, teachers' experiences working with nurses validated them as a valuable conduit to health due to their increased visibility compared to other health professionals. Assertion statements two, five, and eight, are within this theme.

The third and final theme, *Teacher's Role in Supporting Student Health and Wellbeing,* contemplates staff roles in the context of designated role responsibility and the school and teachers' perceptions of their professional role in supporting the health and wellbeing of their students. Assertion statements three, nine, and ten, are within this theme.

Separate and siloed systems

The view of study participants that education and health are logistically and conceptually separate is not unreasonable, given that, in New Zealand, the education and health sectors function as discrete organisations. The New Zealand education and health systems are state-owned, service-driven sectors with individual agendas, targets, and resources. There is currently no legislative requirement or mandate for formal intersectoral collaboration between the two sectors. Although there was an expectation from the MoH that DHBs would prioritise access to health services for vulnerable children attending schools in more socioeconomically deprived communities (Ministry of Health, 2021b), there is no nationally agreed model for delivering these health services. In addition, there is no formal opportunity for education providers to inform decisions with DHBs on health service provision in their schools. The impact of this separation was evident throughout this study, particularly concerning accessibility, visibility, role expectations, and shared understandings of the interrelatedness of learning and health.

The logistical separation of the education and health sectors and the subsequent siloed working practices in the relationship between schools and health providers in New Zealand relies on the interpersonal relationships between education and healthcare providers and the actioning of referrals. The schools reach out to health through a referral process to bring in the health service or support required, which relies on school staff identifying health concerns and having knowledge of the appropriate referral process.

According to the current study, some referral processes are time-consuming, complex, and inefficient, with no guarantee of success. These difficulties directly influence whether or not school staff will complete referrals to health services, potentially denying their students an opportunity to be considered for further health support and,

in some cases, funding. This finding is consistent with Allison et al. (2008), who observed that teachers were less likely to refer to health services if the pathway was not 'user-friendly'. In their study, based in Australia, complex referral pathways proved an obstacle to the referral of children and young people who would have otherwise benefited from treatment and support. Further, the Australian study reported the need for streamlining and simplifying the referral processes, along with providing support from health providers to complete more complex referrals. In addition to those reported by Allison et al., the current study findings provide evidential support for a streamlined and accessible inter-sectoral referral process to ensure that all eligible children have an opportunity to be considered for further assistance.

The challenges to achieving effective collaboration and coordination

This study showed that the current siloed working practices of the education and health systems, as currently worked in the three cases in this study, have the potential to negatively impact the health and wellbeing of students and their ability to optimise learning opportunities. A lack of familiarity with the health sector and service provider agendas, ways of working, and contribution meant education staff participants in this study were often unclear about what could be offered and by whom, to support students with health needs. There was also ambiguity and tension over where responsibilities lay for coordination and action.

Turf protection issues may arise, resonating with the findings of Burgess et al. (2015) and Johnson et al. (2003), who referred to this as 'turf issues' and of Harbitt (1996), who discussed this in the context of 'turf guarding'. Harbin contemplated whether this was due to the interaction of multiple differences among agencies when they come together. In accordance with this view, participants in my study suggested that some 'turf issues' currently exist between primary schools and health services in New Zealand. These data appeared to relate to understanding professional boundaries, a lack of role clarity, and confidence in identifying, supporting and referring children with health issues to relevant services rather than people from different agencies being unwilling to collaborate. Further complicating this situation were issues related to access and visibility of health services in New Zealand primary schools.

The current siloed working practices within and across the education and health sectors in New Zealand undermine opportunities for the two systems to collaborate and cooperate efficiently and effectively. Effective collaboration relies on three fundamental principles: developing professional relationships, building supportive networks, and communication (Burgess et al., 2015; Harris, 1995; Ministry of Health, 2005b; Tooher, 2017). Participants in this study signified a willingness to work more closely with health professionals to benefit their students. However, the lack of even a most basic arrangement for intersectoral working between the education and health sectors means achieving and sustaining such cooperation and collaboration is frequently problematic.

Considering what is understood about the interrelatedness of education and health in other studies (Costante, 2002; Cutler & Lleras-Muney, 2006; Michael et al., 2015), and assuming a future-focused stance, developing a more informed and coordinated approach for the two sectors to work together would seem logical and reasonable. Studies in the United Kingdom, the United States, and Australia have highlighted that for intersectoral collaboration to be truly effective, communication both between sectors and at all levels of contributing sectors is critical (Burgess et al., 2015; Garvey et al., 2020; Tooher, 2017; Weist et al., 2012). Equally important, Burgess et al. (2015) suggested, is establishing and aligning service agendas early in the collaborative process to ensure both sectors meet their core business objectives. The current study has found no evidence that these initiatives are on the agenda of either the New Zealand education or health sectors. Yet, internationally, the need for establishing and aligning services has been reported for at least the past decade (Baciu et al., 2015; Kolbe, 2019).

One of the challenges to advancing collaboration between education and health lies in the complexity of the two sectors. Both the education and health sectors are considered complex systems (Keshavarz et al., 2010; Plsek & Greenhalgh, 2001) but have several interdependent common features. Delivering health outcomes in school settings is particularly challenging (Tooher, 2017) because it requires two complex systems (Keshavarz et al., 2010; Plsek & Greenhalgh, 2001) to work together to achieve better health outcomes for students who are served by both systems. In recent years, Organisation Theory (Bush, 2015; Robbins & Barnwell, 2006) has been expanded into

Systems Thinking (Arnold & Wade, 2015; Maani & Cavana, 2007), which focuses on understanding systems in a human context. In combination, these theoretical frameworks have emerged as a way to understand better how complex systems, such as education and health, work and how they can be modified to achieve desired results (Arnold & Wade, 2015; Campbell et al., 2000; Green, 2006; Rosas, 2015).

Ratnapalan and Lang (2020) describe health care organisations more specifically as complex *adaptive* systems and reflected on how such organisations are often likened to machines. In this analogy, the health *machine* is designed and operated to do different things, each part having a specific function that is carried out repetitively and reliably; the machine itself does not change unless the *engineers* that control it require it to do so (McCarthy et al., 2000; Ratnapalan & Lang, 2020). Ratnapalan and Lang considered this notion too simplistic, preferring to draw upon modern Complexity Theory (Homer-Dixon, 2011) to explain how organisations such as education and health represent an ecosystem rather than a machine. This alternative analogy provides a framework for understanding patterns and relationships within a given system or systems. Drawing on the principles of Systems Thinking and Complexity Theory to help understand the common properties that complex systems, such as the education and health sectors, share, would strengthen initiatives aimed at promoting better intersector relationships and collaboration between the two sectors in New Zealand (Homer-Dixon, 2011; Ratnapalan & Lang, 2020).

Health as a 'guest' in the school

Health providers are deemed *guests* in the New Zealand primary school setting, partly attributable to the lack of a formal requirement to work together. In my study, the guest status of health providers was evident through the mechanisms of referral (being invited in) and by school staff perceptions of their professional role and responsibility in supporting the health and wellbeing of their students.

The notion of a health practitioner being considered a guest in schools is not new; international literature suggests this is in part due to the unfamiliarity of both parties with each other's programmes and initiatives (Bronstein & Abramson, 2003; Hartas, 2004; Hasselbusch & Penman, 2008; Mandel, 2008; Richardson & Juszczak, 2008). This finding is new to the New Zealand context, however. The guest concept is

symptomatic of having no supporting legislative and policy frameworks related to health service provision in New Zealand primary schools. In addition, the devolved New Zealand schooling system promotes self-management and autonomy (Hood, 2019; Ministry of Education, 1988; Tomorrow's Schools Independent Taskforce, 2019) over cooperation and collaboration. An enduring consequence of this increased autonomy and control is the unintended barrier it has created to successfully implement a universal and agreed way of working between schools and health services nationally.

Nurses in Schools

Given the long and rich history of nurses working in schools in New Zealand and internationally (Kelsey, 2002; Lambie, 1951; Tennant, 1991; Williams & Dickinson, 2017), it was somewhat unsurprising that, in my study, nurses were recognised as the most visible of all health professionals working in schools. Although this visibility varied significantly across the three school contexts, nurses were still cited as the most common health practitioners that school staff saw, remembered, and interacted with, and were considered a valuable conduit to accessing health services. Fewer years of teaching experience may have biased some participants' preference for nurses being the most appropriate professional to work in schools as experience working with others was limited. Nonetheless, many international studies acknowledge and uphold the contribution school nurses make in supporting student learning outcomes (Costante, 2006; Council on School Health, 2008; Fong, 2014; Kocoglu & Emiroglu, 2017).

Despite the current study's finding of high acceptability by school staff of nurses working in primary schools, New Zealand does not have a standardised school nurse programme at the primary or secondary school level. This current lack of a formal primary school nursing programme may be due to this service receding from view due to a series of health reforms and competition for funding in other more high-profile areas of the health system. Currently, in New Zealand, nursing services in primary schools are usually delivered by PHNs. The public health nursing service in schools is not currently consistent or reliable. This is partly due to PHNs frequently being required to retain workplace flexibility in response to other health priorities and programmes as national and local needs arise.

School nursing in many countries is a specialty area of practice and a much-needed resource at both primary and secondary school levels in New Zealand to help alleviate the persistent health inequities in our communities (Green Party of Aotearoa New Zealand, 2014; Jeffreys et al., 2022; New Zealand Nurses Organisation, 2012). Yet, the advancement of school nursing has been overlooked by those involved in the nursing workforce and career development in New Zealand. Recent studies and reports focus on the provision and benefits of nursing services in New Zealand secondary schools (Buckley et al., 2012; Denny et al., 2012; Ministry of Health, 2009), but there is a lack of research on similar services in primary schools; why, is unclear. Consequently, public health nursing (under which school nursing activities in primary schools currently sit) has long been considered an 'invisible' service in New Zealand (Carryer et al., 1999; Clendon & McBride, 2001; Hansen et al., 2007). The findings from my study have addressed this disparity by bringing visibility to the primary school sector. Specifically, if New Zealand continues to overlook the benefits of early intervention through primary school-based health services, there is a risk of compounding health issues for some children and young people as they transition into adolescence and beyond.

Accessing health services

School and health service collaboration opportunities are impacted by the degree of visibility of health professionals in schools. My study showed this very clearly in one school, Pūkeko Valley Primary, where high visibility and relatively strong relationships with health providers, particularly with the nurse assigned to the school, were reported. The remaining two school cases reported low or no visibility; and correspondingly low or no engagement with health professionals. Reduced engagement with health professionals in the latter two schools directly aligned with their higher education decile ranking. This ranking currently guides how much or how little health service resource is apportioned by DHB providers (Ministry of Health, 2021b).

The original intent of the current education decile ranking system was to guide the education system, not health, in the allocation of targeted funding for educationally at-risk children (Ministry of Education, 2022b; PPTA Waikato Region, 2013; Vester, 2018). Schools can choose how to use this allocated, untied funding, particular to their student's needs. Clark et al. (2017) have questioned whether such funding can

demonstrably raise student educational outcomes, mainly because simply proportioning funding fails to address the broader determinants of academic attainment. It is also important to note that this type of funding allows schools to decide *how* to use it, which ultimately may not benefit those for whom the funding is intended.

School health services in New Zealand are intended to function as a universal programme (Moore, 2008), accessible to all students who need it but recognising that some students may require more input to achieve similar outcomes. Services provided to schools must maintain a significant focus on priority populations (Ministry of Health, 2021b). Despite being intended as a universal programme, the service provider for the three case schools in this study currently uses a targeted approach to achieve a priority-population focus, aligning resource allocation with school decile ranking (Ministry of Health, 2021b).

Targeted allocation of resources is a health strategy that is considered a meaningful way to help reduce health inequalities; it is primarily achieved by providing more significant resources to populations who need these most (Devereux, 2016; Egan et al., 2016). For many years, there has been debate about the impact of targeted programmes in adequately addressing the health and development of babies, children, and young people (Egan et al., 2016; Francis-Oliviero et al., 2020; Gibb et al., 2019; Human Early Learning Partnership, 2015; Marmot, 2010). My study has highlighted the challenges that a targeted approach has created for school staff attempting to access school health services for students who attend non-targeted, higher decile schools. Targeting in this way can lead to many issues, the most prevalent of which is stigmatisation for those targeted and under-coverage of services for those who are not (Devereux, 2016; Francis-Oliviero et al., 2020; Moore, 2008).

Furthermore, my study identified that providers of health services to the three case schools had chosen to draw on school decile ranking to determine health resource allocation. Schools with lower deciles rankings were likely to have a more significant proportion of Māori and Pasifika students who are known to have poorer health outcomes than their New Zealand European counterparts (Simpson et al., 2017a, 2017b). Using the MoE school decile ranking categories as a blunt instrument to help

determine health resource allocation in schools upholds the requirement for focusing school health service resources on priority populations but little else. Ostensibly, this targeted approach by health service providers seems reasonable given the over-representation of Māori and Pasifika children in negative health statistics (Simpson et al., 2017a, 2017b). Yet, participants in this study identified unmet health needs in students across the decile divide, not just those attending schools in lower socioeconomic areas. Having limited or no access to health service support to students attending higher decile schools, as identified in this study, suggests a significant cohort of children who would benefit from accessing health support through schools are currently being overlooked.

Adopting a 'one size fits all' approach to delivering school health services has its issues too, particularly regarding ignoring existing inequalities, increasing inequities and cost (Carey & Crammond, 2014; Devereux, 2016; Gibb et al., 2019; Moore, 2008). Studies of other universal child health programmes in New Zealand indicate that it is often the most disadvantaged who experience barriers to accessing such services (Egan et al., 2016; Expert Advisory Group on Solutions to Child Poverty, 2012; Gibb et al., 2019; Ministry of Justice, 2010; Moffat et al., 2017; Smith, 2013). These barriers most often relate to transport, cultural appropriateness, health literacy, and acceptability.

The findings of my study raise the question of whether school-based health services in New Zealand primary schools should adopt a combination of universal and targeted approaches. A properly structured, universal suite of supports and services visible and available to all children, regardless of their school or socio-economic background and that maintains a capacity to add additional targeted services for the most vulnerable and disadvantaged children has been adopted elsewhere (Burström et al., 2017; Dierckx et al., 2020; Egan et al., 2016). This model is not a new concept and is known as proportionate universalism (Marmot, 2010). The approach provides an ability to tackle health inequalities by making health services available to all children while responding proportionately according to the level of need (Carey et al., 2015; Dierckx et al., 2020; Maharaj et al., 2012; Marmot, 2010).

In a review of health inequalities in England, Marmot (2010) concluded that targeting the most disadvantaged does not address inequity adequately. Marmot upheld the

need for equitable action across the population. Arguably, this is what the providers of health services in the three case schools in my study were trying to do. Somehow this balance has become tipped in favour of targeting, resulting in minimal visibility or perceived unavailability of health service resources to students attending non-targeted schools. Conceivably, the impact of devolved funding and responsibility to a local level has contributed to fragmented and disparate publicly funded resources for school health services nationally in New Zealand (Buck & Dixon, 2013; Fong, 2014).

Regarding services that have adopted an approach consistent with the principles of proportionate universalism, Maharaj et al. (2012) described a successful community paediatric service in England that used the approach of proportionate universalism and multi-agency collaboration. The service focused on removing barriers to access by offering services closer to home (including in schools), simplified referral and booking systems, flexibility in appointment times oriented around what worked best for families, accepting referrals from all agencies, and prioritising needs over where the referral originated. Maharaj et al. used a health equity auditing tool embedded within their service planning and development to demonstrate that their service model had a two-fold effect in lessening the barriers to accessing health care for deprived families. Similar barriers to those addressed by Maharaj et al. have surfaced in the three schools within my study, particularly regarding referral processes and accessibility.

The benefit of placing greater emphasis on better access to health services in New Zealand primary schools is that early intervention can significantly support positive outcomes for children experiencing health-related barriers to their learning (Hoffman et al., 2018; Neil & Christensen, 2009). There is likelihood of better access to parents and caregivers in primary schools, given that many younger children (although not all) are often brought to school rather than making their own way. This potential for access to parents and caregivers offers opportunities to meet with families to offer health support for their children. Interacting regularly with families, helps health providers understand the context of a child living and growing up; this holistic approach helps to facilitate appropriate and timely health and social support.

In New Zealand, it is beneficial to consider a more coordinated and collaborative approach to health service provision in primary schools nationally. The findings from

my study help inform such an approach. For example, findings such as the acceptance by school staff of nurses working in schools, plus the need for all schools to have increased visibility and access to health services if working relationships are to be strengthened and upheld between the two sectors. An investment in strengthening these relationships will positively contribute to long-term health and educational outcomes for children in New Zealand and their future contribution to society.

Developing and managing intersector collaboration

This study shows that many strategic challenges influence the relationship between primary schools and health services, including intersector collaboration. Participants across the three school cases acknowledged the need for better intersector collaboration between education and health to support learning and health outcomes for children and young people.

Working together

Formal opportunities for school staff and health professionals to meet were considered valuable by the interview participants in this study; however, these opportunities were viewed as infrequent and ad hoc. This lack of opportunity is consistent with findings from international studies (Ball & Howe, 2013; Glover et al., 2015; Mukherjee et al., 2002; Vanclooster et al., 2018). Some participants in the current study suggested that opportunities to enhance collaboration and coordination between teachers and health professionals could include existing school structures such as the SENCO and interagency meetings as a time to meet. Findings from the school cases revealed that health professionals' attendance at these meetings was inconsistent as they were not always invited or able to attend. Being invited to meetings depended on how each school chose to manage their relationship with health services providers and if a provider was known and visible to them. Therefore, relying on these meetings to achieve ongoing, sustainable opportunities for collaboration is not currently feasible. The self-governing nature of schools in New Zealand means that schools can independently choose what value an opportunity to interface with health providers in this way holds for them and whether they create opportunities to facilitate this. In this study, a unique finding is the differing perceptions and understanding of the interview participants of the positive value such

an interface between the health and education sectors has. It is important to acknowledge that the higher decile schools in this study were not confident that they could access a health provider with whom they could interact regularly; such services were largely invisible to them.

Currently, in the absence of a structured and coordinated relationship between the education and health system in New Zealand, the two sectors rely heavily on service level cooperation and interpersonal relationships to drive function, inclusion, and positive outcomes for students. Cooperation between education and health services relies on the mutual understanding between them that they will try to help one another meet their individual goals (Burgess et al., 2015; Garvey et al., 2020; Harbitt, 1996; Melaville & Blank, 1991). An example in New Zealand is schools being willing to co-locate health service facilities within the school environment, such as with the Whare Hauora project outlined in Chapter One. Relying primarily on service level cooperation for effective and sustainable delivery of health services in schools is problematic in that it upholds the separation of the two sectors and is a fragmented approach. With this approach, the focus remains on each sector's agenda and service-driven priorities rather than on working together towards common goals and a shared vision. Other international studies also highlight this issue (Bersamin et al., 2015; Chuang & Lucio, 2011; Johnson et al., 2003; Melaville & Blank, 1991).

Conflicting agendas can be a potential stumbling block to successful collaboration (Burgess et al., 2015). In particular, policymakers' political context and decisions can interfere with effective working relationships at the service level. In New Zealand, national health priorities can influence the health service delivery model in primary schools. New knowledge to arise from my study was participants sharing with me that keeping abreast of variances in the availability and access to health services is challenging for schools. Too often, communication concerning a change in service provision is poor, affecting credibility, perceived value, and, ultimately, relationships.

An example of the challenges that arise through poor communication and reliance on cooperation over collaboration was evident in the Rheumatic Fever Prevention Programme (RFPP) initiative implemented in some New Zealand schools between 2011 and 2016. The programme focused on intensive throat swabbing in primary and

intermediate schools. The selected schools, situated in socioeconomically deprived communities, were advised that health clinics were to be established within them and that these would be resourced by health staff. Schools were required to find space to accommodate health workers, often for prolonged periods. The decision was not made in collaboration with schools and had the unintended consequence of redirecting health service provision to these schools from a traditional holistic public health approach to a singular and targeted health priority focus aligned with a traditional biomedical model of care. This focus did not correspond with parents' and caregivers' health priorities or that of schools (Grigg & McDuff, 2013). Schools identified classroom disruption, finding space for health workers to run clinics, and lack of feedback on the programme as challenging (Grigg & McDuff, 2013; King et al., 2014). In addition, health services for schools not in the RFPP programme functioned at a minimum, if at all; frequently, there was no communication about this change to the affected schools (King et al., 2014).

The RFPP programme was overtly referred to by Pūkeko Valley participants when they shared their experiences of nurses interrupting classes and learning time to remove children with self-identified sore throats. The programme required health providers to detect sore throats and perform throat swabbing. Whilst the RFPP programme was planned using a cross-ministry approach, study participants reported that an opportunity to implement a cross-sectoral approach at a service delivery level was overlooked. There was limited time for schools to plan how to incorporate this programme and they were not routinely included in the day-to-day planning process, despite being key stakeholders and potentially gatekeepers. These outcomes support the ideas of St Leger and Nutbeam (2000), who recommended that health systems use a holistic and integrated approach and work *with* schools rather than *on* schools. With this approach, health service providers are more likely to achieve public health goals and better health outcomes for students and their families.

The same but different: Acknowledging the uniqueness of New Zealand primary schools

The advancement of collaborative and coordinated ways for health services to work with New Zealand primary schools is further complicated by the differences between schools and how they are managed and led. The case reports in this study have

provided a clear snapshot of this diversity and uniqueness. Across the school cases, differences existed in the physical and social environment; the culture of the staff; students and local community; variation in leadership and priorities; and a distinction between school ethos and degree of health service interaction. This plurality reflects New Zealand society, represented through the co-existence of multiple cultures: Pākehā (New Zealand European); indigenous Māori; Asian; Pasifika and Middle Eastern, Latin American, and African. The freedom to practice one's language, religion, and culture is the foundation of New Zealand's multiculturalism, upholding a pluralistic stance. Differences and uniqueness, in general, are embraced. These differences can cause tension when attempting to implement national goals, standards, and ways of working that are inclusive, can accommodate differences, and reduce inequity experienced by both the education and health sectors (Sheridan et al., 2011; Williams et al., 2016).

The complex and diverse nature of school systems and the communities in which they are situated must be acknowledged if the health sector is to develop more sustainable ways of working with schools in the future (Hasselbusch & Penman, 2008; Keshavarz et al., 2010; Mukherjee et al., 2002; Plsek & Greenhalgh, 2001; Ratnapalan & Lang, 2020; Resnicow & Page, 2008). To endorse this acknowledgement in practice settings will require the readiness of both sectors to champion collaboration and understanding at every level - from the service provider to Government-supported policy and legislation (Altshuler, 2003; Garvey et al., 2020; Paavola, 1995). It is the responsibility of both sectors to deconstruct and circumnavigate the barriers that currently exist and be future-focused in putting forward new and achievable options. This study has both exposed current influences on the relationship between school staff and health services and proposed ways to strengthen the relationship for both parties and benefit children and young people across New Zealand.

Maintaining relationships

The self-governing nature of New Zealand schools is reflected in how each school chooses to work and engage with health providers at a service level. Without a directive to work together, there is a reliance on individual health practitioners to foster and maintain local-level relationships with primary schools in New Zealand. The sustainability of these relationships is often dependent on the school's relationship

with the individual practitioner. The risk of this person-dependent relationship is that the practitioner may not always remain in their current position, thus creating a potential void for the school when they leave. Participants in the three case schools in this study acknowledged loss and frustration when health practitioners known to the school staff (usually nurses) left or changed. These sentiments often contributed to a period of detachment as school staff got to know and trust the new person. This finding is consistent with Tooher et al.'s (2017) study of intersectoral collaboration in Australia's school-based health programmes; familiarity and understanding are essential components to maintaining relationships, and minimising changes to assigned visiting practitioners should be a priority to providers of health services in schools (Burgess et al., 2015; Chuang & Lucio, 2011; Dale et al., 2021; McIntosh et al., 2021).

Shared understandings of the interrelatedness of education and health

The interrelatedness of education and health is well documented (Basch, 2011a; Cohen & Syme, 2013; Costante, 2002, 2006; Eide & Showalter, 2011; Haycock, 2010; Zimmerman & Woolf, 2014). This relatedness is not consistently reflected in everyday working practice in New Zealand primary schools. There is, however, an association between how well this interrelatedness is understood and contextualised by teaching staff and how promptly they engage with health providers to support their students. The more experienced teachers relayed how they had observed that a happy, healthy, and well child was likely to engage better in learning activities than one who was not. Some researchers suggest that if collaboration between education and health is to be supported, the education sector needs to change how it views health (Basch, 2011a; Kolbe, 2019; Kolbe et al., 2015; Slade, 2003). Instead of regarding health services and programmes in schools as purely health initiatives, the education sector must understand the benefit of healthy students for education's sake.

Fifty years ago, in New Zealand, it was expected that teachers would engage with health services to support students and the school health programme (Tennant, 1991). This relationship was underpinned by expectations outlined in the Ministerial goals, policies, legislation, and practices of the education and health sectors. Health education was viewed as a collaborative process with involvement and responsibility

extending beyond the classroom teacher (Sinkinson, 2011; Tennant, 1991). This expectation is no longer apparent.

The teaching of the health curriculum and the provision of health services in schools are managed separately, without any requirement for formal cooperation or collaboration between the education and health sectors. The health curriculum is determined by the education sector (Ministry of Education, 2020b); its delivery is the teachers' collective responsibility. Correspondingly, the management and interventions related to student health concerns remain within the health sector. Thus, a separation in the working relationship is perpetuated. Another of the explanations for this evolving separation over time could lie in the individual sector agendas, goals, and work priorities that have arisen under neoliberal-influenced government-imposed management and reporting requirements for both sectors to date.

Today, health in the New Zealand curriculum is considered in conjunction with individual wellbeing (Ministry of Education, 2020b) and continues to draw on an ecological model of health (MacBlain & Gray, 2016; Sinkinson & Burrows, 2011). This holistic health concept contrasts with health services provided to primary schools that predominantly uphold a biomedical approach to health. These services focus on the absence of illness and disease through the early detection and treatment of health-related ailments affecting a child's overall development, including their hearing, vision, and behaviour (Ministry of Health, 2021b). Notably absent in the current health provider service specifications is any reference to wellbeing; however, there *is* a requirement to provide health education and information to users of the service, which ostensibly would include schools and school staff (Ministry of Health, 2018a, 2021b). Some studies have reported that these different working concepts of health can affect each sector's expectations of the other, potentially undermining the relationship between school staff and health providers (Burgess et al., 2015; Tooher, 2017).

Understanding the interdependence between education and health has its foundation in teacher tertiary education at the undergraduate level. This study's findings imply that there is currently limited teaching on health-related barriers to learning in the Bachelor of Education curriculum in New Zealand. In addition, findings relating to PLD

offered to school staff also lacked such content. Teacher participants in this study expressed their wish for more focus on physical and psychosocial conditions that may impact learning in their ongoing PLD. This desire for more learning opportunities is highlighted in previous studies (Clark, 2001; Elek et al., 2017; Ministry of Health, 2005b; Olson et al., 2004; Reinke et al., 2011). Specifically, a need for further dialogue relating to education and health professionals collaborating, partnering, and supporting each other with PLD in the future. In addition, opportunities to gain knowledge of each other's roles, activities, and ways of working will support a better understanding of what each requires from the other and the benefits of collaborating overall (Baweja et al., 2016; Flood et al., 2014; Gracy et al., 2017; Widmark et al., 2011).

The influence of communication on relationships

Issues relating to communication between schools and health providers were evident in the findings across the three school cases in this study, particularly concerning knowledge of available services, referral processes, and obtaining information and feedback from health providers to teachers about student health. Teachers perceived the importance of clear and open communication at both an organisational and interpersonal level as an important contributor to sustaining effective and collaborative working relationships. This finding is supported in other studies, although it is acknowledged that this is not always straightforward to achieve in practice (Gracy et al., 2017; Harbitt, 1996; World Health Organization, 2011b). Communication issues are diverse - from experiences where privacy laws had been cited that prevented information sharing to a lack of clarity about what services were available to schools and how to contact these services. In addition to effective communication as a conduit for information sharing, some participants shared their experiences of unfavourable interpersonal communication styles between health practitioners and school staff, which negatively affected their working relationships. This finding is consistent with other international studies (Biag et al., 2015; Helleve et al., 2020; Nancarrow et al., 2013) that report an individual's personality characteristics influence building positive interpersonal relationships and promoting effective teamwork.

The influence of interpersonal attributes on relationships is highly relevant in the school-health service relationship in New Zealand. This study identifies that this

relationship is currently held together and entirely reliant upon creating effective interpersonal relationships at the service delivery level. If health service providers do not foster positive relationships with schools, schools can unwittingly act as gatekeepers to health services for those who need these services most. A lack of supportive legislation that requires the education and health sectors to work collaboratively or of a national framework for the delivery of school health services means it is unlikely that the status quo will be challenged.

Communication is essential in supporting and sustaining interprofessional relationships, and good relationships are central to effective collaboration (Helleve et al., 2020; Murray, 1948; Parmar, 2013). Achieving across-sector sharing of health information is complex and fraught with challenges, specifically regarding privacy and obtaining consent to share personal information (Gregory, 2020; Hart & O'Reilly, 2018; Yang & Maxwell, 2011). How much information is permissible to share is an issue grappled with daily for those working across sectors such as education and health, with competing tensions between maintaining privacy and confidentiality and upholding a duty of care (Hart & O'Reilly, 2018). Currently, there is no approved platform or system for sharing or obtaining consent to share information across the education and health sectors in New Zealand.

Teachers are usually unaware of the collective health profile of their class cohort. When teachers *are* made privy to relevant health information, it allows them to identify students who might be at risk and make the necessary adjustments to how they teach, adjust the classroom environment, or manage behaviours appropriately (Cunningham & Wodrich, 2006). Understanding students' identified health and behaviour needs creates more opportunities to offer individualised and targeted interventions and be able to advocate for safer and more supported learning environments (Cunningham & Wodrich, 2006; Dotterer & Lowe, 2011; Gregory, 2020; Hart & O'Reilly, 2018).

Teachers in this study wanted to know and understand the health needs of their students; however, this was often complicated by not having access to relevant health information or not receiving feedback after making a referral to a health provider. Various factors can influence information sharing across public sectors, including

professional culture, differences in interpretation, policy and legislation, governance structures, information system compatibility and access (Hart & O'Reilly, 2018; Richardson & Asthana, 2006). Navigating these factors from two different sector perspectives is complex, yet the consequences of not sharing information can be detrimental to the child or young person (Richardson & Asthana, 2006). Equally detrimental are the consequences of inappropriate and careless sharing of information where there is potential for misuse and misrepresentation of health data (Gregory, 2020; Richardson & Asthana, 2006).

In a study by Hart and O'Reilly (2018), teachers felt that to promote safety regarding information sharing with other professionals, they needed to have specific professional development opportunities made available to them. This professional development concerned not only managing confidentiality, sharing processes, and consenting but also specific health-related topics, such as mental health. Other studies have also highlighted a desire by teachers for more professional development about safety in information sharing both within and across sectors (Cunningham & Wodrich, 2006; Gregory, 2020; Hart & O'Reilly, 2018).

Teachers' role in supporting student health and wellbeing

In this study, school staff did not always feel adequately prepared or supported in their professional practice to identify, manage, or advocate for their students' health-related needs. Lack of time to seek health support and complex processes for referral were themes that resonated with participants across the three school cases.

Providing care

An unanticipated finding in the current study was the discrepancy between some teachers' theoretical understandings of the interdependence of education and health and their everyday working practice. Teachers' expected degree of investment in supporting their students' health and wellbeing, particularly when balanced with their teaching workload, was not always clear to them, and participants' opinions differed. The data suggest that the level of health-related support offered by teachers varies because of several reasons. Firstly, ambiguity in teachers' roles and responsibilities in supporting and being involved with students' ongoing health needs and medical care; secondly, differences in teachers' awareness and understanding of health needs; and

thirdly, variance in their ability to recognise behavioural signs and symptoms that may indicate an underlying health concern.

Although unexpected, these findings are consistent with other international studies (Brunette, 2017; Ekornes, 2015; Mukherjee et al., 2000; Wyn, 2007). Essential to consider in relation to this topic and the study's findings are the findings from international studies that suggest teachers' personal health beliefs, practices, and interest in health influence the extent to which they engage in actions that promote student health (Brunette, 2017; Metos et al., 2019; Shepherd et al., 2013). If this is the situation in New Zealand, it will have implications for initial teacher education and ongoing professional development.

According to the present study's findings, teachers' provision of care concerning student health and wellbeing was influenced by the extent to which the presenting issues impacted student learning in the classroom. If the issues significantly impacted student learning and behaviour, participants in this study expressed that they were more likely to seek help for the child. The school staff recognised they had a *duty* of care to students and some accountability, particularly in relation to accidents and injuries. When this was explored further with respect to supporting *general* health and wellbeing, perspectives on their role and responsibilities in caring differed. Many teacher participants perceived that being overly focused and involved in students' health and wellbeing needs drew them away from what they believed should be their key focus - teaching. In this respect, Solbrekke and Englund (2011) argued that the concept of professional accountability has dominated that of professional responsibility in recent years. This outcome might be expected given that accountability has been the dominant agenda across the education and health sectors since the public sector reforms of the 1980s and 1990s and the ensuing adoption of NPM practices (Cranston, 2013).

Concepts of accountability and responsibility are subtly different in professional practice. Accountability emphasises a duty to account for the actions carried out, and responsibility emphasises a moral obligation to act responsibly (Bivins, 2006; Martinsen & Kjerland, 2006; Solbrekke & Englund, 2011). In teaching and health, professional responsibility presupposes those individuals will act responsibly and

proactively regarding meeting the needs of their students and patients. In considering the views expressed by teachers in this study, there is a clear need to assist teachers in understanding their professional responsibility in attending to and supporting their students' health and wellbeing needs. It is not simply about *duty* of care or being *accountable*; it is the teacher's *professional responsibility* to proactively care about their student's health and wellbeing. Duty and accountability are not either/or options; instead, are located on a spectrum of teacher responsibilities which the teacher must continually evaluate.

Over 40 years ago, Hull (1979) proposed that in order to understand caring in the context of pedagogical caring; that is, teaching which integrates caring through being student-centred and holistic in its approach (Christopher et al., 2020; Hull, 1979), it is essential to consider the difference between caring *for* and caring *about.* Both are distinct processes. Caring *for* someone usually happens after their needs have been recognised and understood, whereas caring *about* someone involves determining their needs.

More recently, Nguyen (2016) explored *why* teachers need to care about their students' health and wellbeing in a holistic sense, given that their key responsibility is to attend to the educational needs of their students. Nguyen argued, "the very act of teaching can be seen as an act of caring for students since doing so addresses their educational needs" (p. 291). Nguyen maintained that caring about the health and wellbeing of students contributes to "effective teaching and morally good teaching…meaningful education is conceptually connected to caring-about" (p. 291). Both Hull (1979) and Nguyen argue that for effective teaching to happen, teachers need to care *about;* otherwise, they may overlook what educational (or other) needs to care *for.*

The impact of being time-poor

Regarding the three school cases in this study, the perception of being time-poor hampered teachers' ability to support or find support for students with health needs or concerns, nor was there time to meet and collaborate with health professionals. These findings are consistent with those in international studies where time is considered a scarce and precious resource for both teachers and health professionals

and impacts their ability to feel adequately prepared and supported to assume responsibilities around students' health and wellbeing (Bronstein & Abramson, 2003; Ekornes, 2017; Helleve et al., 2020; Kidger et al., 2009; Mukherjee et al., 2002; Ødegård, 2005; Weist et al., 2012). In a study conducted in the United Kingdom, teachers' experiences of assuming some responsibility in the early identification of mental health problems were examined (Rothi et al., 2008). Whilst the teachers felt that they had a duty to help with early identification, they felt ill-equipped to assume the responsibility of supporting student mental health. One of the reasons for feeling this way was attributed to a sense that, as teachers, they lacked time to attend the necessary training, reflect on what they had learned, and consider how they might implement their learning into classroom practices. Another reason was a shared concern about the evolving and changing nature of teachers' professional role and responsibility in supporting students with mental health concerns and whether this was appropriate. The findings from a study by Mukherjee et al. (2000) concur with Rothi et al. (2008). Mukherjee et al. revealed that teachers lacked time to deal with non-teaching responsibilities, including supporting children with chronic illnesses or physical disabilities.

Teachers described themselves as very busy and, at times, overwhelmed with the demand to meet pedagogical targets and goals. This description of feeling overwhelmed could be partly attributed to the impact of neoliberal-influenced education reform and its focus on the attainment of schooling goals being determined by ability to measure learning achievement (De Saxe et al., 2020; Morton, 2014). This notion is supported by Podeschi (1976), who suggested that education's drive to achieve such targets and goals poses challenges for teachers, particularly in balancing this drive with the holistic needs of their students. Acknowledging the reality of the individual student learning experience (including any barriers they may have to their learning) and valuing students' uniqueness in the learning process have long been considered essential components of a teacher's professional role; however, time-challenged they are (Thrupp & Hill, 2019).

In acknowledging the time constraints and role demands experienced by teachers, it is timely to consider how health professionals working in schools could foster ongoing, sustainable intersectoral collaboration with their education counterparts. One solution

would be the New Zealand government's investment in advancing the relationship between the education and health sectors from a policy perspective. If mandated, organisational structures and practices could be implemented that allowed specific time investments for teaching and health staff to come together for a common purpose and uphold this practice as fundamental to improving student education and health outcomes in the long term.

Preparing teachers

In this study, school staff described not always feeling they were adequately prepared or supported to identify, advocate for, or manage students' health-related needs. Classroom teachers commented that behavioural issues were becoming more frequent, particularly anxiety and behavioural conditions. These issues contributed to teachers' classroom workload and frequently impacted their wellbeing and job satisfaction. As previously mentioned, shortage of time, plus a degree of burden and lack of preparedness experienced by the teacher participants, are findings consistent with other international studies, particularly in regards to supporting students' emotional health and wellbeing (Ekornes, 2015, 2017; Kidger et al., 2009; Mukherjee et al., 2000; Rothi et al., 2008; Tooher, 2017).

How New Zealand is preparing and assisting teachers to identify and support their students' health and wellbeing is worthy of further consideration to safeguard teacher and student wellbeing in the long term. Previous studies have highlighted teacher stress and burnout as a cause for serious concern, with overt linkage made to heavy workloads and an increasing number of students with high levels of learning needs as the cause (Flockton, 2019; Herman et al., 2018; Howard & Johnson, 2004; Vickers, 2014; Whitehead & O'Driscoll, 2000). In the longer term, assisting teachers to support the health and wellbeing needs of students is vital to enabling better educational and health outcomes for children (Ekornes, 2017; Elek et al., 2017; Kidger et al., 2009); however, neither individual teachers nor the education sector alone can meet these outcomes. In New Zealand, it will require collaboration with other sectors, including health, and a mandate for interagency collaboration to occur. A significant number of children and young people in New Zealand have complex health, social, and emotional needs commonly associated with socioeconomic disadvantage (Ministry of Health, 2018c; Simpson et al., 2017a, 2017b). If these needs are not met in a timely way

through collaborative action, it is less likely that these children and young people will be able to fully engage in their schooling experience and ongoing learning.

Providing adequate teacher education has been linked to positive outcomes of health-related projects in schools and improves knowledge and teachers' confidence and values relating to health (Brunette, 2017; Shepherd et al., 2013). This linkage was reinforced by teachers interviewed in this study, who wanted more PLD about health topics that had the potential to impact student learning and academic achievement. In addition, teachers and school staff wanted clear referral criteria and pathways to the different health providers. Others have supported this wish, stating that adequate preparation leads to feelings of empowerment and furthers understanding of the interrelatedness of education and health (Costante, 2002; Cutler & Lleras-Muney, 2006; Michael et al., 2015). Still, what PLD does *not* reliably do is convince teachers that promoting student health is part of their role; neither does it convince school leaders that it should be considered a priority within the school environment (Brunette, 2017; Ekornes, 2015; Kidger et al., 2009).

Of significance, as shown in the three school cases, is the influential role of school leadership and a tacit whole-school approach to health and wellbeing on how students with health issues are managed and supported by those working with them; this aligns with other international studies (Ekornes, 2015; Kidger et al., 2009; Lewallen et al., 2015). In all three school cases, practical steps were taken to mitigate the burden on classroom teachers to manage their students' health, behaviour, and learning issues. Support was offered by implementing designated school roles such as the SENCO and senior teachers assigned lead roles in pastoral care and behaviour. The schools had self-funded the SENCO role because it was not currently funded centrally via MoE; this allocation of funding had a significant impact on their school budget. Yet, all the school principals agreed that this was money well spent, particularly concerning minimising the time spent by the classroom teacher in following up on learning and health-related needs.

In the context of education and health systems, the benefit of working together is undeniable. This study proposes that, in New Zealand these benefits are not wholly appreciated nor comprehensively practised. Some existing local infrastructures can

support collaborative working, such as the Communities of Learning|Kāhui Ako initiative (Kamp, 2019), but this requires the commitment and willingness of both parties to want to do so. Drawing from my experiences as a researcher and clinician, during this study, I have had the privilege of leading two community-level projects, which promise to improve education and health interface, at least at a local service level. These initiatives demonstrate that service collaboration does not have to be complex; collaboration and commitment can lead to positive outcomes.

Cultural considerations

International literature posits that education is positively associated with health, and poor health can negatively influence educational achievement. However, less research focuses on this relationship in an indigenous context, particularly from a New Zealand Māori perspective (Johnston et al., 2009; Reid et al., 2022; Tagalik, S., 2010). Whilst the New Zealand government has included the nation's wellbeing as a measure of its success (Department of the Prime Minister and Cabinet,2019a), inequities in health and education for Māori are persistent in New Zealand (Bishop et al., 2009; Bolton, 2017; Henare et al., 2011; Martel et al., 2019; Ministry of Education, 2020; Simpson et al., 2017a, 2017b). Despite increased efforts at reducing these inequities, there has been no tangible reduction in recent years, raising the question of whether current policies aimed at this are particularly effective.

The findings of this study are relevant for informing progress in the attempts to reduce current inequities for Māori in health and education, particularly given the acknowledged interrelatedness of the two (Basch, 2011a; Braveman & Gottlieb, 2014; Ma et al., 2018; Michael et al., 2015; Zimmerman & Woolf, 2014). Concerning the identified convergent themes 1 and 2 in this study*: 'Separate and siloed systems'* and '*Developing and managing intersector collaboration',* creating effective and different ways of working together, plus establishing collaborative working relationships between the two sectors would be a good starting point to address existing inequities for Māori children and young people. For Māori, the notion of relationships, as captured in the context of whanaungatanga, is a core value (Mead, 2003; Ware & Walsh-Tapiata, 2010). This value joins people together, providing the foundation for a sense of togetherness and belonging. In a Māori worldview, relationships and

connections are central to Māori as individuals, whānau/family members, and as communities; these connections are also central to Māori wellbeing. Whanaungatanga is about establishing and maintaining relationships and strengthening ties between people and communities. This study aligns with this core value in seeking to improve connections and nurture reciprocal relationships between the health and education sectors to benefit all children and young people in New Zealand.

The third convergent theme: *'Teachers' role in supporting the health and wellbeing of their students'* speaks to the Māori value of manaakitanga, which relates to expressing care and respect for others as a way to safeguard collective wellbeing. Enacting the value of manaakitanga emphasises responsibility, reciprocity and the importance of nurturing positive relationships (Mead, 2003; Ware & Walsh-Tapiata, 2010). Manaakitanga is expressed differently depending on the nature of the relationship and those involved. In the context of this study's findings, practising manaakitanga relates not only to the teacher-student relationship but also to teachers' interprofessional relationships, including those with providers of health services. People fundamentally influence children and young people's life course (Freeman & Lunardi, 2020; Foulkes et al., 2018; Johnston, 2009; Tomlinson et al., 2021); these people include teachers and health professionals as well as family/whanau and peers. Adults supporting children and young people are responsible for enacting manaakitanga; this includes facilitating whanaungatanga.

School-based health services offer an opportunity to increase access to healthcare for Māori children and others for whom access is problematic due to socioeconomic disadvantage and negotiating the current health system structure (Cram, 2014; Ellison-Loschmann & Pearce, 2006; Graham & Masters-Awatere, 2020). Children living in low socioeconomic communities often encounter barriers to accessing health services due to cost, transport difficulties, challenges navigating the health system and cultural barriers to accessing the care needed (Cram, 2015; Ellison-Loschmann & Pearce, 2006; Jeffreys et al., 2022). Providing more health services in a particular geographical location is not always sufficient to improve access to care. However, taking health services to schools is one way of overcoming inequities in access; schools are institutions located in all communities and are a logical place to provide health services. International research has repeatedly demonstrated that school health

services improve and preserve students' health and indirectly support school attendance and academic outcomes (Caan et al., 2015; Clayton et al., 2010; Geierstanger et al., 2004; Mason-Jones et al., 2012; St. Leger & Nutbeam, 2000).

In the context of health research, Māori health advancement can be defined as positive contributions and improvements to Māori health and wellbeing and/or reduction in health inequity (Health Quality and Safety Commission New Zealand, 2014; Health Research Council, 2019). Advancements can occur in different ways; this study has contributed to two of these, notably the development of new and relevant knowledge and its potential to impact individuals and organisations.

Summary

This study has provided new and unique insight into the current relationship between primary school staff and health services in New Zealand and the barriers and enablers contributing to this relationship. The day-to-day functional relationship is separate from one another and relies on work-related interpersonal connections between school staff and health professionals to bridge this separation. Relying on ad hoc interpersonal relationships as the bridge between education and health in New Zealand is neither sustainable nor acceptable.

Over time, both sectors have become inwardly focused on meeting children and young people's learning and health needs separately, despite the burgeoning evidence of interdependency between the sectors. Sustaining this inward focus has meant both sectors are falling short of making optimal contributions to children and young people's education and health needs. Arguably, the cause of inward-focused siloed working practices stems from decades of state sector reform. These reforms embraced NPM practices focused on in-house efficiency and effectiveness incentives, effectively discouraging inter-sector collaborative working.

A practical starting point for instigating collaborative working across the New Zealand education and health sectors is to develop a shared understanding amongst teachers and health professionals of the interrelatedness of education and health to help better understand the benefits of collaborating. This study has provided a greater appreciation of the inconsistencies in the understanding of this interrelatedness by

teachers across the three case schools and identified a desire by teachers for further PLD. In addition, teacher participants revealed a shared uncertainty over what extent their professional role should play in supporting their students' health and wellbeing. Providing role clarity and expectation through open dialogue within school teams and in the education and health sectors will help lessen this uncertainty and, ultimately, improve collaboration for the benefit of children.

Achieving successful collaboration across organisational boundaries is not always easy, but in the case of education and health, the benefits clearly outweigh the challenges. This study has highlighted that the current relationship between the education and health sector needs to change. From a future-focused perspective, those working within these sectors need to be the champions of this change to benefit all New Zealand's children and young people.

Chapter 6 Implications for Policy and Practice

Health and education are human rights (United Nations, 1989). The interrelatedness and interdependence of the two have been well-documented in the international literature over many years (Costante, 2002; Cutler & Lleras-Muney, 2006; Michael et al., 2015). The present multicase study examined the relationship between school staff and health services in New Zealand primary schools, and the findings have highlighted areas for improvement and change. The previous chapter discussed the study's findings in detail and linked these with existing literature and current-day practices. This final chapter considers the implications of the study findings for policy and practice.

Neoliberal-influenced reforms from the 1980s onwards have shaped the relationship between the education and health sectors. As a result, there are currently complex influences on the working relationship between primary schools and health services. These influences are evident at intersectoral, interprofessional, and interpersonal levels. In particular, the study has highlighted current working practices that can both enable and disable effective collaborative relationships between the two sectors. This study provided new insights into the relationship between school staff and health services that contribute to the current knowledge of working practices between the two sectors in New Zealand and may inform future health service delivery models and practices.

Chapter Two highlighted the gap in collaborative working practices between the education and health sectors in New Zealand. A review of the literature highlights that there is currently no legislative requirement for the two sectors to work together nor an existing framework on which to build a formal working relationship. A suite of issue statements presented in Chapter Three (Table 1) provided a conceptual framework outlining some of the foreshadowed influences on relationships between school staff and health service providers. The new data collected during this study revealed the significant contemporary influences on the relationships between the two sectors and the challenges faced by school staff when trying to address the health issues of their students. One of these influences was the distinctly different perspectives school staff

held of their professional role and linked responsibility in supporting their students' health and wellbeing. This finding was unexpected and has not been highlighted or described previously in New Zealand.

This chapter considers the implications for policy and practice as informed by the study's findings. The limitations of the study and suggestions for further research are also described. The study recommendations are introduced under three separate headings: policy, practice and workforce development. A summary of these recommendations is presented in Table 12 (page 207).

Policy

Past neoliberal policies have increased social inequities through the conflicting ideologies of choice and equity (Barnett & Bagshaw, 2020; Nairn, 2012; Podder & Chatterjee, 2002). Neoliberal reform has ignored that individual choice is limited by social circumstances such as poverty and socioeconomic status (Boyle, 2013; Fishkin, 2014a). As a result, persistent inequities in New Zealand exist across education, health, employment, and income (Bolton, 2017; Goodyear-Smith & Ashton, 2019; Marriott & Sim, 2014; Tomorrow's Schools Review Independent Taskforce, 2018). The interrelatedness of education and health (Gracy et al., 2017; Haycock, 2010; Zimmerman & Woolf, 2014) emphasises a need for both sectors to work together to help counteract the effects of these increasing inequities.

This study has highlighted the challenges of forming and maintaining collaborative working relationships without a formal requirement at intersectoral, interprofessional, or interpersonal levels to do so. As previously stated, New Zealand has no legislated requirement or directive for the education and health sectors to work together. This lack of requirement is concerning when considering the overwhelming evidence from international studies on the benefit of doing so (Blank, 2015; Dilley, 2009; Geierstanger et al., 2004; Kocoglu & Emiroglu, 2017; Murray et al., 2007; Walker et al., 2010). Commitment and investment by the New Zealand government to advance the relationship between both sectors through policy would enable the development of cohesive cross-sector working practices. Recommended high-level policy priorities are to:

1. *Implement a Ministry of Education-led directive that specifies schools' requirement to collaborate with providers of health services in schools*
2. *Implement a Ministry of Health-led mandate that explicitly specifies how publicly funded health care providers will collaborate with providers of state-funded education*

Under such policy, the education and health sectors are directed to initiate and develop improvements in their collaborative working practices to enable student access to health care in a timely and appropriate manner, and support their ongoing learning and educational needs. A clear mandate for supporting collaboration would strengthen the working relationship between the two sectors; together, they would be responsible for making the relationship work. An essential aspect of supporting collaborative efforts through such a mandate is to ensure a congruent focus between the education and health sectors, with clearly defined roles and responsibilities.

A policy mandate would provide the foundation for both sectors to consider how they work together to improve outcomes for children and young people and help establish and develop shared objectives. However, this study has highlighted that internal issues such as time, different professional cultures and values, resource constraints, and lack of shared understanding between the two sectors influence collaborative working. From a future-focused orientation, these differences should not be perceived as barriers but as an opportunity to form a unique relationship that optimises learning and health outcomes for children and young people and simultaneously assists each sector in achieving its goals and related objectives. These include the health sector's goal of optimising the ongoing health status of children and the education sector's goal of enhancing children's learning development and achievement.

Practice

As described in Chapter Two, the influence of neoliberalism and the accompanying NPM practices has resulted in the disaggregation of public sectors such as education and health (Pollitt et al., 2001; Verhoest, 2017). An unintended consequence of disaggregation has been the formation of both *intra*- and *inter*-sector silos and siloed working practices (Bezes et al., 2013; Fenwick et al., 2009; Pollitt et al., 2001). The current inward-looking and self-contained nature of the education and health sectors

arising from this persistent siloed way of working means that each sector has little or no regard for the other's predetermined goals and outcomes. This disregard is despite some goals and outcomes of each sector being inextricably linked to the other.

The findings in this study have identified several important implications for future practice that relate to bridging the current gap and reducing silo working between the education and health sectors. These implications include increasing the visibility and profile of health services in all New Zealand primary schools. The first recommendation is for the implementation of a national (or regional) intermediary entity that supports the education and health sectors on agendas relevant to both, acknowledging where these intersect and being responsible for implementing and upholding government policy directives.

Intermediary entities have the potential to integrate a wide range of services in order to address the health, education, and social needs of children and their families (Blank et al., 2003; Center for Public Research and Leadership, 2017; Healthy Schools Campaign, 2021; Singh & Butler, 2015). As convenors, intermediary entities bring together key stakeholders to plan and strategise new initiatives that support a common goal: "intermediaries make it easier for partners to come together, learn together and be jointly be accountable" (Blank et al., 2003, p. 3). In this instance, an established intermediary entity would be responsible for bringing together those involved in helping children succeed but should not be delivering services themselves in order to remain 'turf' neutral and instead focus on the anticipated outcomes.

The second recommendation for practice change is to increase the visibility and profile of health services in New Zealand schools. This could be achieved by developing a national school health services programme that can integrate universal and targeted approaches to health service delivery in schools. This programme would be available across all publicly funded primary schools and accommodate nuanced and targeted service delivery where needed. Implementing a standardised approach to delivering school health services would help ensure that all schools across New Zealand are supported to provide access to health care for their students.

The third recommendation for future practice is for those working in the education and health sectors to proactively seek ways to circumnavigate barriers in the functional working relationships of schools and health services. This could be achieved by leveraging existing infrastructures supporting collaboration and interagency working. An example of this was described in Chapter One, where a Community of Learning/Kahui Ako was used to extend limited health service resources across a group of schools that had previously experienced less visible and accessible health service delivery. Another example described in Chapter One was the Whare Hauora project (Appendices A & B), where a District Health Board funded and built dedicated health spaces in two primary schools. These schools were situated in low socio-economic communities and had provided space to accommodate health professionals to work with children who experienced high health needs. The dedicated health spaces provided a fit-for-purpose, child-friendly facility for health providers to work from for longer periods than they could previously.

The fourth recommendation relates to a change in current practices regarding how health service providers work alongside schools. From a functional working perspective, the findings from this study imply that the health system should be more attentive to how it currently works and delivers services in schools. The health system must be conscious of working *with* schools rather than *on* schools, using a holistic and integrated approach to delivering services to children and young people. The traditional biomedical approach to delivering health services in primary schools focuses on diagnosing and treating physical illness rather than prevention and early intervention or considering the broader determinants of health and the interrelatedness of physical, mental, emotional, and spiritual health. The biomedical model is outdated and inadequate for addressing the diversity of health needs of New Zealand children and young people as members of a multi-cultural society. Adopting a more holistic model that acknowledges social determinants of health and considers individual child and whānau-centred perspectives would assist health providers in finding common ground to build and sustain working relationships with school staff.

The fifth and final recommendation relating to practice change is for the New Zealand education and health sectors to establish an effective and safe system for sharing relevant and appropriate student information. The sharing of appropriate and timely

information across the two sectors was perceived as problematic by the participants in this study, with no consistent guidelines or framework currently in place. However, section 141 of the Privacy Act 2020 allows public sector agencies to enter into an information-sharing agreement should they wish to do so. Drawing on this new legislation provides a framework for building and managing an information-sharing agreement between the education and health sectors.

Workforce Development

Without a clear directive for the education and health sectors to work together, plus operational structures that create barriers, the relationship between primary school staff and health services depends almost entirely on interpersonal relationships. Influencing these relationships are personal attributes and opportunities to spend time together building respect and trust (Flood et al., 2014).

Nurses working in schools have been cited as a valuable workforce, accepted by school staff, children, and their families, and positively contributing to education and health outcomes (Baisch et al., 2011; British Youth Council, 2011; Buckley et al., 2012; Chayer, 1953; Kolbe, 2019; Magalnick & Mazyck, 2008). These findings were clearly evident in my study, reinforcing a need for the health system in New Zealand to revisit the roles of nurses in primary schools and consider developing this role as a designated specialty area of practice similar to other countries, such as the United Kingdom and the United States. The nursing workforce is currently already located in schools, but sporadically. Currently, there is no specified MoH framework for embedding nursing service delivery in schools or proposed workforce development in this area.

In addition to advancing the role of nurses working in schools, teachers in this study highlighted the need and a desire for increased professional development concerning health-related conditions that may create barriers to learning and school attendance to support their day-to-day professional teaching practice. Ideally, this professional development would be integrated into the curriculum at an undergraduate level, allowing the knowledge to be built upon as the teacher progresses through their professional career. There is an opportunity to consider the role health professionals might play in supporting teachers to understand, identify, and meet the needs of students with long-term health conditions. Similarly, teaching staff could advance

health professionals' knowledge about schools and students' expected learning trajectories. Further dialogue relating to education and health professionals collaborating, partnering and supporting each other with their PLD would be advantageous in advancing knowledge acquisition across both sectors and developing and optimising the teacher-health provider relationship.

Concerning the differing perceptions held by participants in this study of their professional role and responsibility in attending to and supporting their students' health and wellbeing needs, attention is drawn to the importance of further work needed to establish where uncertainties lie. Further dialogue with teachers on this topic would assist in understanding what is required to clarify role expectations and responsibilities for themselves as a sector and the health professionals who work alongside them.

Table 12. Recommendations

Primary Recommendations
Policy
Implement a Ministry of Education-led directive that specifies schools' requirement to collaborate with the providers of health services
Implement a Ministry of Health-led mandate that specifies how publicly funded health care providers will collaborate with providers of state-funded education.
Practice
Establishment of a national intermediary entity (or regional entities) to bring together the education and health sectors in New Zealand
Development of a national, standardised school health services programme that has integrated universal and targeted components
Leverage existing education and health infrastructures to support collaboration and interagency working at a local level
A commitment by health providers to work *with* schools rather than *on* schools using a holistic and integrated approach
Establish a system for sharing relevant and appropriate student information across the education and health sectors
Workforce Development
A national review of school-based nursing services and investment in the development of school nursing as a workforce and as a career development pathway for community nurses
A review of undergraduate teacher training curriculum content and ongoing PLD for qualified teachers to include education about health conditions that impact student learning and school attendance

Limitations of the Study

This multicase study was undertaken to better understand the current relationship between primary school staff and health services from the perspective of education staff. Data were gathered through pre-interview questionnaires, individual interviews, observation of interactions during meetings, and a review of the health-related PLD offered to school staff.

Each of the three schools in this study (referred to as Cases) had notable differences in culture, ethos, internal operating systems, and access to health services, which influenced their unique relationship with health providers. The unique nature of each case needs to act as a caution when considering to what degree the individual case findings can be generalised across other primary schools in New Zealand.

This study focused solely on the influences and experiences of school staff working with health service providers. This group is one partner in the relationship; the current study did not consider health providers' perspectives or those of students and their families. Understanding the experiences of these other key stakeholders in the relationship would provide a more holistic and comprehensive overview on which to inform policy and change in working practice.

The small number of cases limits the capacity for generalisation. However, the cases span decile rankings and the schools that participated served diverse communities. In addition, each case study was robust, with in-depth data collected from 18 interview participants and supplemented by observations of special education needs meetings and a review of professional development opportunities for school staff.

It is necessary to be cognisant of the many demands on teachers' time and their limited availability to spend time out of class. I remained conscious of being careful not to overburden teachers or for my presence in the school to impact the teachers' behaviours. For example, these constraints prevented the inclusion of focus groups in this study.

Despite working as a health provider in schools for many years, prior to conducting this study, I was somewhat naïve about the intricacies of the working relationship between

the health and education sectors. It is challenging to fully understand the complexity of this relationship until a significant amount of time is spent in school settings and an appreciation is gained for the uniqueness of individual schools and their communities. What has become apparent through the data collected from this study is that it will be essential to consider the relationship from both sectors' perspectives if any form of intersector collaboration is to be championed and sustained in the future.

Future Research

This study provides insight into school staff's relationships with health services and health professionals in the primary school setting. It highlights the challenges classroom teachers currently experience in supporting and advocating for children with health needs. School staff are willing to work alongside health providers at a service level, provided access is not onerous, and health support is visible. The following section proposes several further research recommendations to enable the knowledge from these case studies to inform broader improvements in intersectoral relationships.

Nurses working in schools provide an essential conduit for school staff to access support for students, but their visibility and relationship with individual schools impact the uptake of services. A subsequent study could assess *how* teachers and health professionals work together at an individual level to optimise health outcomes for their students. This would inform the future development of operational models and the workforce. As a component, studies that focus explicitly on understanding the experiences of students' and caregivers' access and use of health services through and in primary schools would be invaluable.

More in-depth research is needed to understand the current varied perspectives teachers have on their professional role in supporting the health and wellbeing of their students and what influences this variance. The current study drew attention to the fact that this is an ongoing dilemma for teaching staff, particularly when balanced with the need to achieve curriculum targets and outcomes. Providing greater clarity around role expectations and responsibilities would benefit teachers and those working alongside them.

The New Zealand health and education systems are unique and complex. Further investigation on the application of proven and successful models of intersectoral collaboration between education and health that have been trialled and adopted elsewhere is recommended (Blank, 2015; Miller & Bice, 2014; Murray et al., 2015). Based on the applicability of these models (with appropriate modification) to the New Zealand setting, a pilot project involving a group of schools would be undertaken. The aim and objectives of this project would be to develop a model of intersectoral collaboration that will work effectively for New Zealand primary schools and providers of school health services.

A final recommendation for further study is research that draws on systems thinking (Maani & Cavana, 2007) to develop an understanding of the interaction, perspectives, boundaries, and overlaps of the education and health systems in New Zealand. Undertaking research in this topic area would inform the ongoing development of the education-health relationship in the current era of health reform. A systems approach would assist in understanding the structural changes needed to allow for meaningful and sustainable collaboration between the two sectors.

Summary

This study aimed to explore the relationship between education staff and health services in New Zealand primary schools and what influences that relationship. It was proposed that the subsequent findings would help inform how school health services are designed and delivered in the future.

The emergent findings highlight system issues impacting schools' relationship with health services in New Zealand, including time, trust, specific knowledge and practice territory. The findings from this research also highlight the need for education and health providers to work together more collaboratively, aided by an established infrastructure underpinned by legislative policies. The influencing factors on the relationship were shown to be quite distinct; however, the relational interactions were indicative of the complex nature of establishing an effective and sustainable education and health sector collaboration.

This study has highlighted an urgent need for an across-sector focus on improving access to health services for children attending primary schools and those attempting to obtain support for them. To date, there has been a lack of focus and attention on health service delivery in primary schools in New Zealand; this has hampered the ability to provide early intervention and support for children experiencing health-related barriers to their learning. The findings from this study suggest that creating new policies and practices to support the creation and implementation of a national model of health service delivery in primary schools would be beneficial.

From a future-focused perspective, the findings from this study have emphasised the importance of identifying and understanding the barriers and facilitators to successful intersectoral collaboration. In this chapter, recommendations are made on how future collaboration successes might be gained and supported. However, if these initiatives are to be successful, it remains vital that all key stakeholders be included and consulted when any new intersectoral initiatives are proposed, developed, and evaluated. In the context of the findings from this study, stakeholders need to include school staff, health professionals, students, families and caregivers.

To date, the enduring logistical siloing of the education and health sectors in New Zealand, plus a lack of shared understanding of their interrelatedness, has made it challenging to align, coordinate and link the two sectors purposefully or sustainably. The way the relationship currently works relies on goodwill and the establishment of effective interpersonal working relationships, which is not acceptable, practicable, or sustainable. Continued reliance on this way of working, with no formal requirement for the two sectors to collaborate, leaves the relationship vulnerable to breakdown. The ongoing risk of such breakdowns impacts those who need education and health to work together if they are to have any chance of fulfilling their educational potential. A commitment from both sectors to be open to doing things differently, plus a shared vision and mutually agreed goals, is imperative if collaboration is to be successful. The education and health sectors must be strongly encouraged to work together in the future to optimise positive education and health outcomes for all children and young people living and growing up in New Zealand.

Collaboration between the education and health sectors can enhance student learning and health outcomes, impacting the life course of an individual and society as a whole. Intersector collaboration benefits children and young people and has been endorsed by the World Health Organization (1997, 2011c) as a strategy to improve population health. It is hoped that the findings from this study will provide insight and understanding in support of the need to change how the New Zealand education and health sectors work together in the future.

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Glossary of Terms

The following is a glossary of words, names, and terms used throughout the thesis.

Assertions	The researcher's summary of interpretations and claims
Constructivism	The belief that knowledge is constructed as a result of social interpretations rather than knowledge of external realities
Decile	In the New Zealand education system context, decile refers to the extent to which the school draws their students from low socio-economic communities. Decile 1 schools have the highest proportion of students from low socio-economic communities, and decile 10 schools have the lowest (the decile system is currently under review)
District Health Board	An organisation responsible for providing health and disability services within a defined geographical area: https://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/district-health-boards
Emic issues	Research questions revealed by the participants
Etic Issues	Issues bought into the study by the researcher
Health Professionals	Persons who diagnose, treat and prevent ill-health, injury and other physical and mental conditions in people
Health Provider	A person or organisation that provides a healthcare service
Health Services	Services focusing on improving health, including public health, services to individual health and health promotion
Instrumental case study	Researching a case to gain an understanding of something else
Interagency	Between agencies
Intersector	Relationship between two or more organisations or sectors
Kahui Ako (Community of Learning)	A group of education and training providers that work together to help children and young people to achieve their full potential https://www.education.govt.nz/communities-of-learning/
Māori	The indigenous people of New Zealand
Māori Medium Education	Māori-medium education is offered in some state school settings, with *some* of the students taught subjects in the Māori language for at least 51% of the time https://www.educationcounts.govt.nz/directories/maori-medium-schools

Multicase study	Studying several cases within the same research project
Primary School	In New Zealand, a 'full' primary school covers school years 0–8, or years 0–6 if it is a 'contributing' primary school. https://www.education.govt.nz/school/new-zealands-network-of-schools/about/types-of-schools-and-year-levels
Public Health Nurse	Nurses who work in community settings, including schools, undertaking health assessments and disease prevention activities
Resource Teacher Learning and Behaviour	Often abbreviated to RTLB, this role is funded by the MoE to work with teachers to support the learning and achievement of students with learning and behavioural difficulties
School-based health services	Health services provided to schools and formal, onsite health clinics in secondary schools
Special Educational Needs Co-ordinator	Often abbreviated to SENCO. This role has the responsibility in schools of managing and coordinating the wellbeing, learning, and education of students identified with special educational needs.
Whānau	Often translated simply to mean 'family', but its meaning in Māori is more complex. It includes physical, emotional, and spiritual dimensions and is based on the extended family group.

Appendices

Appendix A. Whare Hauora 1

Amazing Spaces: The 'Whare Hauora'
Taking Child Health Clinics to School

S Williams*[1], P Seymour[2], R Johnson[3], A Leversha[1]
[1]Starship Community, [2]Starship Child Health, [3]Panmure Bridge School, Auckland, New Zealand

whare hauora
STARSHIP COMMUNITY

Background

In New Zealand there is an identified need for improved access to health services for children and families in communities with significant socio- economic disadvantage. One response has been to deliver healthcare in schools. Unfortunately due to increasing rolls and demands on schools, there has been a lack of appropriate spaces resulting in poor working situations for healthcare workers. A survey of 15 nurses working across 15 primary schools identified suboptimal working environments across them all *(Fig 1 and 2)*. Having considered alternative options and any potential barriers, the concept of a semi-permanent, relocatable clinic space proved a viable solution *(Fig 3)*.

Fig 1: School Clinic Resources

Aim

To provide a child and practitioner friendly, fit-for-purpose clinic for nurses working in schools.

From Concept to Reality

The Power of Relationships:

- Who are the supporters?
- Who are the key stakeholders?
- Who are the key players
- Who could build this?
- Who can finance this?

This project provided an ideal opportunity for community collaboration between health, education and local business. A space was owned by health, funded by local business and housed by education – in the community, for the community.

Timeline

55 days to design and cost

274 days to engage stakeholders and secure funding

484 days to manage project through to completion

Fig 2:

Strengths & Weaknesses

Fig 3:

Result

Fit-for-purpose child-friendly, safe and appropriate workspace for nurses in schools.

Specifications:

- 7.2m long x 3.1 wide x 3.0 high
- 22m² workspace
- Owned by Health
- Housed by Education
- Relocatable
- Self-contained (own power, waste, water supply) but linked to school utilities on site
- Accessible
- Secure
- MoU

Why Does This Matter?

In order to learn, a child must be able to attend school and be able to partake in learning opportunities. Health issues play a major role in limiting or preventing these opportunities and are a significant contributor to poor educational outcomes. Positioning health services alongside education not only increases accessibility to health services but also encourages education and health professionals to work together to support positive health and education outcomes for children.

"Alone we can do so little, together we can do so much"
Helen Keller

Outcome

This was collaboration at its finest:

Education, Health and Business coming together to effect change. The project has been about so much more that a clinic space; it has been about belief, relationships and a willingness to work together.

The Whare Hauora has:

- Improved service delivery by providing a safe, fit-for-purpose facility for health staff
- Enhanced patient experience by enabling quality healthcare to be delivered in the community for the community
- Increased access to outpatient services by utilising the space as a satellite clinic for other health services

Acknowledgements: Cube Solutions, Barfoot and Thompson, Starship Foundation, Auckland District Health Board, Panmure Bridge School

AUCKLAND

Welcome Haere Mai | Respect Manaaki | Together Tūhono | Aim High Angamua

Starship Foundation

Appendix B. Whare Hauora 2

Success Story: Starship Community

The project: Amazing Spaces: The 'Whare Hauora' – taking child health clinics to school

Which SDG it links to: This project links to three SDG's: Good Health & Wellbeing; Quality Education and Reduced Inequalities

The sectors involved: Health, Education & Business

The outcomes you're seeking: The health and education of children are inextricably linked. In order to learn a student must be able to attend school and be able to partake in learning opportunities. Health issues play a major role in limiting or preventing learning opportunities and are a significant contributor to poor educational outcomes. Positioning health services alongside education not only increases accessibility for children to health services but also encourages educators and health professionals to work together to support positive health and education outcomes for children.

The Whare Hauora is a relocatable, modular, purpose-built clinic space. The Whare Hauora provides an innovative solution to the delivery of healthcare in primary schools, particularly those situated in low socio-economic communities and where space is an issue. Health and Education professionals collaborated in the design and logistics. Funding for the build and installation of the inaugural Whare Hauora was generously donated by Starship Five Star Partner Barfoot & Thompson.

Hugely popular from the outset, this child, family and practitioner friendly clinic space has:

- Improved health service delivery by providing a safe, fit for purpose facility for health staff
- Enhanced patient experience by enabling quality healthcare to be delivered in the community for the community
- Increased access to outpatient health services by utilising the space as a satellite clinic for other health professionals
- Enabled children with mild to moderate health needs to have these needs met in a timely way and therefore support regular attendance at school.

For more information on this project follow the link: Starship Community Whare Hauora

Contact
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Nurse Consultant
Starship Community – Central Locality
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Most relevant SDGs:

Appendix C. AUTEC Committee Approval

AUTEC Secretariat

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T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

20 November 2017

Dr Annette Dickinson
Faculty of Health and Environmental Sciences

Dear Annette

Re Ethics Application: **17/359 The relationship between health services and education in the context of primary schools**

Thank you for providing evidence as requested, which satisfies the points raised by a subcommittee of the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 20 November 2020.

Standard Conditions of Approval

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through http://www.aut.ac.nz/researchethics.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through http://www.aut.ac.nz/researchethics.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: http://www.aut.ac.nz/researchethics.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. You are reminded that it is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

For any enquiries, please contact ethics@aut.ac.nz

Yours sincerely,

Kate O'Connor
Executive Manager
Auckland University of Technology Ethics Committee

Cc: sarahwilliams@xtra.co.nz; Margaret Anne Jones

Appendix D. AUT Mātauranga Māori Committee Feedback

School of Clinical Sciences Verification of Māori Consultation Processes

This document provides verification that the research project named below was discussed with the School of Clinical Sciences Mātauranga Māori Committee, AUT University. Specific comments and recommendations are indicated below.

Research Title: *The relationship between health services and education in the context of primary schools* (Doctor of Health Science research)		
Researcher(s): Sarah Williams		**Date:** 6/9/17
Discussion Areas	**Addressed**	**Comments/ Recommendations**
Whakapapa: Relationships		
Researcher experience in field	X	C1
Consultation with local stakeholders	X	R3, R5
Consenting process		
Clarity of data usage		
Dissemination of findings	X	R6
Benefits to participants	X	R5
Tika: Validity of the research		
Clear purpose of project	X	C1, C2, C3
Relevance to Māori	X	C1, C5
Likely outcome for participants, communities, other stakeholders	X	C4, R6
Participant recruitment methods	X	C4
Māori involvement in project (participants, researchers, etc.)	X	R2, R4
Manaakitanga: Responsibility and respect		
Participants' access to appropriate advice	X	R3, R4
Participants treated with dignity and respect	X	R4, R5
Privacy and confidentiality	X	R5
Whānau support	X	R6
Transparency of research process		
Mana tangata: Power & Authority		
Reciprocity (acknowledgements, compensation, gifts)	X	R5, R6
Risks of participation identified		
Ownership of outcomes		
Informed consent process		

Comments

1. The researcher's background is in paediatric nursing and public health nursing, both in the United Kingdom and New Zealand. Her current focus is on children and families and the difficulties around the relationship between health and education, which can lead to disadvantages in both areas for the most needy.
2. The researcher feels that before different ways of working can be proposed and established, it is necessary to find out how health services are perceived in the education sector and by the people working in the schools. The project will be run in schools within the ADHB area. School staff who liaise with health services will be interviewed regarding how they feel about health workers being in the educational space.
3. The three primary schools will be decile 1, 3-4 and 10 to enable a cross-case analysis of differing decile levels. An observational study will also be undertaken, to highlight how health is contextualised when there is an educational need. Finally, the researcher will review the professional development opportunities offered to staff, and whether they cover health matters or only educational matters.
4. The researcher already has some good contacts with primary schools that have a high Māori roll, e.g. Panmure Bridge School.
5. Traditionally, the educational system has not been viewed as safe by Māori. Therefore, inclusion of Māori staff may bring different perspectives to the project.

Recommendations

1. Contacting the teacher who runs the school kapa haka group might be a good way to increase Māori participation. They may inadvertently provide information about community views of the health and education systems.
2. The questionnaire and interview questions should use simple terms and include Māori or Pasifika words that are in common usage – e.g., kaupapa, whānau.
3. Be aware that Māori perspectives of health can differ from the Western model, in terms of such matters as the land and spirituality. The Māori perspective (for example, Te Wheke, Te Whare Tapu Whā) would be important to incorporate into the case study, and they could drive the types of questions that are asked.
4. Māori staff participants may have their own culturally safe space that they would prefer to be interviewed in.
5. Interpretation of the findings: Having a Māori support person during the interviewing would be helpful in ensuring that answers are not misinterpreted. This could be a community health worker or an AUT student in the Faculty of Health and Environmental Sciences. The Committee will be able to provide contacts for appropriate students, if required. These people should receive a koha acknowledging their contribution.
6. Disseminating the results: Make sure you inform participants that you will let them know the outcomes. The study findings should also be made available to the school itself. The local marae may be an appropriate venue to disseminate this information. Again, make sure to respond with koha.

Feedback on these comments and recommendations may be requested 12 months following the meeting.

Signature:  Date: 7/9/17

Grant Mawston

Mātauranga Māori Consultation Committee

Appendix E. Transcriber Confidentiality Agreement

Transcriber Confidentiality Agreement

Project title: The relationship between health services and education in primary schools.

Project Supervisor: Annette Dickinson

Researcher: Sarah Williams

- ○ I understand that all the material I will be asked to transcribe is confidential.
- ○ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ○ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: .....

Transcriber's name: .....

Transcriber's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Project Supervisor's Contact Details (if appropriate):

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.....

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.....

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Appendix F. Participant Information Sheet

Participant Information Sheet

- **Information Sheet for Interview Participants**

Date Information Sheet Produced: 10 September 2017

Project Title

The relationship between health services and education in primary schools.

An Invitation

My name is Sarah Williams and I am a registered nurse working for Starship Community services and also a student enrolled in a Doctor of Health Science (DHSc.) programme. The research I am conducting will contribute to the completion of a DHSc qualification at the Auckland University of Technology (AUT).

You are invited to take part in a research study which aims to examine the relationship between health and education within primary schools. I am particularly interested in the experience of people who work within a primary school and their perspectives of working with health services in the school environment

What is the purpose of this research?

The purpose of this study is to increase our understanding in regard to the relationship between health and education within primary schools. The findings of this study will contribute to the development and planning and delivery of health services in schools. I also anticipate the knowledge and expertise gained during the study will contribute to the development of my practice as a community nurse working with schools. The findings will be presented and published both nationally and internationally.

How was I identified and why am I being invited to participate in this research?

You have received this information sheet because a person in your school has indicated that you may be interested in participating or you yourself have registered an interest in knowing more about this study. Any adults working in the school and who have had experience of interfacing with health services are invited to participate. A total of twelve to fifteen participants will be recruited for this study across three different primary schools in order to provide a range of opinions and views.

How do I agree to participate in this research?

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. If you decide to participate, you will be asked to sign a written consent form provided by me indicating your agreement to participate in the study.

You are able to withdraw from the study at any time and for any reason. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allow it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

Being involved in this research will mean participating in an interview with me, the researcher (Sarah Williams) at a mutually agreeable location. Prior to the interview you will be asked to fill in a brief questionnaire, the responses to this questionnaire will help guide the individual interview and should take no longer than 60 minutes. The interviews will be audio recorded. During the interview process you may stop the interview at any time and you do not have to answer all of the questions if you choose not to. You do not need to provide a reason for stopping the interview or choosing not to answer a question(s).

On completion of the interview the recording will be transcribed by a person who has signed a confidentiality agreement. If requested by you, the transcription will be sent back to you for review and confirmation.

What are the discomforts and risks?

There is minimal risk in being involved in this study; you will not be required to respond to any questions that you do not feel happy to answer and you reserve the right to stop the interview at any time.

What are the benefits?

There are no direct benefits to you however; it does provide an opportunity to share your experiences, thoughts and feelings about health services in schools. It is anticipated that this study will inform the further development of nursing service delivery in primary schools. The benefit to the researcher will be in completion of the necessary requirements for fulfilment of a Doctor of Health science qualification.

How will my privacy be protected?

No material which could personally identify you will be used in any reports arising from this study. Participant interview transcripts will be identified by an alias (false name) and any quotes used will have any potential identifiers removed. Interview data will be stored electronically on a password encrypted external storage device inside a locked cabinet at AUT. Hard copies of the consent forms will be stored in a separate office at AUT in a locked cabinet.

What are the costs of participating in this research?

The cost incurred by you is in the time taken to attend the interview of approximately 1-1.5 hours and the time, if requested, to read and check your transcript.

What opportunity do I have to consider this invitation?

From the time of receiving this information sheet, there are three weeks for you to consider participating in this research.

Will I receive feedback on the results of this research?

A summary report of the research findings will be sent to you unless you have specifically requested not to on your consent form.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Annette Dickinson, annette.dickinson@aut.ac.nz or 09 921 9999 ext 7337 . Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* or 09 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details: Sarah Williams sarahjw@adhb.govt.nz or phone 021 938 542 or 021 158 7387

Project Supervisor Contact Details: Annette Dickinson, annette.dickinson@aut.ac.nz or 09 921 9999 ext 7337

Approved by the Auckland University of Technology Ethics Committee 20 November 2017, AUTEC Reference number 17/359

If you have any questions or complaints about the study you may contact the Auckland and Waitematā District Health Boards Maori Research Committee or Maori Research Advisor by phoning 09 4868920 ext 3204.

If you require Māori cultural support, talk to your whānau in the first instance. Alternatively, you may contact the administrator for He Kamaka Waiora (Māori Health Team) by telephoning 09 486 8324 ext 2324.

Appendix G. Individual Interview Consent Form

Consent Form

❖ **Consent Form for Interview Participants**

Project title: The relationship between health services and education in primary schools.

Project Supervisor: Annette Dickinson

Researcher: Sarah Williams

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 10 September 2017.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○
- ○ I would like a copy of the interview transcript sent back to me to review: Yes○ No○

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

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S Williams The relationship between health services and primary schools in New Zealand September 2017

Appendix H. Individual Interview Question Guide

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Semi-Structured Interview Guide: School Staff

Pre-Interview:

Thank the participant for agreeing to take part in the study and ask if they have any questions or aspects of the study that they want clarified before the interview commences.

Take the time to introduce the interview, its purpose and confirm that the participant is happy for the interview to be audio-taped. Remind the participant that they can stop the interview at any time and/or delete any information that they do not wish to be used as data.

Indicative Interview Questions:

- What do you view as 'health services' in schools?
- In your current role what is your experience of working with health services?
- Tell me about health services that operate in your school.
- What do you think about health services operating in schools?
- What do you see as some of the things that influence the delivery and uptake of health services in schools?

Prompts may include:

Can you tell me more about that? You mentioned....can you explain that to me a little more?

Why do you think that happened? How did that make you feel? Why was that? What happened then?

Closing the Interview:

Provide an opportunity for the participant to add anything – Is there anything else you would like to add?

Thank the participant for giving up their time for the interview and let them know that you will be giving them a copy of the recording and transcript when it is ready for those that have requested this on their consent form.

Appendix I. Information Sheet for SENCO Meeting Participants

Participant Information Sheet

❖ **Information Sheet for SENCO Meeting Participants**

Date Information Sheet Produced: 10 September 2017

Project Title

The relationship between health services and education in primary schools.

An Invitation

My name is Sarah Williams and I am a registered nurse working for Starship Community services and also a student enrolled in a Doctor of Health Science (DHSc.) programme. The research I am conducting will contribute to the completion of a DHSc qualification at the Auckland University of Technology (AUT).

You are invited to take part in a research study which aims to examine the relationship between health and education within primary schools. I am particularly interested in the experience of people who work within a primary school and their perspectives of working with health services in the school environment.

What is the purpose of this research?

The findings of this study will contribute to the development and planning of health service delivery in primary schools. I also anticipate the knowledge and expertise gained during the study will contribute to the development of my practice as a community nurse working with schools. This study will contribute to my completion of a Doctor of Health Science (DHSc.) qualification. The findings will be presented and publish both nationally and internationally.

How was I identified and why am I being invited to participate in this research?

You have received this information sheet because you are likely to attend the regular Special Education Needs Co-ordinator (SENCO) meetings at the school.

How do I agree to participate in this research?

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. If you decide to participate, you will be asked to sign a written consent form provided by me, indicating your agreement to participate in the study.

I, as the researcher will confirm consent both individually and as a group prior to the start of the meeting. If for any reason not all members consent to my presence, I will not attend the meeting. As an individual and as a meeting group you reserve the right to ask that I leave the meeting and/or cease observation at any time. If I am requested to leave the meeting before it is finished then you will be offered the choice whether any data collected can continue to be used.

What will happen in this research?

Being involved in this research will mean that the researcher (Sarah Williams) will attend a scheduled SENCO meeting. Prior to the meeting I will confirm both individual and collective consent has been granted from all those present for me to be there observing the meeting.

The meeting will be run and led as usual and I will be observing and taking notes but not participating in any other way. The focus of my observations will be on staff interactions and discussion that relates to the relationship between health and education. Participants at the meeting will not disclose any student's health information without consent to the researcher. My notes will be written up by me and will form part of my research data. No data will be collected about any children discussed. No data will be obtained or recorded that will identify any actual children, staff member or service.

After the notes have been written up and interpreted, you will be offered an opportunity (if indicated on your individual consent form) to check my interpretations on what was happening in the meeting.

I will be using the observational data from this meeting to inform the research project for the purpose of gaining a DHSc qualification, for academic publications and conference presentations.

What are the discomforts and risks?

There is minimal risk in being involved in this study; as an individual you are free to request that the observation is stopped or that I leave the SENCO meeting at any time. As a meeting group, collectively you also reserve the right to ask me to cease the observation and/or leave if you feel that my presence is interfering with the usual running of this meeting.

What are the benefits?

There are no direct benefits to you. It is anticipated that this study will inform the further development of nursing service delivery in primary schools. The benefit to the researcher will be in completion of the necessary requirements for fulfilment of a Doctor of Health science qualification.

How will my privacy be protected?

No material which could personally identify you will be used in any reports this study. Meeting observation notes which form the data will not identify any individual person or service specifically. The data will be stored electronically on a password encrypted external storage device inside a locked cabinet at AUT. Hard copies of the consent forms will be stored in a separate office at AUT in a locked cabinet.

What are the costs of participating in this research?

Costs incurred by you are in the time, if requested, to read and confirm my interpretation of what happened in the meeting.

What opportunity do I have to consider this invitation?

From the time of receiving this information sheet, there are three weeks for you to consider participating in this research.

Will I receive feedback on the results of this research?

You will receive a summary report of the research findings unless you have specifically requested not to on your consent form.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Annette Dickinson, annette.dickinson@aut.ac.nz or 09 921 9999 ext 7337.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* or 09 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details: Sarah Williams sarahjw@adhb.govt.nz or phone 021 938 542 or 021 158 7387

Project Supervisor Contact Details: Annette Dickinson, annette.dickinson@aut.ac.nz or 09 921 9999 ext 7337

Approved by the Auckland University of Technology Ethics Committee 20 November 2017, AUTEC Reference number 17/359

If you have any questions or complaints about the study you may contact the Auckland and Waitematā District Health Boards Maori Research Committee or Maori Research Advisor by phoning 09 4868920 ext 3204.

If you require Māori cultural support, talk to your whānau in the first instance. Alternatively, you may contact the administrator for He Kamaka Waiora (Māori Health Team) by telephoning 09 486 8324 ext 2324.

Appendix J. SENCO Meeting Consent Form

Consent Form

❖ **Consent Form for SENCO Meeting Observation**

Project title: The relationship between health services and education in primary schools.

Project Supervisor: Annette Dickinson

Researcher: Sarah Williams

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 10 September 2017
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I wish to read and confirm the researchers interpretation of what happened in the meeting (please tick one): Yes○ No○
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○
- ○ I agree to take part in this research.

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

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Appendix K. Access Agreement Schools

Permission for researcher to access school staff & School Professional Development general records

Project title: The relationship between health services and education in primary schools.

Project Supervisor: Annette Dickinson

Researcher: Sarah Williams

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 10 September 2017
- ○ I give permission for the researcher to undertake research within _____
- ○ I give permission for the researcher to access the staff of _____
- ○ I understand that no information will be sought from individual staff professional development records_____

Principal's signature: .....

Principal's name: .....

Principal's Contact Details :

.....

.....

.....

.....

Date:

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Appendix L. School Profile Questionnaire

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School Profile Questionnaire	
School Identification Number:	
Address:	
Decile:	
Ethic Mix:	
Does your school receive regular visits from a Public Health Nurse?	Yes/No
Do you have an assigned Special Educational Needs Co-ordinator (SENCO)?	Yes/No
How often are SENCO Meetings held?	
Who decides who attends the SENCO meetings?	
What roles do regular attendees of the SENCO meeting hold?	
Do health providers regularly attend the SENCO Meeting?	
What information is shared in advance of and after the SENCO meeting? Who is it shared with?	
How often are Professional Development (PD) sessions provided at the school?	
Who decides the content/topic of the Professional Development sessions?	
What health services are provided or do you have access to at the school?	

Appendix M. Pre-Interview Individual Questionnaire

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Individual Pre-Interview Questionnaire
Participant Number:
Age:
Gender:
Ethnicity:
Position held in the School:
Total length of time in role/profession:
What is your knowledge of health services offered at the school?
Do you regularly attend the school SENCO meetings? If not, why?
Do you regularly attend the Professional Development sessions offered at the school? If not, why?

Appendix N. Reframed Interview Questions

Semi-Structured Interview Guide: School Staff *(Revised & Reframed Questions following C1 interviews)*

Introductions:

- Thank the participant for agreeing to take part in the study and ask if they have any questions or aspects of the study that they want clarified?
- Give consent form and ask participant to sign – ensure you give a copy back to them. Check best contact details and enter recording number a,b,c,d or e?
- Enter time and date of interview on reverse of consent form alongside recording file number
- Give pre-interview questionnaire to complete
- Take the time to introduce the interview, its purpose and confirm that the participant is happy for the interview to be audio-taped. Remind the participant that they can stop the interview at any time and/or delete any information that they do not wish to be used as data. Inform participant that they will be able to check their transcripts

Guiding Interview Questions:

- What do you view as 'health services' in schools? / What do you understand by the term 'health services' in schools?
- In your current role what is your experience of working with health services?
- Tell me about health services that operate in your school: *what types of things might you refer to them?*
- What do you think about health services operating in schools: *or being available in schools?*
- What do you see as some of the things that *might* influence the delivery and uptake of health services in schools?
- How much PD have you had relating specifically to health issues that may interfere with learning?
- In your professional career what experiences have you had where the health of a student *was* impacting on their learning? *Can you provide a specific example(s) and what did you do?*
- If health services **were not** available in the school how would that impact you? / *If health services **were** more available in the school how would that impact you?*
- *How has it been without an acting SENCO position at the school this term? (added for C3)*
- *What would you describe as the key functions of your role? (as a primary school teacher? /other)*
- *In your view where does the role teachers play in supporting the health needs of their students, begin and end?*
- *In your view where does **your** role (as the Principal/ Receptionist at the school) in supporting the health needs of the students begin and end?*

Appendix O. Observation Data Collection Sheet

SENCO Meeting Observation Data Collection Sheet	
School:	
Date:	**Observation**
Meeting Set Up/Context	
Who is at the meeting and what are their roles?	
What services are represented?	
How many professional attendees and how many lay people e.g Teacher Aide?	
Where is the meeting held?	
What time of day is the meeting held?	
How structured is the meeting process – does it follow an agenda/protocol?	
Who presents the cases for discussion?	
How many cases? – Of these, how many new cases and how many existing?	
Meeting	
Who leads?	
Who dominates?	
Who has least involvement?	
Who contributes? Is everyone's opinion sought for every case?	
Is health expressed as influencing learning? If so, *how* is this expressed?	
How and what did health providers contribute to this meeting?	
How and what did Educators contribute to this meeting?	
Were any factors that might impact on delivery of health services discussed?	
In what ways were health related issues that might impact on learning, discussed?	
What did discussion between health providers and educators focus on?	
Decision Making	
What problem solving process was used?	
How did the group come to a decision about a case?	
In the context of accessing health services, how were decisions influenced by resourcing/access issues?	
Was the group aware of what health services were available in the school?	
Conclusion of Meeting	
How long was the meeting?	
Did all attendees stay for the entire duration of the meeting?	
Were there some informal discussions after and what sort of things were these about?	
Was there minutes taken at the meeting?	
If so, are the meeting minutes distributed to all attendees?	

Appendix P. Observation Protocol

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SENCO Meeting Observation Protocol*

Meeting Set Up/Context

- Who is at the meeting and what are their roles?
- What services are represented?
- How many professional attendees and how many lay people e.g Teacher Aide?
- Where is the meeting held?
- What time of day is the meeting held?
- How structured is the meeting process – does it follow an agenda/protocol?
- Who presents the cases for discussion?
- How many cases? – Of these, how many new cases and how many existing?

Meeting

- Who leads?
- Who dominates?
- Who has least involvement?
- Who contributes? Is everyone's opinion sought for every case?
- Is health expressed as influencing learning? If so, *how* is this expressed?
- How and what did health providers contribute to this meeting?
- How and what did Educators contribute to this meeting?
- Were any factors that might impact on delivery of health services discussed?
- In what ways were health related issues that might impact on learning, discussed?
- What did discussion between health providers and educators focus on?

Decision Making

- What problem solving process was used?
- How did the group come to a decision about a case?
- In the context of accessing health services, how were decisions influenced by resourcing/access issues?
- Was the group aware of what health services were available in the school?

Conclusion of Meeting

- How long was the meeting?
- Did all attendees stay for the entire duration of the meeting?
- Were there some informal discussions after and what sort of things were these about?
- Was there minutes taken at the meeting?
- If so, are the meeting minutes distributed to all attendees?

**No individual health related data about specific children will be gathered by the researcher*

Appendix Q. Observation Field Notes

SENCO Meeting Observation Data Collection Sheet		
School: Pūkeko Valley Primary School		**Abbreviation Key**
Date: 5 June	**Observation**	PHN - Public Health Nurse
Meeting Set Up/Context		RTLB - Resource Teacher of Learning and Behaviour
Who is at the meeting and what are their roles?	*Attendance Officer , SENCO , SWIS, RTLB , Public Health Nurse, SLT .*	SENCO - Special Education Needs Co-ordinator
What services are represented?	*DHB - Health, MOE, School Staff*	SLT - Speech Language Therapist
How many professional attendees and how many lay people e.g Teacher Aide?	*5 Professionals, No lay persons*	SWIS - Social Worker in Schools
Where is the meeting held?	*Principals Office, Pilbark Primary School*	DHB - District Health Board
What time of day is the meeting held?	*11am*	MOE - Ministry of Education
How structured is the meeting process – does it follow an agenda/protocol?	*List issued to partcipants of all children currently on SENCO list, went through this one by one*	
Who presents the cases for discussion?	*SENCO*	
How many cases? – Of these, how many new cases and how many existing?	*42 existing - 3 new*	
Meeting		
Who leads?	*SENCO*	
Who dominates?	*SENCO*	
Who has least involvement?	*PHN & SLT*	
Who contributes? Is everyone's opinion sought for every case?	*Everyone contributes at some stage of the meeting but some more than others. SENCO dominates conversation. Meeting serves as more of an update rather than consultative*	
Is health expressed as influencing learning? If so, *how* is this expressed?	*No, only where there was a previously identified health need. 10 out of 42 children on the list had their health discussed at the meeting in any form*	
How and what did health providers contribute to this meeting?	*The PHN and SLT provided updates on individual cases if they were already involved*	
How and what did Educators contribute to this meeting?	*This was an education based meeting with the focus on educational attainment as well as manging behaviours and numbers of special needs children across the classes. However, no classroom teachers were present at this meeting only the SENCO of the school.*	
Were any factors that might impact on delivery of health services discussed?	No	
In what ways were health related issues that might impact on learning, discussed?	*Generally when there was a known health condition and where the PHN or SLT were already involved, they would be asked to provide an update*	
What did discussion between health providers and educators focus on?	*Updating each other*	
Decision Making		
What problem solving process was used?	*None, this meeting was run more like an update. There was just one child where all the meeting participants chipped in ideas going forward on how best to to support the child*	
How did the group come to a decision about a case?	*No collaborative decision making - the SENCO was the lead decision maker*	
In the context of accessing health services, how were decisions influenced by resourcing/access issues?	*The time and effort it took to make referrals to some services was frequently a barrier to access. The PHN offered help with transporting to clinic appointments for one child who had not attended previous appointments; another she had supplied antibiotic treatment and had been able to visit the family home to do this.*	
Was the group aware of what health services were available in the school?	*Yes*	
Conclusion of Meeting		
How long was the meeting?	*1 hour 15mins*	
Did all attendees stay for the entire duration of the meeting?	*Attendance Officer left after 50 mins*	
Were there some informal discussions after and what sort of things were these about?	*Informal discussions had about scholarship placements for students at certain schools. Researcher had discussion with SENCO who disclosed her tiredness*	
Was there minutes taken at the meeting?	*No, not that I was aware of. Everyone worked off their printed lists and people seemed to write their own notes on these.*	
If so, are the meeting minutes distributed to all attendees?	*N/A*	
Additional Observations:		
I observed that the SENCO appeared to prefer to keep the number of agencies involved in a case to a minimum but listening to the context and background of the cases, I was not always sure that they were the right people.		
At one stage the SENCO discussed dividing the complex children across the classrooms so that one teacher was not having to manage too many at a time. This was challenged by the SLT who didn't think it was a good thing for some of the children to be moved. The SENCO was quite assertive and dominant about this. I also noted that the resources available were not always being utilised.		
Classroom teachers were not involved in the SENCO meeting. If they have concerns about a child in their class, they refer this to the SENCO who then follows up and actions any referrals.		
I interpreted this as 'filtering' and was surprised that the teachers did not do direct referrals to the assigned public health nurse of the school: Refer reflections		

Case 1: Pūkeko Valley Primary School SENCO Observation Notes

Comments noted about particular cases:

Individual	Areas of Need listed on SENCO sheet	Comment	By Whom	Health currently involved/Health and wellbeing discussed at mtg?
1	New entrant: Language & behaviour issues – hitting, throwing things	*"Quite full on"; "high energy kid"; "Likes attention"; "Mum does spoil him";* *"Mum puts him on the iPad all the time"* *Who's talking to him at home?"*	SENCO SLT	No – behaviour management was discussed Comment not taken any further by meeting participants
2	Health/absenteeism	*"A family of non-attendees"* *"Not ever going to change is it?"*	Attendance Officer SENCO	Yes, but no utilisation of health resource at the meeting. Not known to PHN
3	Suicidal tendencies when angry	*"He's just the same – no change";* *"He will be intensive when he goes to secondary school"*	RTLB SENCO	No – issue seen as behavioural; no linkage made with health
4	Global Delay & Speech	*"He's fine, he's bouncing along"*	Education	No, SLT did not offer input into conversation. Not known to PHN
5	Often appears to zone out	*"Do we think he may have autism?" (noted to be rocking in class)* *"He needs some exercises to help his posture"*	PHN PHN	Comments only- no ensuing discussion, comments not picked up on by other meeting participants. No referral made to health
Observation Summary Points				
I captured these comments as I was concerned about what I perceived as missed opportunities for health to offer input and support. I felt there was at times a lack of context or understanding of the 'bigger picture.				

Appendix R. Researcher Reflections

Researcher Personal Notes and Reflections from Interagency Meeting Tarāpuka Beach School

This turned out to be an interagency meeting: RTLB, SENCO coordinator, SWIS, DP, and Psychologist present. The meeting was held in a classroom, we sat around a table. I wasn't introduced to anybody at first so I had to figure out everyone's roles as we went along. I had arrived at the very start of the meeting. In retrospect I should have come a bit earlier, they were signing my consent forms when we really should have been getting going with the meeting – no-one seemed to mind though, I was just conscious of this. I introduced myself and the study and asked them all if they were happy for me to be there and take notes; they were all absolutely fine with that.

It was a really collegial, friendly meeting from the outset – everyone knew each other and the atmosphere was such that they appeared happy to get together to talk about the children they had concerns with– it didn't appear as if it was a chore…

The premise of this meeting is to discuss children who are on their caseload that they are each working with, and to discuss progress and the role that each of the agencies were playing with those children. All of the children discussed were experiencing issues around behaviour and a couple of children had definite diagnoses of ADHD, ADD, ASD etc...

Everyone at the meeting appeared to have the children's interest at heart and the conversation focused on student's progress with their learning, behaviour, and social interactions with their peers. There was a lot of reference made to funding affecting what they were able to provide; for example, with one child they had happened to have some extra funding floating around/unallocated so they had put it towards helping this child (who wasn't eligible for his own specific funding) and as a result with the support they had been able to put in place, he had made phenomenal progress. However, they knew that they wouldn't have that same money next term because it was a 'one off', so they were worrying if that was going to limit the progress from now on for that boy as they couldn't direct the same resource to him next term. They were saddened as he had done so well but he didn't meet the criteria for his own specific funding.

It was tabled that for a lot of these children with behavioural conditions working in the new Modern Learning Environment just wasn't working for them for various reasons, whether it was concentration, or interacting with others, being easily distracted, that sort of thing….

It was a very collaborative meeting; the participants all gave each other a fair amount of time to feedback on their individual work with the children. There was no-one who dominated the meeting but it was led by the SENCO co-coordinator of the school in the sense that she facilitated the meeting; closing topics of conversation then opening another. There was no formal list to work from. A couple of the participants had their laptops up in front of them and the SENCO was referring to something on a piece of paper but no formal list was circulated, they just seemed to be going through the children on an eList. Because of this I wasn't privy to the names or numbers of children each member was working with, or if there was more than one professional support in place for a student. They meeting participants prioritised the students they chose to discuss. I was informed afterwards that they have 40 on the SENCO list out of 239 students at the school. For almost 2 hours the participants fed back at length the children that they were struggling with. They definitely considered the child in the context of their family; they talked a lot about family impacts on behaviour and trying to work with that as well and what have you. I felt that they had a really good understanding of how changes in family situations can affect children with or without a behavioural diagnosis on top of that.

The principal came in towards the end and it was obvious that he had a very good working relationship with all of those present; the mood was really light and easy. We had a really good discussion at the end of the meeting around the role plays in schools and I asked what the participants felt about the Modern Learning Environment for the children we had discussed and they were really willing to share their thoughts, they were really open. In the main they found the new environments challenging both for the teacher and the student with special needs.

The school has an interagency meeting once a fortnight and they have an additional meeting that they call a 'new referral' meeting twice a term. At this meeting, new referrals are put up and the team discusses them; this includes the team that were there today, plus a few others.

They collectively discuss the best strategy going forward for a particular child, e.g., should there be a referral to psychologist or SWIS etc.

It would be interesting to see how many health referrals are made at this meeting. Today's meeting seemed more about existing referrals and who was doing what. Although it was really interesting, if it was possible to go to the other one as well, it might provide more insight. I will see if this is possible.

Overall, the meeting today did throw some light on the relationship between the school and health services but it felt more like a professionals 'check in' than a strategising and planning meeting but perhaps it was not intended to be this. I was surprised that there was no representation from the health sector.

Researcher Reflections of SENCO Meeting at Pūkeko Valley Primary School

There was a diverse group of people who had been invited to the meeting; they all readily welcomed me, being there in my researcher role. I assumed my non-participatory position in the corner of the room and conversations appeared to flow freely despite my presence. The meeting was run very efficiently; at the beginning we were all given handouts listing the students to be discussed. The services that the students were currently under were colour-coded and highlighted on the sheet.

The meeting was led and controlled by the SENCO, including deciding what would happen next for a child in regards to educational support or otherwise. This was a very structured, business-like meeting which kept to time. We moved from student to student very quickly – I felt almost too quickly; as soon as the conversation became too in-depth, the meeting was moved swiftly on to the next student on the list. I didn't know if this was reflective of the workload of the SENCO, or the time constraints of the meeting? Perhaps it was a bit of both. I also had a sense that issues or concerns were 'filtered' in relation to 'quick fix" versus 'no quick fix' without much in-between. I noted that the SENCO bought no questions for the other meeting participants. The meeting was collective but not consultative.

Throughout the meeting occasional suggestions were put forward by other meeting participants, but the SENCO often overrode these; deeming a family too complex to make a referral such as the one being suggested, or that too many people were already involved: "we've been down that track once before and it didn't work" (SENCO). The SENCO was very much in control.

In some cases, it seemed as if there was a mindset of "why would we try again?" when referrals had not been successful the first time round (usually due to waiting lists, referral criteria and suchlike). What concerned me with this perspective was that children and their families could potentially be denied a second chance. In addition, there was emphasis from the SENCO about the 'effort' put into making referrals to external services, particularly Health. Likewise, if the effort was made, how likely were the family to engage? I had the impression that the SENCO would often 'weigh up' whether making a referral to an external service was worth the effort (based on the likelihood of referral acceptance and/or family engagement) before taking any action.

The meeting was very much orientated toward education with Health merely a guest in the room. In the majority of cases, where there were known health concerns (listed on the SENCO sheet), these were rarely discussed in the meeting; the focus being solely on educational progression. I also noted the speed at which we got through the meeting given the number of cases o the list. The meeting served more as a check in/update rather than an opportunity for review. Health concerns or issues were only raised if the case was known to the visiting nurse or speech language therapist; they were afforded a brief opportunity to feedback to the other meeting members and provide a very basic update.

I was surprised to observe that a child with newly diagnosed autism and under the care of a Paediatrician, was not known to the visiting school nurse. The child had on-going co-existing health needs.

Sometimes during the meeting, the nurse would interject to suggest that she could 'look into' a case that was not already open to her to check if there were any health needs of concern – this was often done when a mention was made relating to ear or skin issues. I noted that the nurse was not ever invited to give an opinion, so it did rely on her being pro-active in coming forward to offer help and support. I observed that there was a number of opportunities for Health to be involved or consulted with, but these were not acted on.

There were students who had been on the SENCO list for some time but had made little educational progression, despite learning supports being put in place. I wondered whether there was any opportunity to conduct a case review/evaluation, or something similar, with meeting members being able to put forward their own thoughts and ideas in an effort to problem solve collectively? I felt that there could have been better integration and utilisation of those present at the meeting, it seemed a missed opportunity to draw in everyone's expertise and different professional perspectives.

The health needs of students on the SENCO list were noted, but only if the child had an existing concern, and even then, these concerns were not spoken about at the meeting or even alluded to in conversations. If there were new children on the list, or issues around absenteeism or behaviour, their health was not automatically addressed. There were no questions from any of the meeting participants like: "is there a health issue?" or "how is the general health and wellbeing of this child", I found this interesting and a little surprising. Perhaps I shouldn't have been surprised, this was after all, a meeting held in a school for education purposes, but for a school that has an assigned and visible nurse I thought there

may have been more integration. The opportunity was there with representatives from the health sector present at the meeting, yet I felt they were not utilised to the extent that they could have been. However, it was evident that the student and their family did appear to be at the heart of the SENCOs decision making and intentions were good. It was clear that access to services and supports such as Health are not always easy and this affected the decision-making process around actioning referrals.

Appendix S. Example NVivo Codebook

NVivo Codebook: The relationship between health services and primary schools

Nodes\\Pūkeko Valley Primary School

Themes & Sub-Themes (Nodes and Child Nodes)	Description	Issue Statement
Schools as Venues for Health Services		3,4
Availability and Accessibility	*There are perceived benefits to available and accessible school-based health services for parents and teachers*	4
• Visibility	*Health services need to be physically visible in schools*	
Barriers		
• Referral Systems	*Referral pathways for schools vary and can potentially create a barrier for teachers wanting access to health services or support for their students*	4
Collaboration	*Perceived power of working together - wanting to work collaboratively*	2,5
Health is Separate	*Seen as a separate entity - not as part of school community, very contradictory views in parts*	
Health needs vary across deciles	*Sound awareness of different types of health issues for children living in different socioeconomic communities*	
Knowing the school community	*Importance of health services coming in, to take time to know and understand the school community to avoid tensions*	5
Respecting Cultural Differences	*Acknowledging different cultural perspectives and how this might influence engagement is important*	

Page 1 of 6

Themes & Sub-Themes (Nodes and Child Nodes)	Description	Issue Statement
Space for the Health Services	*Provision and availability of space out of which health services can function in the school is an issue*	4
What are schools for?	*Some debate and tension about school's role: Educating? or everything else as well?*	
Who does What	*Sometimes confusing as to who is responsible for what - some health services available through MoE some through MoH - can be confusing for teacher to know who does what*	
Value Added		2,5
With Health Service Support in Schools		
○ Early Intervention	*Having access to health services at schools allows for early intervention for health concerns*	
○ Support for teaching staff	*Having nurses around for teachers to refer to and get timely advice/resources is really helpful*	
○ Decrease in Absenteeism	*School would have more student absentees if no health service available*	
Impact of Poor Health on Students	**Impact in relation to learning, school attendance, socialisation and self esteem**	1
On Learning	*decreased engagement, lack of progress*	
On socialisation and self esteem	*Ostracising - effect on individual and peers where there is a health issue*	
School Attendance	*Increase in absenteeism*	
Teachers Perception of their Roles and Responsibilities	**Roles and responsibilities in relation to supporting the health needs of their students**	2,3,4,5
Getting the Resources		

Page 2 of 6

Themes & Sub-Themes (Nodes and Child Nodes)	Description	Issue Statement
• Completing Referrals	*Challenge of completing referrals - paperwork, time etc.*	
⊙ Health Promotion		
⊙ It's my role	*Teachers feel that it is their role to flag health concerns and to do something about it*	
• My role is more than just teaching	*Teachers described how their roles often go beyond teaching – health and wellbeing of their students, social needs.*	
⊙ It's not my role	*Teachers don't think it is their role but often have to attend to the health issues of their students*	
⊙ No Time	*Time is precious - no time to attend to health and social needs or to make referrals*	
⊙ Not my priority	*Teaching is my priority*	
⊙ Professional Boundaries	*Parents don't always want teachers delving into health issues of their child*	
⊙ Professional Development	*Professional development opportunities for school staff relating to health conditions varies so knowledge varies – not everyone offered PD*	3
⊙ School Culture affects perceptions of roles and responsibility	*School Culture affects perceptions of role and responsibility in relation to health needs of students. Participants perceived that If the school has a positive view on engaging with health services and seeking resources to support their students then it would happen.*	3
⊙ SENCO Role	*roles and responsibilities of SENCO role in health*	
O What can the teacher know?	***Teachers want to know what they are allowed to know. Also want to be kept in the loop but don't want to have to do anything if they don't have to***	2,5
⊙ Feedback	*No consistent feedback to the staff member making the referral*	

Themes & Sub-Themes (Nodes and Child Nodes)	Description	Issue Statement
⊙ Need to know but not to do	*Feedback - want to know what is going on but don't want to have to be involved in doing anything.*	
⊙ Privacy and Information Sharing	*What am I allowed to know as a classroom teacher?*	
O Nurses Attributes		
⊙ Personality	*Participants wanting kind, caring, approachable, friendly health staff*	5
O Nurses way of working	***The way the nurse works in the school influences how school staff can and will engage with her. Frequent turnover of health staff also affects engagement***	5
⊙ Change of health worker impacts relationship	*Frequent changing of nurse affects engagement by staff and can impact referral rate*	5
⊙ Child Centred v Task Orientated	*Teachers want the nurse to focus on the child not the task, to more be child friendly*	
⊙ Collaboration is key	*An understanding exists that collaboration between health and education is important if student health needs are to be met*	5
⊙ Relationship Building	*Importance of building relationships with families, children and teachers. Building relationships takes time*	5
⊙ Role clarity and confusion	*Nurse often confused with CHW - role clarity important. Not always sure what the nurse can and cannot do.*	
○ What does/can the Nurse do	*Role clarity*	
⊙ The Nurse is the Expert	*View the nurse as the expert in all thing's health related and themselves as the experts in all thing's education - almost like never the twain shall meet!*	
⊙ Valued member of the school community	*The school staff value their assigned nurse*	

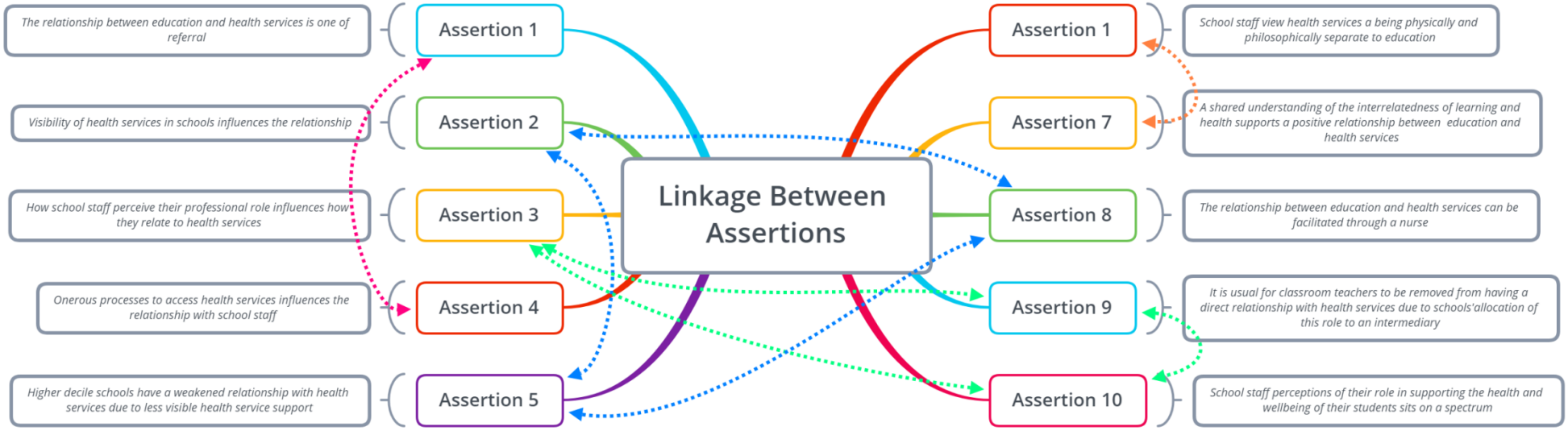
Themes & Sub-Themes (Nodes and Child Nodes)	Description	Issue Statement
⊙ Visibility	*Being visible influences the relationship*	4
⊙ Working WITH the Teachers	○ *The nurse working with the teachers, fitting in with them whilst they are teaching, respectful, considerate etc. was considered important*	5
○ **Access**		
⊙ Accessibility and Availability	*The perceived value of health services being available at school*	4
⊙ Decile ranking as a barrier to access	*Some schools don't have access to health services due to decile ranking*	4
⊙ Effect of Poverty on accessing health services	*Teachers had witnessed the effect of poverty on access to health care.*	4
○ **Empowering or Disempowering Parents**		
⊙ Parental Choice		
• Embarrassment and Shame	*Feelings of shame or embarrassment may influence relationship with health services*	
• Parental Anxiety	*Influences how parents and caregivers respond to health needs of their children*	
• Priorities	*Competing priorities for families often affect choice - influences engagement*	
⊙ Parental Experiences	*Previous school experience may influence how parents feel about accessing health services in the school environment*	
⊙ Parental Responsibility	*Parents are responsible for attending to the health needs of their children*	
○ **Defining Health**	***Cultural Perspective, Personal and professional experience***	
⊙ What is viewed as health by teachers	*How teachers encompassed health/described it has the potential to influence what they*	2

Themes & Sub-Themes (Nodes and Child Nodes)	Description	Issue Statement
	would or would not refer	

Issue Statements

1. Good health is necessary for effective learning
2. Individual experiences shape school staff's perceptions of health services both professionally and personally
3. Organisational and individual culture will shape school staff's perception of health
4. Accessibility of health services will shape relationships between health services and education personnel
5. The opportunities for collaboration between the health service provider and school staff influences the quality of the relationship

Appendix T. Mind Map Linkage Between Assertions



Appendix U. Cross-Case Analysis Process Worksheets

Worksheet 2: The Research Questions of the Multicase Study

These questions indicate primary information about the Quintain (phenomenon) that the Researcher is seeking (Stake, 2006)

Question 1: *Overarching research question*	*What is the relationship between primary schools and health services in New Zealand and how is this influenced?*
Question 2	*How is this relationship influenced from the school staff perspective?*
Question 3	*What are the perceived barriers to health and education working together in New Zealand primary schools?*
Question 4	*What are the enablers to health and education working together in New Zealand primary schools?*
Question 5	*How are health services accessed by school staff and what influences this?*
Question 6	*What are school staff perceptions of their role in the health and wellbeing of students?*

Worksheet 3: Analysts Notes on Case Report

Case ID: PŪKEKO VALLEY PRIMARY SCHOOL

Synopsis:

Decile 1
Designated SENCO
Long hx of working with health services.
Roll = 205
Full primary Years 1-8

Situational Constraints:

- SENCO meetings held only once a term.

Uniqueness of Case:

- 2 Maori school staff participants.
- Cross section of male & female participants
- Designated Community nurse + CHW
- Predominantly Maori & Pacifika 20% European.

Prominence:

Question 1 High++
Question 2 Medium
Question 3 Medium / low
Question 4 Medium +
Question 5 High
Question 6 Medium

Utility:

Question 1 High
Question 2 High
Question 3 Medium
Question 4 High
Question 5 High
Question 6 High++ (first recognised as a theme in this case)

Case Findings:

- Health is accessible, visible but separate
- The designated school nurse is the relationship
- Nurses attributes & ways of working influence both staff & child/whanau engagement.
- Relationship classroom teachers have & school nurse & health is filtered and mediated
- Teachers perception of role.
- Cultural considerations around child & family engagement with health services in schools.
- Decile ranking influences H.S. delivery

Possible Excerpts for Multicase Report

1. Cultural perspectives: Maori participants.
2. Filtering & Mediating access to H.S support - P3 / Page 13.
3. PLD: Greg & Kirsty
4. Teachers perceptions of role: Karen++ / Greg / Rob++
5. Separateness: Rob, Karen Greg.
6. Nurses ways of working / Collaboration page 9 & 10 of report.
7. Decile ranking.

Commentary:

- Useful for discussing issues around filtering & mediating referrals by school staff – potential to influence relationship teachers have ± health services
- Teachers perceptions of their role in supporting the health & wellbeing of their students. first alluded to here.
- Insight into importance of considering cultural perceptions around accessing school health services in the school setting.
- Useful insight into how nurses attributes and ways of working influence the relationship – this case would provide the best insight as they are the only one with a designated nurse.
- Despite having health service support readily available, still considered separate (philosophical silo).

Worksheet 3: Analysts Notes on Case Report

Case ID: TARĀPUKA BEACH SCHOOL

Synopsis:

Decile 4
Designated SENCO
Roll = 340
Years 1-6
Past hx of working with school nurse

Situational Constraints:

- Unable to observe SENCO mtg.
- Unable to interview SENCO
- Observed Interagency mtg
- No formal PLD record.

Uniqueness of Case:

- Equal ethnic mix: European, Samoan, Maori, Indian, Tongan
- Satellite special school
- Modern Learning Environ.
- Pacifica participant.
- New to practice participant

Prominence:

Question 1	Medium
Question 2	High
Question 3	High
Question 4	Medium+ (Interagency PLD)
Question 5	Medium
Question 6	High++

Utility:

Question 1	Medium
Question 2	High
Question 3	Medium
Question 4	High
Question 5	Medium
Question 6	High++

Case Findings:

- Health services not visible
- Health services not readily accessible
- Teachers perception of their roles vary
- Cultural considerations
- ↓ PLD relating to health
- Ways of managing: how school compensates for not having a visible & accessible health support
- Decile ranking has affected visibility of H.S.
- Undergraduate teacher training includes little health topics.

Possible Excerpts for Multicase Report

1. Kare: p7&8 ? PLD. Fran
2. H.S visibility - Cassie p9&10 Jen, Neil, Fran
3. Filtering: 'managing without' p10 & 11 case report
4. Teachers perception of role: p15&16 case report
5. Neil: p17, 'managing without': home visiting, funding..

Commentary:

School staff wanting to be able to work ± health but services not visible nor easy to access. School has worked out ways to mitigate this.

Lack of PLD & knowledge of what health resources are available influences the relationship between school staff and health services.

Filtering: (pragmatic purposes and part of managing without) affects relationship teachers have with health providers.

SENCo unwell, unable to attend a SENCo mtg

Nillingdon only case to have both a SENCo mtg and Interagency mtg.

Worksheet 3: Analysts Notes on Case Report

Case ID: RANGURU COVE PRIMARY SCHOOL

Synopsis:

- Decile 10
- Designated SENCO but role vacant at time of study
  ROLL - 600
  Years 1-6

Situational Constraints:

- All participants female
- Unable to observe SENCO meeting – none happening. due to vacancy.

Uniqueness of Case:

Maori Immersian Unit
21% students Maori
(not all in immersian unit)
Large primary school.

Case Findings:

- Health services not visible to staff & students
- Do not know what services they are entitled to
- Creative & pragmatic ways of managing without
- Culture of school, (Ethos & Ethnicity) influences engagement
- Teachers / staff perception of their role influences action / referral / involvement & their students health & wellbeing
- Parental Pressure influences action.
- Percieve themselves as having 'different' needs.
-

Prominence:

Question 1	High
Question 2	Medium
Question 3	High++
Question 4	Medium
Question 5	Medium
Question 6	Medium+.

Utility:

Question 1	High
Question 2	High
Question 3	High
Question 4	High
Question 5	High
Question 6	Medium

Possible Excerpts for Multicase Report

1. Ex- SENCO role insights p 4-6 Case Report
2. PLD p 7-8 CR.
3. Visibility: Tanya & Suzie p 9-10
4. Barriers p. 10.
5. Perception of roles: Kendra, Kate, Suzie & Jodie. p. 12 & 13.
6. Managing Without++ — Kendra's role & SENCO. 'Passing on' to designated others. p. 13-16.

Commentary:

Decile 10 school with no relationship with visiting health services → perception is that this is not available to them

Useful data on how the school manages without a visiting health service — use of designated staff to support certain health & wellbeing issues.

Maori Immersion unit — cultural perspective important to consider: Ethnicity as well as ethos.

Designated roles: Separation of physical & behavioural concerns: different pathways.

Worksheet 4: Ratings of Expected Utility of Each Case for Each Research Question

Utility of Cases	Case A: Pūkeko Valley Primary School	Case B: Tarāpuka Beach School	Case C: Ranguru Cove Primary School
Original Research Questions			
Question 1 *What is the relationship between health services and education in the context of state funded New Zealand primary schools?*	H	M	H
Question 2 *How is this relationship influenced from an education perspective?*	H	H	H
Added Multicase Questions			
Question 3 *What are the barriers to health and education working together in New Zealand primary schools?*	M	M	H
Question 4 *What are the facilitators to health and education working together in New Zealand primary schools?*	H	H	H
Question 5 *How are health services accessed by school staff and what influences this?*	H	M	H
Question 6 *School staff perception of their role in the health and wellbeing of students*	H	H	M

H=High Utility; M=Medium Utility; L=Low Utility

Worksheet 5B: Matrix for Generating Theme-Based Assertions from Merged Findings Rated Important

Rank	Merged Findings	Cases	Importance to the Research Questions					
			1	2	3	4	5	6
1.	**Barriers exist to schools accessing Health Services** ▪ *Invisibility of health support* ▪ *Time taken to complete referrals* ▪ *Filtered and mediated referral systems* ▪ *School nurse attributes and ways of working* ▪ *Decile ranking* ▪ *Staff Knowledge & inclusion*	 1,2,3 1,2,3 1,2,3 1,2,3 1,2,3 1,2,3	H (C1 ATYP)	H	H	H	H (C1 ATYP)	H
2.	**Teachers perceptions of their professional role influences how they respond to the health and wellbeing of students** ▪ *Is it or isn't it the teacher's role to follow up on health concerns for their students?* ▪ *Demands on teacher's time'* ▪ *Role descriptors*	 1,2,3 1,2,3 1,2,3	H	H	M	M	H	H
3.	**School staff view health as external to education** ▪ *Health and education are siloed from each other both practically and philosophically*	 1,2,3	H	H	H	M	L	L
4.	**Nurses attributes and ways of working influence the relationship between education and health services** • *Personal attributes of the nurse affect engagement* • *Different ways of working can support or inhibit the relationship*	 1,2,3 1,2,3	M	H (C1 ATYP)	H	H	H (C1 ATYP)	L

Worksheet 5B cont.

Rank	Merged Findings	Cases	Importance to the Research Questions					
			1	2	3	4	5	6
5.	**The culture of both the school and the children and families within it, influences how and when health services are accessed.** ▪ *Ethos of the school in relation to accessing health services* ▪ *Cultural appropriateness of health services in schools* ▪ *Managing without: Ways of working to address need in the absence of health services* ▪ *Who is responsible?*	1,2,3 1,2,3 (2,3) 3 1,2,3	H	H	H	M	M	L
6.	**How schools perceive themselves as a venue for delivering health services, influences the relationship.** ▪ *Perception of value added* ▪ *Available space*	1,2,3 1,2,3	H	H	H	H	H (C1 ATYP)	H
7.	**School staff understanding of the impact of poor health on learning influences how and when health service support is utilised.** ▪ *Professional Learning and Development opportunities* ▪ *Undergraduate teacher training*	1,3 2	H	H	L	L	L	M

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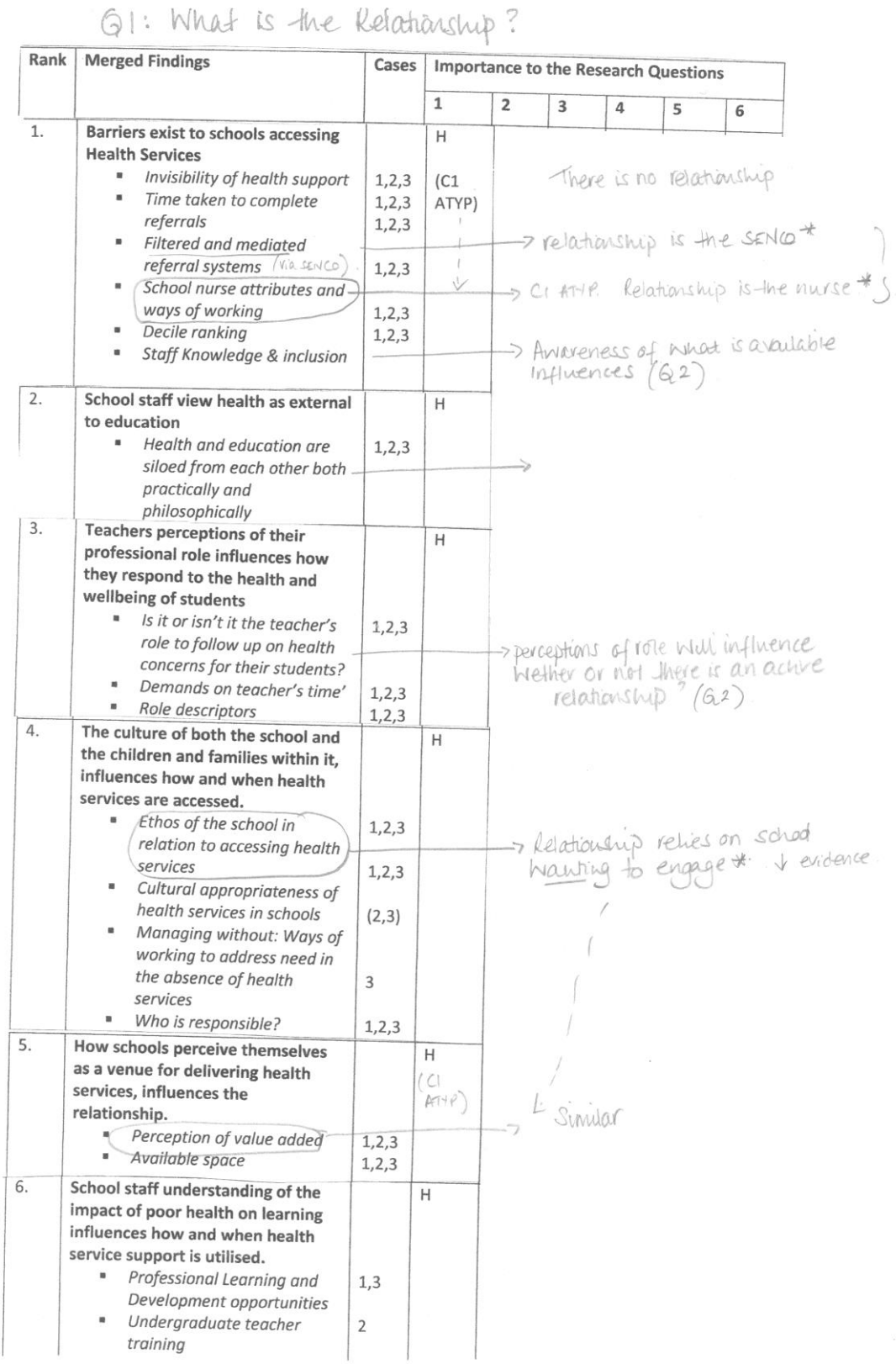
Appendix V. Developing the Cross-Case Assertions



Q1: What is the Relationship?

Rank	Merged Findings	Cases	Importance to the Research Questions					
			1	2	3	4	5	6
1.	**Barriers exist to schools accessing Health Services** ▪ *Invisibility of health support* ▪ *Time taken to complete referrals* ▪ *Filtered and mediated referral systems* (via SENCO) ▪ *School nurse attributes and ways of working* ▪ *Decile ranking* ▪ *Staff Knowledge & inclusion*	1,2,3 1,2,3 1,2,3 1,2,3 1,2,3 1,2,3	H (C1 ATYP)					
2.	**School staff view health as external to education** ▪ *Health and education are siloed from each other both practically and philosophically*	1,2,3	H					
3.	**Teachers perceptions of their professional role influences how they respond to the health and wellbeing of students** ▪ *Is it or isn't it the teacher's role to follow up on health concerns for their students?* ▪ *Demands on teacher's time'* ▪ *Role descriptors*	1,2,3 1,2,3 1,2,3	H					
4.	**The culture of both the school and the children and families within it, influences how and when health services are accessed.** ▪ *Ethos of the school in relation to accessing health services* ▪ *Cultural appropriateness of health services in schools* ▪ *Managing without: Ways of working to address need in the absence of health services* ▪ *Who is responsible?*	1,2,3 1,2,3 (2,3) 3 1,2,3	H					
5.	**How schools perceive themselves as a venue for delivering health services, influences the relationship.** ▪ *Perception of value added* ▪ *Available space*	1,2,3 1,2,3	H (C1 ATYP)					
6.	**School staff understanding of the impact of poor health on learning influences how and when health service support is utilised.** ▪ *Professional Learning and Development opportunities* ▪ *Undergraduate teacher training*	1,3 2	H					

Q2: How is this relationship influenced?

Rank	Merged Findings	Cases	Importance to the Research Questions	
				2
1.	**Barriers exist to schools accessing Health Services**			H
	▪ *Invisibility of health support*	1,2,3		
	▪ *Time taken to complete referrals*	1,2,3		
	▪ *Filtered and mediated referral systems*	1,2,3		
	▪ *School nurse attributes and ways of working*	1,2,3		
	▪ *Decile ranking*	1,2,3		
	▪ *Staff Knowledge & inclusion*			
2.	**School staff view health as external to education**			H
	▪ *Health and education are siloed from each other both practically and philosophically*	1,2,3		
3.	**Teachers perceptions of their professional role influences how they respond to the health and wellbeing of students**			H
	▪ *Is it or isn't it the teacher's role to follow up on health concerns for their students?*	1,2,3		
	▪ *Demands on teacher's time*	1,2,3		
	▪ *Role descriptors*	1,2,3		
4.	**The culture of both the school and the children and families within it, influences how and when health services are accessed.**			H
	▪ *Ethos of the school in relation to accessing health services*	1,2,3		
	▪ *Cultural appropriateness of health services in schools*	1,2,3		
	▪ *Managing without: Ways of working to address need in the absence of health services*	(2,3)		
	▪ *Who is responsible?*	3		
		1,2,3		
5.	**How schools perceive themselves as a venue for delivering health services, influences the relationship.**			H
	▪ *Perception of value added*	1,2,3		
	▪ *Available space*	1,2,3		
6.	**School staff understanding of the impact of poor health on learning influences how and when health service support is utilised.**			H
	▪ *Professional Learning and Development opportunities*	1,3		
	▪ *Undergraduate teacher training*	2		

* Visibility influences relationship the more visible the more integration (PB school?? not necessarily philosophically).
→ filtering affects teachers relationship & health, not necessarily the schools.
→ Knowledge of available services will influence relationship* (see merged finding 6 too)
* influences degree to which teacher will flap –
→ Is it my role
→ time taken to access influences relationship (see merged finding 1 too)
→ Culture of managing without – what is the added value?
→ Is space available? If not will influence how H & E work together.
→ If don't understand the interrelatedness, less likely to refer.

Q3: What are the barriers to health & Ed. working tog.?

Rank	Merged Findings	Cases	Importance to the Research Questions		
			:	:	3
1.	**Barriers exist to schools accessing Health Services**				H
	▪ *Invisibility of health support*	1,2,3			
	▪ *Time taken to complete referrals*	1,2,3			
	▪ *Filtered and mediated referral systems*	1,2,3			
	▪ *School nurse attributes and ways of working*	1,2,3			
	▪ *Decile ranking*	1,2,3			
	▪ *Staff Knowledge & inclusion*				
2.	**School staff view health as external to education**				H
	▪ *Health and education are siloed from each other both practically and philosophically*	1,2,3			
4.	**The culture of both the school and the children and families within it, influences how and when health services are accessed.**				H
	▪ *Ethos of the school in relation to accessing health services*	1,2,3			
	▪ *Cultural appropriateness of health services in schools*	1,2,3			
	▪ *Managing without: Ways of working to address need in the absence of health services*	(2,3)			
	▪ *Who is responsible?*	3			
		1,2,3			
5.	**How schools perceive themselves as a venue for delivering health services, influences the relationship.**				H
	▪ *Perception of value added*	1,2,3			
	▪ *Available space*	1,2,3			
3.	**Teachers perceptions of their professional role influences how they respond to the health and wellbeing of students**				M
	▪ *Is it or isn't it the teacher's role to follow up on health concerns for their students?*	1,2,3			
	▪ *Demands on teacher's time'*	1,2,3			
	▪ *Role descriptors*	1,2,3			
6.	**School staff understanding of the impact of poor health on learning influences how and when health service support is utilised.**				L
	▪ *Professional Learning and Development opportunities*	1,3			
	▪ *Undergraduate teacher training*	2			

Similar to Q2

Visibility, time ↓ (influencers not a barrier) Q2

Decile ranking *

School staff viewed as a separate entity both physically & philosophically no requirement to work tog. *

Space? (influencer ? barrier)

Q2 Teachers percep (influences but not a barrier)

Q4: What helps facilitate health & Education working together?

Rank	Merged Findings	Cases	Importance to the Research Questions				
							4
1.	**Barriers exist to schools accessing Health Services** ▪ *Invisibility of health support* ▪ *Time taken to complete referrals* ▪ *Filtered and mediated referral systems* ▪ *School nurse attributes and ways of working* ▪ *Decile ranking* ▪ *Staff Knowledge & inclusion*	 1,2,3 1,2,3 1,2,3 1,2,3 1,2,3 1,2,3					H
5.	**How schools perceive themselves as a venue for delivering health services, influences the relationship.** ▪ *Perception of value added* ▪ *Available space*	 1,2,3 1,2,3					H
2.	**School staff view health as external to education** ▪ *Health and education are siloed from each other both practically and philosophically*	 1,2,3					M
3.	**Teachers perceptions of their professional role influences how they respond to the health and wellbeing of students** ▪ *Is it or isn't it the teacher's role to follow up on health concerns for their students?* ▪ *Demands on teacher's time'* ▪ *Role descriptors*	 1,2,3 1,2,3 1,2,3					M
4.	**The culture of both the school and the children and families within it, influences how and when health services are accessed.** ▪ *Ethos of the school in relation to accessing health services* ▪ *Cultural appropriateness of health services in schools* ▪ *Managing without: Ways of working to address need in the absence of health services* ▪ *Who is responsible?*	 1,2,3 1,2,3 (2,3) 3 1,2,3					M
6.	**School staff understanding of the impact of poor health on learning influences how and when health service support is utilised.** ▪ *Professional Learning and Development opportunities* ▪ *Undergraduate teacher training*	 1,3 2					L

Q5: How are health services accessed by schools?

Rank	Merged Findings	Cases	Importance to the Research Questions				
							5
1.	**Barriers exist to schools accessing Health Services** ▪ *Invisibility of health support* ▪ *Time taken to complete referrals* ▪ *Filtered and mediated referral systems* ▪ *School nurse attributes and ways of working* ▪ *Decile ranking* ▪ *Staff Knowledge & inclusion*	1,2,3 1,2,3 1,2,3 1,2,3 1,2,3 1,2,3					H (C1 ATYP)
5.	**How schools perceive themselves as a venue for delivering health services, influences the relationship.** ▪ *Perception of value added* ▪ *Available space*	1,2,3 1,2,3					H (C1 ATYP)
3.	**Teachers perceptions of their professional role influences how they respond to the health and wellbeing of students** ▪ *Is it or isn't it the teacher's role to follow up on health concerns for their students?* ▪ *Demands on teacher's time'* ▪ *Role descriptors*	1,2,3 1,2,3 1,2,3					H
4.	**The culture of both the school and the children and families within it, influences how and when health services are accessed.** ▪ *Ethos of the school in relation to accessing health services* ▪ *Cultural appropriateness of health services in schools* ▪ *Managing without: Ways of working to address need in the absence of health services* ▪ *Who is responsible?*	1,2,3 1,2,3 (2,3) 3 1,2,3					M
6.	**School staff understanding of the impact of poor health on learning influences how and when health service support is utilised.** ▪ *Professional Learning and Development opportunities* ▪ *Undergraduate teacher training*	1,3 2					L
2.	**School staff view health as external to education** ▪ *Health and education are siloed from each other both practically and philosophically*	1,2,3					L

Q6: What are School Staff perceptions of their role in the health & wellbeing of their students?

Rank	Merged Findings	Cases	Importance to the Research Questions					
								6
1.	**Barriers exist to schools accessing Health Services**							H
	▪ *Invisibility of health support*	1,2,3						
	▪ *Time taken to complete referrals*	1,2,3						
	▪ *Filtered and mediated referral systems*	1,2,3						
	▪ *School nurse attributes and ways of working*	1,2,3						
	▪ *Decile ranking*	1,2,3						
	▪ *Staff Knowledge & inclusion*							
3.	**Teachers perceptions of their professional role influences how they respond to the health and wellbeing of students**				I			H
	▪ *Is it or isn't it the teacher's role to follow up on health concerns for their students?*	1,2,3						
	▪ *Demands on teacher's time'*	1,2,3						
	▪ *Role descriptors*	1,2,3						
5.	**How schools perceive themselves as a venue for delivering health services, influences the relationship.**							H
	▪ *Perception of value added*	1,2,3						
	▪ *Available space*	1,2,3						
6.	**School staff understanding of the impact of poor health on learning influences how and when health service support is utilised.**							M
	▪ *Professional Learning and Development opportunities*	1,3						
	▪ *Undergraduate teacher training*	2						
2.	**School staff view health as external to education**							L
	▪ *Health and education are siloed from each other both practically and philosophically*	1,2,3						
4.	**The culture of both the school and the children and families within it, influences how and when health services are accessed.**							L
	▪ *Ethos of the school in relation to accessing health services*	1,2,3						
	▪ *Cultural appropriateness of health services in schools*	1,2,3						
	▪ *Managing without: Ways of working to address need in the absence of health services*	(2,3)						
	▪ *Who is responsible?*	3						
		1,2,3						

Influences too ↓ Is it myrole.

There is a tension in how School Staff perceive their role in supporting H+W of L

Do I have time

on a spectra

Don't Know what you don't Know

Separate franhea#

Worksheet 6: Multicase Assertions

Designator	Assertions	Related to which Questions	Evidence from which Cases
CCA1-1	The relationship between health services & education is one of referral (invitation in & referral)	1	1, 2, 3 (C1 Atyp)
CCA2-1	Visibility of health services in schools influences the relationship	2 & 4 & 3.	1, 2, 3 (C1 Atyp)
CCA2-2	How school staff percieve their professional role influences how they relate with health services	2	1, 2, 3
CCA2-3	Time taken to access health services influences the relationship with schools (staff)	2	1, 2, 3
CCA3-1	Higher decile schools (percieve that they) recieve less health service support (? hsq)	3, 4	2, 3.
CCA3-2	School staff view health services as a separate entity both physically & philosophically	3, 6	1, 2, 3
CCA4-1	A shared understanding of the value of working together will enable/sustain relationship between h + ed	4 + 2	1, 2, 3.
CCA5-1	Classroom teachers access health services via an intermediary ?	5, & 1	1, 2, 3
CCA5-2.	Schools access health services by referral (brokering in) by invitation? (see 1)	5, & 1	1, 2, 3.
CCA6-1	School staff perceptions of their role in supporting the H + W of their students sits on a spectrum.	5, 2.	1, 2, 3

Appendix W. SENCO Interview Questions Ranguru Cove Primary

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Ranguru Cove Primary School: Individual Interview SENCO Questions

1. What is your understanding of the health services that are available to schools?
2. I understand that your role in the school up until last term was as the SENCO?
3. Did you work full time in that role?
4. Tell me a little about that role and the tasks and responsibilities involved
5. Who was invited to the SENCO meetings? /Who attended?
6. How would you describe your relationship with health services in that role?
7. In relation to the SENCO Meetings:
    - How many people on average attended these meetings?
    - How often were they held?
    - How long were the meetings?
    - Did the meeting follow a structure – was there an agenda sent out prior etc.?
    - How were the children who were up for discussion introduced/presented?
    - On average how many cases were discussed/bought to the meeting?
    - What was the problem-solving process?
    - In what ways were health related issues that might be impacting on learning discussed?
    - How did health contribute at these meetings?
    - What do you think it will have been like for the school not to have had the SENCO role this term?
8. In your teaching career what experiences have you had relating to health services in schools? Can you provide an example?
9. What kind of health services were available to you at your most recent school?
10. In your view what might be the barrier to the uptake and engagement of health services in a high decile school & community
11. What do you think about health services being available in primary schools?
12. In your view, where does the role that teachers play in supporting the health needs of their students begin and end?

Appendix X. Tabulated Summary of Findings

Case	Key Findings/Themes
Case A: Pūkeko Valley School	Health is separate – or is it?
	Filtered and mediated relationship between school staff and health services
	The nurse is our relationship with health services
	Cultural perspectives differ
	Teachers' perceptions of their role in supporting students' health needs vary
Case B: Tarāpuka Beach School	Is anybody out there? - school health services are not visible to us
	Filtering of teacher referrals
	Supporting student health and wellbeing; is this a teacher's role?
	Managing without health services
	Cultural considerations
Case C: Ranguru Cove School	Health services are not visible or accessible to us
	What is *my* role in supporting the health and wellbeing of students?
	Getting by without access to health services
	Culture matters
Cross Case Merged Findings	Health services are separate/external/invisible/siloed
	Teachers' perceptions of their role vary
	Strategies are adopted to manage without health services
	Cultural consideration is important
	There are barriers to access and uptake of school health services
	Use of schools as venues for health services
	Teacher knowledge of the impact of poor health on learning varies

Appendix Y. Case Report 1: Pūkeko Valley Primary School

Case Report One: Pūkeko Valley Primary School

Pūkeko Valley primary school is a state funded full primary school situated in a low socioeconomic suburb in a large city of New Zealand. At the time of this study the school had a roll of 205 students of which 25% were Māori, 20% Tongan and 16% Samoan. The local population was ethnically and culturally diverse with just over a third born overseas and just under half of these having lived in New Zealand for less than ten years. Many of the local population resided in state funded housing or private rental accommodation.

Pūkeko Valley primary school was situated within a very welcoming and attractive environment, signified by large open grounds with an expanse of green spaces and child friendly structures for children to play in and around. At the time of my visiting, the school was well presented and the physical spaces well cared for. The cultural diversity of the staff and students was acknowledged in various physical spaces around the school through artwork and structures that represent Māori and Pasifika[10].

The school's mission was to empower children to reach their full potential and become lifelong learners. In line with this, the classroom environments were welcoming and attractive with students having ready access to digital technology to support their learning. The school fostered positive relationships with other schools in the area and was an active member of the local Community of Learning[11]. The fostering of relationships extends to that of the students' parents and families with Pūkeko Valley school offering certain programmes that include parents in learning experiences alongside their child.

Pūkeko Valley is classified as a decile one school by the Ministry of Education based on census data. School deciles indicate the extent to which the school draws their students from low socio-economic communities; Decile 1 schools represent schools with the highest proportion of students from low socio-economic communities, whereas decile 10 schools are those with the lowest proportion of these students (Ministry of Education, 2018). Being a decile 1 school health resources are prioritised as a matter of course by the local District Health Board through the provision of an assigned community nurse and cultural worker who visit Pūkeko Valley school two or more days per week. The majority of presenting health concerns relate to skin infections, respiratory ailments and Group A streptococcal throat infections, the causative organism for acute Rheumatic Fever, a

[10] Pasifika is a term used by the MoE and MoH to describe people living in New Zealand who have migrated from the Pacific Islands or who identify with the Pacific Islands because of their heritage.
[11] A Community of Learning/Kāhui Ako is a group of education and training providers that form around children and young people's learning pathways, and work together to help them achieve their full potential. https://www.education.govt.nz/communities-of-learning/

significant health issue for New Zealand children particularly those living in poverty (Baker et al., 2019; Milne, Lennon, Stewart, Vander Hoorn, & Scuffham, 2012).

In my interactions with Pūkeko Valley school staff, I noted that they appeared a very cohesive, committed team who seemed to value and respect each other, and whose priority focus was the students. I observed this through their interactions and conversations with each other in the staffroom during their teaching breaks. The school had chosen to employ a person four days per week in the role of Special Educational Needs Co-ordinator (SENCO). The SENCO at Pūkeko Valley school, worked alongside the teachers at the school and interfaced with other key professionals, including those in health. The SENCO role was funded by the school out of staff resource funds with the school running larger class sizes to compensate. At the time I visited the school also had an onsite Social Worker who was employed part time by the Department of Social Welfare.

In his conversations with me, the Principal of Pūkeko Valley school, Rob, was very supportive of his staff, the students and their families. Under his leadership I sensed a happy, relaxed, yet orderly feel to the school, coupled with a sense that Rob would do whatever works to ensure things run smoothly. Rob came across as very proactive, frequently going out of his way to build relationships within his community as well as with external stakeholders. Rob discussed how he had many students attending the school with health issues and because of this, he was keen to engage with anything or anyone to support these needs; his approach to engaging with other services was practical and functional.

> *We are nice to people…it helps us get what we need if we work nicely with people, you know, treat them well…* Rob

With respect to this study, the Rob was very open to the school taking part and was extremely supportive in facilitating my access to the school staff, I presented a brief outline of the study at a morning tea break to the staff present. The study information was disseminated to those not present by leaving the participant information sheet in the staffroom with my business card and contact details. Within 48 hours I had a number of volunteers willing to be interviewed and an open invitation from the SENCO to observe the school Special Education Needs Co-ordination meeting. Rob completed the School Profile Questionnaire and a consent form permitting the school to be used as a case in the study. Rob also provided a record of the Professional Learning and Development (PLD) that had been offered to staff over the previous two years (Table 2).

Interview Participants

I conducted eight individual interviews at Pūkeko Valley school; the largest number of participants interviewed in each of the three schools and offering the most diversity.

Participants included males and females; a range of experience (in years) in their role, and some cultural diversity. Table 1 provides an overview of the participants based on the findings from the pre-interview questionnaire. The pre-interview questionnaire and the individual interviews that followed, provided rich information about how individuals perceived health services that were available in the school and the benefits and challenges that sat alongside this.

Table 1. Interview Participants Pūkeko Valley Primary School

Name	Age Bracket	Ethnicity	Position	Experience in Role	Knowledge of available health services	Attendance at SENCO meetings?	PLD Sessions Attendance at school
Rachel	45-50	NZ European	Class Teacher	25 years	*"Social worker, dental, public health nurse, vision, hearing, immunisation, Homecare Nurse"*	No	Yes
Moira	45-50	Other European	Class Teacher	6 years	*"Hearing, dental, immunisations, throat swabbing"*	No	Yes
Angela	55-60	NZ European	SENCO	10 years	*"Public health nurse, Health Promoting Schools"*	Yes	Yes
Greg	30-35	NZ European	Class Teacher	10 years	*"Public health nurse, dental, hearing, vision, social worker, immunisations, puberty education"*	*"Yes, but only for specific students' individual education plans"*	Yes
Karen	40-45	NZ European	Deputy Principal	20 years	*"Public health nurse, vision, throat swabbing, social worker"*	*"Only if I have a student on an individual education plan"*	Yes
Kirsty	35-40	Māori/European	Relief Teacher	18 years	*"Public health nurse, immunisations"*	No	No
Mary	Not disclosed	Māori	Teacher Aide	10 years	*"Dental, vision, hearing, public health nurse"*	No	No
Rob	55-60	NZ European	Principal	30 years	*"Public health nurse, hearing, vision, dental, counsellor, social worker, immunisations*	*"Mostly, based on need to be there and time commitments"*	Yes

SENCO Meeting Observation

The workload of the SENCO at Pūkeko Valley school was high, the role functions as the default position for fielding a lot of health and other issues that the students may be experiencing. These issues are presented to the SENCO first and are then filtered out to whom the SENCO feels is most appropriate to assist with dealing with the concern. In addition to being responsible for actioning referrals to both health and education services, the SENCO was also responsible for facilitating the 'SENCO meeting' which is held once a term. Attendance is by invitation and class teachers only attended if specifically requested to do so, usually if they had a student in their class who was being discussed. The Principal attended if needed and/or he had the time.

Attendees at the meeting, included representatives from both the local District Health Board, represented by the assigned school nurse, and the Ministry of Education; represented by a speech language therapist, Kate; a Resource Teacher of Learning and behaviour (RTLB), Beth and Attendance Officer, Amy. At the time of my observation no class teachers or teacher aides were present but the school social worker, Maggie was. The meeting was held in the morning and a list was provided to the attendees of all the children currently on the 'SENCO register', a list of students experiencing difficulty engaging or progressing with their learning. Typically, the students had been referred by their class teacher or had known education or health needs on starting at the school. There were 42 existing cases and 3 new cases on the register that day. This list included columns into which the following were entered: Student's name, date of birth, school year level, ethnicity, areas of need, intervention, agencies involved and a comments section. The list was compiled and maintained by the SENCO and as such contained information that she deemed important or necessary for attendees to know.

The SENCO led the meeting which ran for one hour and fifteen minutes; all attendees contributed at some stage throughout, although some more than others. The meeting seemed to run more like an update for attendees as opposed to a consultative, problem-solving opportunity. The SENCO spoke most, leading and guiding the meeting throughout, with meeting participants, Erin and Kate contributing the least. This was an education orientated meeting with health as an adjunct, but not in any significant way. Health was on the agenda if a child on the SENCO list was known to have a health concern; health status did not enter into discussions as a matter of course, rather it remained separate, as if waiting for an invitation to be included. An illustration of this was the case of a recent new entrant to the school who was noted to have language and behaviour issues, often hitting out and throwing things. The SENCO commented:

> *He's quite full on, a real high energy kid who likes attention constantly…. Mum does spoil him; she lets him on the iPad all the time…* SENCO-Angela

No-one at the meeting raised the possibility that the child might have a behavioural disorder or speech delay, nor was there any further dialogue of the next stage of assessment or referral before the SENCO's focus moved swiftly on to the next child on the list.

I observed that the meeting ran very efficiently and kept within the time allowed. The SENCO moved through the list of children very briskly, as a result, there appeared to be minimal opportunity afforded for case discussion or review. On reflection this may have been a practical approach to take due to the sheer number of children on the SENCO list and the time allowed for the meeting. The SENCO bought no questions to the meeting for the other professionals in the room; my interpretation was that this meeting was collegial but not consultative. I supposed that the 'updating' nature of the SENCO meeting could simply reflect time constraints, if so, I contemplated whether there were any other formal opportunities afforded to consult or discuss the children on the SENCO list.

When providing the updates on some on the children on the list, The SENCO has commented a few times, about the time and effort it took to her to complete referrals to various outside agencies, particularly health services. The way this was articulated led me to believe that she sometimes had to weigh up whether making a referral was 'worth it'; if she did go to this effort how likely was it that the family would engage or that the child would meet the referral criteria? An illustration of this was imparted when the SENCO mentioned in the meeting that there was no point referring a particular child to a certain special needs school because there was a waiting list to get in. Another member of the meeting commented "*that doesn't matter if there is a waiting list – get the application sent through and the child can be added, you never know..."* However, from an efficiency perspective, the SENCO perceived that it simply wasn't worth the time and effort completing the application as the waiting list was so long, and the team would have to come up with another solution in the interim anyway.

The SENCO talked about her workload with me after the meeting; her weariness and her frustration in relation to managing some of the cases was evident; she appeared somewhat burdened with the responsibility, but at the same time committed in helping the students at the school; she mused: *"A lot of the children's problems are left for me to sort out"*. This was certainly true, the SENCO at Pūkeko Valley school held the responsibility for referring students to health and other services; this was a responsibility that sat almost exclusively with her role.

Following my experience of observing the SENCO meeting, I reflected on the issue of inadvertently denying opportunities for children to access health and other support services because of the workload involved in actioning such a referral. If the effort is not made to complete a referral for a child to be on a waiting list or to access health services or funding, then the chances of receiving that support is zero, whereas if the

referral *is* completed, at least the child has been given a chance, however small, but chance nonetheless.

The relationship between Pūkeko Valley school and services external to it, including health, was influenced by the SENCO role, especially in relation to the process of filtering what referrals were made to whom and when. There was not sense that this 'filtering' was an intentional thing nor one that was done in a way as to deliberately deny access, more it was done as a practicable way of handling complex time-consuming concerns and an attempt to find timely solutions for a large group of children with learning, health and social needs.

Professional Learning and Development

The teaching staff at Pūkeko Valley school are offered professional development as needed, usually as part of the regular staff meetings. The Principal decides on the content or topics for professional learning and development (PLD) and this is typically based on need in response to issues arising in-house or changes in Ministry of Education policy or practices. A review of the PLD that was offered to staff over the preceding 18 months revealed little that specifically related to health (Table 2). Prior to this, staff had received First Aid training, and instructed on how to use an EpiPen for children who had diagnosed allergies.

During the individual interviews, when the participants discussed what PLD they had received specifically relating to health topics, they stated that there had been very little if anything. PLD content was generally focused on pedagogical practices that supported learning and achievement. The participants reflected that although it might be useful to have more education on health topics than they currently had, they probably wouldn't utilise that knowledge unless it was directly relatable at that time:

> *In all honesty, from my point of view I've learned some stuff earlier in my teaching career and I haven't used it, which you don't unless you have a child in your class that's specifically got that same issue…. Its' always worthwhile to know stuff, I'm not discounting that, but again if you don't use the information what's the point?...*

The participants were not motivated to know or understand more than they needed to in regards to health unless they saw an obvious connection with student learning. This sentiment was captured across all the participant interview data.

Table 2. Pūkeko Valley Primary: Professional Learning and Development (PLD) Topics 2017-2018

Topic	Health Related?	Additional Information
Literacy: Reading Across School	*No*	Supporting reading attainment across the curriculum
Sheena Cameron/Louise Dempsey Writing	*No*	Upskilling on teaching writing
Jeff Anderson Writing	*No*	Writing strategies for teachers and students
Math's: Bobbie Math's DMIC	*No*	Developing Mathematical Inquiry
Technology: Pīkau | Toolkits and Ngā Kiriahi	*No*	Upskilling for teachers on digital curriculum
TESSOL	*No*	Teaching English in Schools for Speakers of Other Languages
Community of Learning combined professional learning	*No*	Cross cluster goals; leadership; data collection.
School & other facility visits	*No*	Visiting other education centres to share learning
Education conference attendance	*No*	Selected staff attendance at GAFE; uLearn; ISTE education conferences
Google Level 1 Certification	*No*	Education on how to integrate Google technology into the classroom
School Achievement Facilitator (SAF) Project	*No*	Lifting Pacifika and Māori student engagement at school
Restraint Training by Resource Teachers of Learning and Behaviour (RTLB)	*Yes*	Physical restraint training to meet new legislative requirements:

Individual Interviews and Collective Findings

Through my individual interviews and the subsequent analysis of the data as a collective, I identified four key themes which are presented in the following section. The first theme relates to the separateness of schools and health services as perceived by school staff at Pūkeko Valley school.

Health is Separate from Education

The individual interview participants at Pūkeko Valley school were able to name some of the health services that were available to the students through the school. Health services were consistently referred to as a separate entity, and were viewed as external to the school community. As I read through the interview transcripts, I noted that the participants frequently used the word 'they' when referencing health services, suggesting others who are separate to the school itself. References were also made to the *bringing in* of health services as if to *fix* or *repair* students in preparation for learning. The perception of health services was of them being independent to the schools in which they delivered services

> *They're [health personnel] are not permanent features of schools you know, they come in caravans and they come in to school but they're not actually viewed as part of the school community.* Rob

The participants perceived health services as a separate entity; they recognised and understood the interrelatedness of health and education, but at the same time some did not know how to apply this understanding in their day-to-day working practice.

> *I guess with some of those health things like especially eyes and ears, hearing and vision there are changes that you [teacher] could make that are, manageable and would help their[student] learning if we knew how to...*Greg

A dilemma also lay in how school staff perceived their roles and what their professional role boundaries were in relation to supporting the health needs of their students. Karen was adamant that she did not consider it as her role to follow-up on health needs, but on the other hand pondered whose role should it be? Rob was clearer, suggesting that the health and education needs of students were best dealt with by those with expertise in these areas.

> *It shouldn't, it shouldn't be, it shouldn't be my job, I shouldn't have to make it happen! But at the end of the day, this kids in front of me, I'm going to do everything I can to help this kid but it's not my job. It shouldn't be my job. I'm there to teach them but. You do what you have to do, right?* Karen

> *You know we're education, you are health. You know, I know more about reading than you do!* Rob

Maintaining fixed boundaries was problematic for staff as issues around learning and health were not always clear or separate. From what participants described to me,

this posed an ethical dilemma; they were there to teach but how could they ignore a child who clearly had health issues?

> *Because you know we want these kids to have their best chance and if they need glasses and the family can't get there you know, we can't sit back and do nothing, we've got to, make it happen.* Karen

During interviews with more experienced teaching staff, the toing and froing between what was and what was not perceived as the teachers' role in relation to health was sometimes referred back to me as the role of the school in supporting the health needs of their students as opposed to the role of the individual teacher. Two important facets that indirectly related back to the research question were raised; the position the school took in supporting the general health and wellbeing of their students through day-to-day policy and practice and as reflected in the curriculum; and the role of the teacher in addressing individual student's health needs as they arose.

The Principal's sounded resentful when he described the amount of time that was taken away from teaching to work with health staff, not appearing to perceive it as adding value:

> *We've been siloed into education and health and you know, why are you [health personnel] interfering with my education time? And by-the-way, the health curriculum is there and I just have to deliver that, I don't actually have to work with you...*Rob

For the teachers, it seemed that they were under direction from both the Ministry of Education (MoE), and the school to focus their teaching on reading and writing, with the implication that addressing the health needs of students was an added extra:

> *There's always a tension about what is the school's purpose? You know, so what is it? what is to be educated? And, how do we do that? And we've had some regimes in education that have been really saying well, you just teach them to read, write and get them through to national standards and this is your priority…* Karen

Despite these existing tensions, the impact of poor health on student learning was well recognised amongst the interview participants:

> *if you want children to learn they've got to be happy and healthy and so the two go hand in hand…* Rob

> *I mean as soon as they're not feeling well, they're not going to learn…we all work the same way if we're not feeling 100%, we're not going to give 100%...*Greg

The participants were clearly conflicted; they knew they needed to emphasise reading and writing and deliver the curriculum as specified by the MoE and the school governance team, but they were also aware of the impact health had on learning. The participants recognised the need and value in collaborating with health. This was for two main reasons; the first being to support the student to engage with their learning and the second, to be able to pass on the problem to someone else so they could do their job of teaching. This finding relates to the participants recognition of discipline expertise and how they thought about this from a functional perspective and in regards to benefitting of their students.

> *Teachers are always the jack of all trades and master of none so we do what we can, but when it comes to health sometimes, we know what we're doing but then it's good to have these experts that we can go "hey look", this is what we think and then it's passed on and we work alongside. Because at the end of the day we just want to make sure the kids are learning so whatever's affecting it, we fix.* Greg

Passing the problem on, meant that the teacher didn't have to become involved and could focus solely on teaching, the emphasis being on not having enough time but also of recognising with whom the appropriate expertise sat. However, not all of the participants looked at it this way, some wanted to be more involved and felt they had a duty of care to their student's that extended beyond teaching. Also, as previously identified, participants recognised that some students would need access to health care to achieve learning. Despite recognising the health impacts on learning, some participants perceived the delivery of health care in the school setting had the potential to impact on learning through interruption. This ambiguity in regard to role perception, responsibility and the balancing of learning versus health needs, was a constant theme amongst the interview participants.

> *I think that if there's a problem with anybody in my class you [health professional] can interrupt me, you can talk to me whenever you want to talk to me about that person because it's my job to keep them safe and happy at school. And healthy is even better…* Rachel

> *So long as it (health services) doesn't impact the learning, I'm all for it. Because it goes alongside what we do in terms of we want in order to grow our kids, we want them to have the best opportunities to learn, and if the best way to get them here in class, and focussed on their learning, is to have that service available then that's cool…* Karen

In my attempt to further understand what was creating this tension between the knowing and the doing, I asked the participants to tell me more about what their own relationship was with health services that operated at the school; how did they initiate

a referral or elicit the support they needed for a student? Their responses suggested that this varied depending on the position that the participant held in the school and how experienced they were in working with outside services. Primarily, the relationship that those interviewed had with health services was facilitated via the SENCO, even though a named nurse was consistently available for the school. From Karen's perspective this was because the SENCO usually knew the student and their background and was at the school most days. Being a colleague of the teaching staff and considered a member of the school community, influenced the relationship the SENCO had with them and perhaps made staff more inclined to use her in this way.

> *I think because, the SENCO is here most of the time, and knows our kids, whereas the health nurse's here intermittently and doesn't know the kids, it's easier to go through her [SENCO] somebody that's able to say "oh well two years ago they did x, y and z" and who knows them, knows the history and knows the kid, rather than going straight to the health nurse…*Karen

The Relationship between School Staff and Health Services is Filtered and Mediated

Rob, the school Principal confirmed that he tried to look after his teachers by not putting the responsibility on them for following through on student's health issues, instead he had chosen to hire a full-time SENCO for this purpose, drawing from his school funds for the past ten years to do so.

> *The SENCO plays a very key role, and it was created here by me because first, I think teachers can't do it well enough on top of what they're doing and secondly, I don't want to do it and I'm not probably the best person to be involved anyway…Rob*

This functional stance served a purpose by relieving the teachers of the responsibility and time taken to attend the health concerns and enable them to teach. My interpretation of this was twofold. Firstly, it contributes to a view that health is separate and should be managed separately to, learning and, secondly, it reinforces to the teachers that their priority role is one of teaching, not of actively being involved in the process of referral for students with health needs.

The SENCO role was viewed positively by all of the interview participants with many commenting that they would not manage to fulfil the requirements of their job if there was not such a role at the school. There was also a perception that the role had added value as it was seen as part of the school community; of having focus and permanence.

> *Our SENCO is just incredible. She also works with various health people. I've seen them physically go and drive to some child's house,*

> *grab the mother, grab the child, drive them to the optometrist's appointment, physically pick the glasses up later themselves you know there's so much care out there….* Rachel

For Mary, a teacher aide, having access to the SENCO went further than this; for her it was about role clarity and role boundaries, and of respecting both her role and that of the teachers. In relation to attending to the health needs of students, Mary believed that this was not within the scope of the teacher aide role.

> *In that kind of area* [attending to health issues] *I don't feel it's my territory to do anything with the child, I just send the child to the class teacher…. I know my role and what to do as a teacher aide. I am* ***just*** *a teacher aide, so I just know what I need to do…*Mary

The way Mary described this notion to me implied that she was not convinced that this was necessarily always a good thing; providing comfort and support to a child in need was something she felt was important to do regardless of role but she felt conflicted in what she believed was the correct thing to do and what she innately felt she should to do:

> *When I see someone hurt in the class or in the playground, I make that my move to tend to the child and bring the child to the teacher, because we are not allowed to touch children and all that, you know, we're not allowed to touch children. But if that child comes up to me and holds me round the legs or by the hand, well, I am going to give comfort to that child…*Mary

The SENCO role acts as an intermediary between health and education at Pūkeko Valley primary school. Referrals from teachers and other school staff for children needing support with health issues, are sent to the SENCO who then decides where they go from there, selecting the appropriate service and with whom to engage. The SENCO saw herself as both the student support person and the co-ordinator of health and learning support services for the school. The SENCO was motivated to deal with health issues in a practical, time effective way. This was also evidenced in my observation of the SENCO meeting referenced previously. This was restricted to complex issues such as referrals for behavioural or developmental assessments, but also to being able to get simpler things done that would assist the student in the classroom.

> *it's a constant like, okay, so, this is Sebastian's pair of glasses, a couple of weeks ago he couldn't find his glasses, well he did find them but they were missing an arm and he couldn't find the arm. So, I just took them up to the chemist and they gave me another arm, it's a*

> *different colour arm but it doesn't really matter. So that's the sort of extra little jobs that have to be done.* SENCO-Angela

This desire to be able to deal with things a time effective way was often hampered by barriers beyond the SENCO's control such as the time taken to complete funding applications for children with special needs, often with no guarantee of a positive outcome. In addition to these applications, there were other practical issues such as modifying the physical environment for children with disabilities, that had to be worked through and which involved liaison with multiple different services.

> *It's applying for things and knowing who to go to for what. You know like the moderate needs team or the physical disability team or the team that fixes things when you need a ramp or, more recently we tried to get the toilets fixed for this child who's started who's very small. So, who do you go to for that? There's all these services and they don't always flow like that, they cross over…* Angela

Getting feedback after a referral is made

I sensed that although the teachers wanted to have more information, they didn't necessarily want to carry the responsibility of knowing, as this might mean they were more obliged to do something about the problem or become involved; this reflected a notion of 'wanting to know but not wanting to do'. This takes us back once again, to the degree of functional separateness of education and health at the school.

> *I guess I'd love to know about any health issues, but then if I do know, the responsibility would fall on me to try and follow it up. So, if a child did have a slight vision impairment and it needed to get followed up, would the emphasis be on me to follow it up?...* Kirsty

It wasn't that teachers were not willing to help support their student's health needs, it was more they did not want to be held *responsible* for doing so; to carry the burden of responsibility, after all that was what they believed the SENCO was there for.

> *Obviously, all teachers would love to do something if they could do easily, if there are things, we can do that are manageable…I don't think it's my place to follow up necessarily with parents to say "hey, have you taken your child to an optometrist" and things like that…* Karen

The Nurse is our Conduit to Health Services

Analysis of the data collected from the different sources revealed that the relationship most often described in relation to health service provision within the school was that with the school nurse. In addition, when the overall relationship between the school and health services was discussed, it was usual for this relationship to be personified in the form of a nurse rather than a more impersonal relationship with a system. The essentialness of this human relationship was apparent when the interview participants described to me how the nurse's attributes were key to how and if, the student's engaged with her. This in turn, influenced their own willingness to forge a relationship with that particular nurse. The importance of the nurse working and collaborating in ways that build relationship and trust was essential to the teacher-nurse relationship at Pūkeko Valley school; teachers were not always willing to let their students see the nurse unless they trusted and liked the person acting in that role. It was evident by the way the teachers described this relationship with the nurse that their willingness to engage with health services was influenced by how the health provider related to the children.

> *some of the girls in our class just wanted to go and see the nurse because she was lovely to them. You know they just, there was one who had really bad eczema, she would just trot off down there and she just wanted the nurse to tell her that her skin was looking better. And as long as it came from the nurse, it was okay. And you know that that lifted her spirits and confidence so much...* Angela

> *when you've got somebody who's a nice gentle, friendly face coming to and saying come on my darling, you come with me, you feel confident letting the children go, but not with someone that stands at the classroom door saying Joe Bloggs you need to come, so and so, you need to come…*Rachel

Having access to a nurse at the school was valued by all of the interview participants but as previously mentioned, how they perceived her as a person and her way of working directly influenced how they interacted with her. At the time of interviewing the school had just undergone a change in their assigned nurse and the staff were taking a while to acclimatise.

> *There was a great system that was operating up until the end of last year. Where, the nurses would come around to the classrooms and would ask very generally, "does anybody need their help?". They'd turn up at the door and we'd say* [to the students] *does anybody need to see the nurse? When you have someone turn up at your door and say" does anyone have a skin issue or does anyone need their throat*

> *swabbed?" Well, nobody's going to go, are they? And when they're Year 7 and 8 they're really not going to go...* Moira

Teachers required the nurse to be flexible and to work around them as much as possible to ensure that students learning opportunities were not impacted through being pulled out of the class to see the nurse when perhaps this could wait. Having a more regimented approach that suited the needs of the nurse rather than the student or teacher was counterproductive to the teacher-nurse relationship.

> *Now we've got an allotted 15 minutes twice a week, and my time is 11.15. I can't remember at precisely 11.15 that I've got to track down children, to send them to the nurse between in that 15-minute window. So, for example, within that 15-minute window, on one of my days, half my class is out at sport, and if within that group there's a child who needs to see the nurse, I can't get them. Essentially, what you're asking me to do, is interrupt my teaching of the remainder of the class, and send a child from what they're doing with me, to go and find a child who's out on the field. I don't think that works very well and that's why they* [the nurse] *doesn't have the buy-in here that they had previously. And that's a shame because it's a service that's really needed…* Rachel

Information between the nurse and the teachers about student's health needs was a topic that was frequently deliberated during the individual interviews. There was tension over the lack of feedback to the class teacher following a referral via the SENCO and consequently, many of the teachers felt that they were often left in the dark about health issues relating to their students. In relation to this Rachel commented: "*if I don't physically get that feedback, I can't act on it... I don't know what to look for".* Teachers wanted to be informed enough to be able to 'look out' for their students; to be able to pre-empt issues and accommodate any needs.

Cultural Perspectives

One of my interview participants, Mary, identified as Māori and another, Kirsty as part Māori. Both offered valuable insight into the cultural influences on the relationships between schools, families and health services. This insight included the importance of building relationships and what they perceived the barriers were for Māori and other cultural groups in accessing health care.

In their interviews with me, it was evident that Kirsty and Mary viewed health in holistic way, thus reflecting a Māori view of health. In their interviews, they drew on their own lived experience/mātau a wheako, to provide examples of how these perspectives influenced their expectations on practice.

Mary spoke to me about her concerns for children when they were unusually quiet or withdrawn at school; for her, this served as a 'red flag' in regards to their wellbeing, and she often went out of her way to try and unpack what was going on:

> *There could be a reason for a child being quiet like loneliness that sort of thing, or they could be in pain but not saying anything. Their physical health could be good but they are silent in a way that you know something's wrong but they may not want to talk to you. I always check and see if everything's OK with them…* Mary

Mary shared this holistic viewpoint when she described the importance of teachers adopting a wider lens on health rather than from just a physical perspective and particularly where a child might be struggling with their learning:

> *The staff might put pressure on the child without realising that this child has something going on at home, that's why they are not learning…it could be a lot of things, could be fatigue, it could be hunger. If the student is not doing right, for whatever reason, yeah, it could be things at home…* Mary

From the way Mary spoke with me it was clear that she understood the relationship between learning and health very well.

Kirsty shared with me that the process of gaining access to health support even when it was available at school, was difficult for some Māori families. Kirsty centred her examples around the consent process; families were required to give consent, preferably through signing a consent form, for their children to be referred and subsequently assessed by the school nurse.

> *I know that it's not always easy for families to understand or to be willing, you know, to sign something that they are not quite familiar with or unsure about…* Kirsty

Kirsty elaborated explaining that she didn't feel that Māori families and those with poor literacy skills or where English was a second language, always had the ability to understand some of the processes, including that of consent, that related to accessing health services at school. To illustrate what she meant, Kirsty relayed a story of a young Māori boy in her class who had an ongoing health concern lasting over a period of months. Kirsty and other members of staff at the school had repeatedly suggested to the boy's mother that she take him to see a doctor or to allow the school nurse to review him:

> *It took us a very long time for the mother to actually consent for us to arrange for him to be seen by the school nurse, I don't know why. If*

> *that was my child, I would have taken him but you're just not sure what the families are thinking, or what they understand or just what is going on in their life…*Kirsty

The perspective Kirsty adopts on this is consistent with the Māori concept of 'Taha Whanau' or family wellbeing; this concept involves the practitioner taking a holistic view of the entire family when considering why the child may not be receiving the care expected. In relation to Māori families delaying accessing health care, Mary cautions during her interview, that this may not always be down to a relationship or resource issue; it could be that for Māori, they simply see health differently. Te Ao Māori, the Māori world view, Mary informed me, includes the view that if a child is happy, eating and playing for example, then everything must be alright. As a result, health concerns may be left longer before they are addressed if the child appears otherwise well.

Mary also talked to me about the Māori concept of *whakamā* meaning shame, embarrassment or shyness, and how this had the potential to influence the relationship between families, teachers and health providers at the school, particularly when language or financial resources were an issue. In discussing the concept of whakamā and Māori specifically, Mary alluded to the struggles many Māori families face and their reluctance to reach out for help.

> *For Māori people, there are some families that are suffering but they're a bit too shy to talk to anyone about it. They'd rather treat their own children, their own family, in their own way. They avoid buying prescriptions and all that because it is a struggle. Although, I would say that the children are treated more with medication and it's the older ones that often miss out, or sometimes they just share because of the cost. They will share to help another one that is in need of it [the medication]…Mary*

With respect to teachers and families engaging with health services, Mary felt it was important to draw everyone in together, upholding the Māori practice of whanaungatanga, that of building relationships, connections and kinship. In Māori culture whanaungatanga is created through shared experiences and working together, and aims to provide people with a sense of unity and belonging. To this end, Mary suggested to me that the school should have a health event to draw families, school staff and health service providers together to build connections.

Kirsty also spoke to me about the importance of health providers building relationships and promoting the service better to families and suggested this could be achieved by inviting them in to meet the school nurse and social worker. Kirsty expressed the importance of keeping families updated and informed of what health services were accessible at the school. In regards to visibility and encouraging meeting together,

what Kirsty and Mary alluded to from a Māori perspective is the importance of kanohi kit e kanohi, or face-to-face, a key principle in Māori practice. For Māori, seeing, hearing and feeling the relationship between themselves and others is key to relationship building.

Summary

The findings at Pūkeko Valley primary school provide confirmation and extend *all* five of the issue statements and sub issues identified in the conceptual structure of this study. A brief reference to these issue statements is provided again in Table 3. As implied through the sub-headings in this report there were four main themes from the data that related directly to my research question.

The first theme, which I entitled *'Health is separate to education'* centres on the perception that education was considered separate to health both philosophically and in the system sense. However, participants appeared to understand the impact poor health might have on learning but did not appear to synthesise this understanding in their practice. The key issue statements relating specifically to this theme are Issue statements one, two and three.

Table 3. Issue Statements

	Issue Statements
1	Good health is necessary for effective learning
2	Individual experiences shape teachers' perceptions of health services both professionally and personally
3	Organisational and individual culture will shape school staff's perception of health
4	Accessibility of health services will shape relationships between school staff health and health services
5	The opportunities for collaboration between school staff and health services influence the quality of the relationship

The second theme: *'The relationship between school staff and health services is filtered and mediated'*, focused on the teacher's use of an intermediary to access health support for their students. This intermediary was the SENCO. The teachers and their Principal were happy with this arrangement as it allowed them to focus on teaching. In addition, they were protected from becoming too involved with the health needs of their students. However, teachers still wanted to be included in feedback about their

student's health needs and often felt 'left in the dark' when this didn't happen. The key issue statements relating to this theme are issues three, four and five.

The third theme relates to the relationship school staff had with their school nurse. *'The nurse is our relationship'* daws attention to the fact that the school viewed the nurse as their relationship with Health. Their relationship with their school nurse was viewed very positively although participants were at pains to point out that positive personal attributes such as being warm and friendly as opposed to being brusque and task focused, directly influenced how engaged they were with her. Having a nursing service available to the school was perceived as highly valuable by all the participants. The key issue statements that relate to this theme are issues two, four and five.

The fourth and final main theme was entitled *'Cultural perspectives'* and draws attention to the importance of understanding the different cultural perspectives of families when considering ways of delivering health services in schools. Whilst some of the emphasis in these findings relate to the relationship *families* have with health services, they are important to consider in the context of positioning health services in the school setting. They also and highlight the importance of schools and health services working collaboratively in order to meet the cultural needs of their families. The issue statements that most directly relate to this theme are two and three.

In addition to identifying a link between my findings and my issue and sub-issue statements; I also identified something that was a completely new concept to me. I identified that there was a tension in teachers' perceptions of their professional role in relation to supporting the health and wellbeing of their students. Some participants were adamant that it shouldn't be their role to be involved in following up on health concerns, and others felt obliged to from the sense that they couldn't teach a child who was suffering ill-health. The teachers were outcome focused in regards to their teaching and health got in the way of this.

Pūkeko Valley Primary's relationship with health services is positive but largely pragmatic; a structured system has been developed in response to a large number of students who have health concerns that are or have the potential to be impacting on learning. This pragmatic stance centres on the school's desire for its teachers to be able to get on and teach the children first and foremost. How the school interfaced health services is nuanced by what they perceive the relationship between health and education to be, their filtered internal referral pathway for children experiencing health issues, perceptions of their role and responsibility in relation to health, and how they relate to their assigned school nurse.

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Appendix Z. Case Report 2: Tarāpuka Beach School

Case Report Two: Tarāpuka Beach Primary School

Tarāpuka Beach Primary is a decile four multicultural school positioned in a residential suburb in a metropolitan area of New Zealand. Tarāpuka Beach Primary has a school roll of approximately 340 students and classified as a 'contributing primary school'[12], spanning school years 1-6. The largest groups of student representation are Samoan, New Zealand European, Māori and Indian; these groups are present in comparatively equal proportions to each other, with smaller groups such as Tongan, Cook Island, Filipino and Chinese also represented. The school hosts a satellite class from a Special School[13] in the locality and students in this class are integrated into the school.

My observation as I entered the school for the first time, was that Tarāpuka Beach Primary promotes a culture that is inclusive and values diversity. This is reflected via the various design features, colours, artwork and sculptures that appear throughout the school. My sense was that these represented and celebrated not only the many different cultural groups at the school, but also that of individual diversity and uniqueness.

My initial contact with the school principal was a very positive experience, I had made an appointment prior and was warmly welcomed into his office on my arrival. I spoke about my research and my desire to include Tarāpuka Beach as a case. The Principal was very receptive and arranged for me to talk with his staff at a morning tea the following week. At this meeting with the staff, I introduced the study and left participant information in the staffroom and my contact details. Staff were instructed to email me if they wanted to take part in the study. I subsequently received six individual emails over the course of the following week, including one from the school principal, each indicating a willingness to be an interview participant in the study.

All of the participants selected, indicated that they preferred to be interviewed at school, either in their lunch break or before and after school. The Principal, although very keen to support his staff to be a part of the study, was also conscious of the need to minimise disruptions to school functioning and of teachers being able to have their usual breaks. The Principal decided the best solution was for me to come and spend the day at the school interviewing, and he would provide and pay for a relief teacher to cover the staff members who wanted to take part. The Principal explained to me that this substantive offer was borne out of his belief in the value of the study and of

[12] Contributing primary schools are those which cater for school years 1-6 and are more common in New Zealand than full primary schools which cater for years 1 to 8.
https://www.newzealandnow.govt.nz/living-in-nz/education/school-system

[13] Special schools support high needs students, either in day schools or residential schools across New Zealand.
https://www.education.govt.nz/school/student-support/special-education/day-special-schools-for-students-with-high-needs/

optimising opportunities for his staff to contribute without them having to give up their own free time. There was no obligation to be interviewed on this day, rather it was put forward as an option to staff. All of the participants took up this offer.

Interview Participants

Other than the Principal, the remaining teaching and support staff employed by the school are female. From the very first meeting I had with the Principal, I acquired a sense of how committed he was to both the students and staff at the school; to them aiming high and achieving to the best of their ability. The Principal's commitment to celebrating diversity, reducing inequity and to going the extra mile was tangible; he spoke passionately to me about children's rights and about what he perceived as failures in both the education and health systems.

The other staff that I met at the school were also warm, friendly and keen to support the research study whether in Principal or as a participant. Amongst those who chose to take part, the more experienced were able to draw upon many personal encounters in interfacing with or utilising health services to support the needs of their students.

In total seven participants consented to be interviewed however, one was unable to follow through due to ill health. The participants ranged in age between 31 and 62 years and included four females and one male. Table 1 provides an overview of the interview participants from Tarāpuka Beach Primary based on the data collected from the individual pre-interview questionnaires. The participants had experience ranging from first year graduate to over forty years teaching experience. With the exception of the school principal, the remaining participants were all classroom teachers at the school.

The data collected from the participants was valuable and informative with interviews ranging from 35 to 45 minutes in length. Each participant provided their own accounts of working with children who were or had experienced health issues that were impacting on their learning and the challenges that had accompanied this.

Table 1. Interview Participants Tarāpuka Beach Primary School

Name	**Age Bracket (yrs.)**	**Ethnicity**	**Position**	**Experience in Role**	**Knowledge of available health services**	**Attendance at SENCO meetings?**	**Attendance at school PLD Sessions**
Neil	60-65	NZ European	Principal	42 years	*"Dental, Public Health Nurse, Health Promoting Schools, Mental Health service"*	Yes	Yes
Kate	30-35	NZ European	Class Teacher	1 year	"*Hearing, vision and dental"*	No "*not part of my role"*	Yes
Jennifer	55-60	Other European	Senior Teacher	22 years	*"Public Health Nurse"*	*"No, unless one of my students is being discussed"*	Yes
Cassie	30-35	Cook Island Māori	Class Teacher	7 years	*"Public Health Nurse"*	*"Only if one of my students is being discussed"*	Yes
Fran	50-55	NZ European	Senior Teacher	30+ years	"*Public Health Nurse and Social Worker"*	*"If I have a student on the list"*	Yes

SENCO Meeting Observation

I made contact with the SENCO[14] of the school and arranged to attend and observe a SENCO meeting. On the day of the meeting, I was shown to a classroom where five meeting attendees were seated around a table talking to each other. Despite it being a collegial and friendly meeting from the outset, when I was introduced to the meeting attendees by the SENCO, the attendees responded by saying "hello" and their name but did not divulge their professional role; it was as if they assumed that I already knew. There was some urgency in getting the meeting going and I felt awkward asking everyone to stop and explain their role to me. Not wanting to interrupt the flow of their meeting, I had to deduce what the meeting attendees' roles were as the meeting progressed and I proceeded to confirm this with the SENCO when the meeting had ended. It eventuated that this meeting was not a true SENCO meeting in the way that I understood it to be, in fact the school, despite having a SENCO person, didn't actually have a meeting entitled 'SENCO meeting' like other schools, instead they had what they called an 'Interagency meeting' held once a fortnight, and a 'New Referrals' meeting held twice a term. Both of these meetings were inclusive of the SENCO herself. The meeting I had been invited to observe was the Interagency meeting.

The five meeting participants present were the deputy principal, a behavioural psychologist from the Ministry of Education (MOE); the Tarāpuka Beach Primary Social Worker in Schools (SWiS); the school SENCO and a Resource Teacher for Learning and Behaviour (RTLB)[15]. Absent on the day was the Speech Language Therapist (SLT) assigned to the school though MoE. There was no representative from the MoH; the school had requested from the local health service provider that a Public Health Nurse have a regular presence at these meetings but nothing had been forthcoming to date.

My perception of this meeting was that it served more as a collegial update on where each member of the group was at with the children that they were working with, rather than a formal update on progress and future planning. Ideas were floated amongst the group and challenges discussed. It was a very collaborative meeting with participants offering each other time to feedback on their individual work and progress with the children. However, no collective decisions were finalised, or minutes recorded; I reflected later on that this was a missed opportunity for more formalised interdisciplinary dialogue; a lost chance to share different disciplines perspectives on issues affecting children and their learning, as well as affording an opportunity to learn from each other. I was concerned that working in this separate, discipline-specific way

[14] The Special Educational Needs Co-ordinator. (SENCO) has the responsibility of managing and coordinating the well-being, learning and education of students identified with special educational needs (SEN). The SENCO liaison meeting brings together other professionals involved in supporting children with SEN both from within the school and external agencies such as health and social services.
[15] An RTLB is funded by the Ministry of Education to work with teachers to support the learning and achievement of students with learning and/or behavioural difficulties. https://rtlb.tki.org.nz/The-RTLB-service/What-RTLB-do

could unintentionally hinder learning progression for students experiencing difficulty in this regard for whatever reason. I considered a more formal approach to discussing and planning that focused on priority goals for individual students may be more effective. It is important to acknowledge to the reader, that my attendance and observation at this meeting provided only a snapshot of this meeting on a particular day, as such, I was careful when undertaking my analysis not to create assumptions that the meeting was always run in this way and to consider my findings alongside those from my other data sources.

Professional Learning and Development

The professional learning and development offered at Tarāpuka Beach Primary (Table 2) during the preceding 18 to 24 months, revolved mainly around pedagogy and managing challenging behaviour. A session had been offered by an outside charitable agency on supporting children on the autistic spectrum; of note, the Principal did enquire after the interagency meeting, if I knew of anyone who could present some education on Attention Deficit Disorder (ADD) and Attention Deficit Hyperactive Disorder (ADHD). There was an awareness amongst all the study participants that I interacted with, that they needed more health related PLD, but most were unsure who could provide this. It was clear that the school was actively pursuing PLD around health conditions but appeared to want this so as to be able to categorise health by diagnosis rather than maintaining a holistic view encompassing environment and healthy lifestyle. Whilst having such condition-focused information might enlighten teachers about the general features of a diagnosis, it would not necessarily help them to understand the unique needs of each child or the best way to meet them.

The majority of the interview participants at Tarāpuka Beach Primary disclosed there was a lack of PLD that had been offered by the school that related directly to health topics either as general information or to specific health needs of individual children currently at the school. There was consensus amongst those interviewed, that more PLD relating to physical and mental health would empower them to identify issues sooner and to refer on.

> *We've all had to have PLD on learning how to use an epi pen. I also remember getting a little bit of training on asthma and using the big long inhaler but often it's parents who teach us you know; they come in I get a little lesson from them, but often it's really short and I don't take it all in because I don't know a lot about asthma. I can't think of any other health PLD…Fran*

I detected discontent over the lack of preparation and education that the teachers were offered when children with identified special learning and health needs started at the school. This frustration was not directed at the school itself, rather to the other

organisations already involved, particularly health. Also, there was concern that the transition of these students was not always well planned or supported. In her interview, Fran shared a particular incident that happened to her:

> *You don't have PD but you do get a child and you just have to deal with it… You know I remember getting a new boy with cerebral palsy. I didn't know he was coming and he came to visit and I knew nothing about his condition, I had nothing, to tell me he was coming and he turned up at the door and I had to move all the furniture because he had a walker and couldn't get around. I had no idea about what his health needs might be. I had no idea about toileting or anything. What happens in an emergency? Do I pick him up and run? There was no discussion around what might be useful for me to know…*Fran

Fran seems to be saying that even when there is no information, she has no choice but to get on with managing the situation. Often this additional work was extensive, such as her description of rearranging the classroom plus it was evident that she was worried about practical safety issues.

I was curious to understand how involved the teaching and support staff at Tarāpuka Beach were, in planning and evaluating PLD offered at the school each year and how the programme was put together. In the school profile questionnaire, I specifically ask who decides the content of the PLD at the school; the Principal had completed this for me and had stipulated that it was he and the senior teacher for curriculum management who did this. Table 2 provides a list of the PLD topics offered at Tarāpuka Beach Primary school over the previous two years. I contemplated that with more involvement in planning the programme, the teachers may have an opportunity to include other, non-pedagogical topics that had equal relevance to their day-to-day role.

Table 2: Tarāpuka Beach Primary: Professional Learning and Development (PLD) Topics 2017 – 2018

Topic	Health Related?	Additional Information
Maths	*No*	
Literacy	*No*	
Oral Language	*No*	
Positive Behaviour for Learning	*No (emphasis not on health as a possible determinant of behaviour)*	
De-escalating behaviour	*No*	
Restorative Practice	*No*	
Cultural Responsiveness	*No*	
Te Reo Language	*No*	
Developing the Pedagogy	*No*	
ESOL – Innovative Learning Environments	*No*	
Tips for Autism	*Yes*	
First Aid	*Yes*	Outside expertise bought in to teach
Dealing with Trauma	*Yes*	
Technology: Pīkau | Toolkits and Ngā Kiriahi	*No*	Upskilling for teachers on the digital curriculum

Individual Interviews and Collective Findings

Through my individual interviews and the subsequent analysis of the data as a collective, I identified five key themes which are presented in the following section. The first theme relates to health service visibility at Tarāpuka Beach Primary.

Reduced Visibility of Health Services

Although staff knew about *some* of the health services available to the school, particularly public health nursing, the visibility of such resources at Tarāpuka Beach Primary was low or non-existent. A few were unaware that certain services were accessible to them, particularly those with less years of teaching experience. The interview participants referred to nurses more often than any other health professional. This was because most had encountered nurses in the school setting and had more experience of working alongside nurses compared with health professionals. Nurses were in the main, considered synonymous with the term 'health services' when it came to participants reflecting on specific services that were available in schools generally.

Interview participants spoke about their past experiences of having access to a visiting nurse, and the benefits such a relationship offered in supporting their students and themselves. They often described the nurse as the health 'expert' and I had the impression that they respected nursing's contribution to supporting their learners and that they wanted to work collaboratively.

> *it's really tricky for a teacher to know, should I broach this with the family or should a professional person be involved? A public health nurse could make that decision better than I could. You kind of feel like you want to hand some things over a little bit because maybe they're too hard for the teacher because, we don't have that kind of expertise…*Fran

> *I think it would help just so it's not just me talking or a teacher talking or the school talking, it's the teacher, school and the professional…*Jennifer

Whilst noting this positive affirmation of the perceived value of the nursing service, I also contemplated whether the teacher's confidence in dealing with health concerns could be improved if more professional development relating to health, was offered both in their undergraduate training and in their day-to-day professional practice.

One participant, Kate, a first-year teacher, had no personal experience of working with public health nursing, nor had this support been discussed with her as a new to practice teacher; to Kate the service simply didn't exist. I was curious to find out to what extent health conditions and health services in schools had been discussed in Kate's undergraduate university programme by way of preparing students for what they may encounter in the classroom. I asked her:

> ***Researcher:*** *As a more recent graduate can you tell me how much education around health and its relationship with learning you received in your undergraduate programme?*
>
> ***Kate:*** *We had a major paper on health and physical education, which was actually one of my favourite papers. It ran in conjunction with social studies. so, it was more on the social side of things. It was more about sexuality education, physical education, and a lot of emotional things as well. It wasn't necessarily about physical health or conditions...*

We went on to discuss whether Kate thought that more teaching on physical health conditions might have been useful in her undergraduate curriculum? Kate believed that it would, and went on to add:

> *Yeah, we didn't get any of that. Autism was a thing that I was very mystified about and other conditions like that. And I've had two, maybe possibly three boys, in my class who I'd say would be on the autistic spectrum but, I've only learned to notice the signs since I've been in the job so, all things like that I've learned on the job...*

As I reflected on this, I noted to myself that it would be valuable to understand this a bit more in future research; how do undergraduate teacher training programmes address health and wellbeing of students in their curriculum? This may have potential to influence the foundational relationship between new to practice teachers and health services.

Coming back to the visibility of health services, it wasn't just Kate, who was unsure about nursing service availability in the school. Fran a more experienced teacher at the school commented "*I don't currently know who the public health nurse is. I don't know if there is one and I'm not sure if they ever come".* Although once highly visible, I was informed by Neil, the Principal, that nursing service availability at the school had slowly dwindled over the years to virtually nothing. At the time of conducting the study, there was no representative from the health sector attending the interagency or referral meetings at the school:

> *Sometimes in a meeting where we've got concerns about a child's learning or their care or whatever, the representative of health, isn't there. We might have our social worker and related parties, but the health piece isn't present. We have had that presence at different times over the years where, depending on the nurse, a nurse will attend when where possible. Now, a nurse is invited to come but doesn't come…*Neil

As Neil explained this to me, I had a sense from him that he believed that an essential piece of a puzzle was missing from these meetings, a piece that he believed could potentially help inform and provide support where student learning and attendance at school was being hindered by health issues.

This lack of visible nursing resource in particular, at Tarāpuka Beach Primary, was the topic of much robust discussion in the individual interviews and staff pondered why this lack of resource might be so. References were often made to the service being 'taken away' or having 'vanished'

> *We used to have a public health nurse who would come regularly on a weekly basis. This is a few years ago. But I think the services must be too stretched now and they don't. We used to always know who the public health nurse was but now I wouldn't have a clue…*Jennifer

Neil tried to make sense of this lack of visibility during his interview:

> *It's about how they operate. So, in terms of being proactive and actively seeking out the school, I think they [health nurse] tend to sit back and wait. Or, they're under resourced and don't have the support they need to be able to be seen frequently or visibly within a school. So, I think it could be a resourcing issue, or perhaps a structural issue, or it could be just the way they're used to operating um. I'm just not sure…*Neil

Neil went on to say how frustrated he felt that the degree of nursing service support that the school had access to was determined by their decile ranking. As a decile 4 school, Tarāpuka Beach Primary was not considered as high need compared to that of a decile 1 or 2 school.

> *It's [the service] not being flexible. They're trying to operate it rigidly and fairly but it's not fair. It's needs to be equitable. It needs to be delivered in a differentiated way…*Neil

Another of the participants, Fran, wondered if the lack of availability of a nurse was due to privacy issues:

> *I'm not too sure about how the Privacy Act works now and if that's affected the whole thing? We used to just send someone to the public health nurse or she'd go to someone's house and you'd sort it out within an hour. I'm not sure if that's changed with the privacy laws…*Fran

Whatever the reason for the lack of visibility, the majority of those interviewed articulated that this directly influenced how they engaged with nursing services, despite some knowing it was available to them. This point is illustrated really well in Jennifer's comment to me:

> *I think it makes us less likely to do a referral. Whereas if we saw the public health nurse on a regular basis we would say, just in passing, "oh by the way I've noticed that so and so's not looking so good" or say that there have been issues with somebody's health, and the health nurse would follow up. But now we don't have that contact anymore…*Jennifer

The nursing service was used consistently as an example of how access and prominence of health services as a whole, in the school setting, was notably lacking at Tarāpuka Beach Primary.

Filtering of Teacher Referrals

With respect to gaining access to health services and making referrals, there is a system in place at Tarāpuka Beach Primary, through which the teachers refer children who have health or behavioural issues; teachers don't directly follow-up themselves, instead they pass this referral on to be picked up by someone who can action the necessary help and support. This person is usually the SENCO, Team Leader, Principal or the Deputy Principal:

> *We have a system where if we think there's a health issue with a student, such as school sores, or nits that haven't been treated or anything else, we have a form that we fill out. We leave the form at the office and the public health nurse gets contacted…* Jennifer

> *I go through my team leader who then, once we've filled out application forms for RTLB support, gives it to the SENCO. So, we I don't have any interaction with the nurse or social worker directly, the referral just goes to the SENCO…*Kate

This seemingly 'filtered' referral system meant that frequently, the SENCO, Principal or Deputy Principal act as the conduit between the school, the health service provider and the family. This appeared to be a pragmatic decision based on the fact that these persons are perceived as more readily able to do so as they did not have classroom teaching responsibilities. The interview participants often made reference to their relationship with health services as one by way of invitation; for example, a nurse was now accessed by completing referral rather than them having an active and regular presence in the school as they had previously:

> *She [the nurse] comes, when we require her. And at one stage we didn't have one because they (the DHB) didn't know we didn't have one so it was two years without being able to access a public health nurse, so we weren't aware what the status of them was really...*Neil

There was an air of resignation tinged with frustration from the Principal that this was just how it was and not just for nursing. Access to heath support in general was difficult for the school, compounded by them not always being aware of what resources were available:

> *There's not much to say, I can't say much because there is very little [health service] provision. And if there is, it's siloed and they operate independently from everybody else. They[health service providers] don't have that understanding or interest in communicating or*

> *actively going out and promoting their service within the schools to be more effective…* Neil

To Neil, access to health services was one issue, another was the separation of services *within* the health sector once entry had been gained. Navigating the different departments and specialist resources such as developmental paediatrics, and mental health services required tenacity and time.

Kate was concerned that without an effective interface and referral pathway, children with unmet health needs may not get these needs met; and like Fran, she held concerns around safety:

> *Schools can be really good at picking those things up and making things better for the child, but I wonder if the less power and ability we [teachers] have in referring kids ourselves, whether, those children who need that safety net will suffer…*Kate

Within this comment it is evident that some teachers wanted to be able to access health services themselves, not necessarily via another person or system. This included having face to face contact with health professionals so they could share nuanced information about the needs of their student in respect to their learning; information that was best received first-hand rather than via an intermediary. This is echoed in the previous quote by Jennifer. Cassie confirms this further in her response which followed from me asking her what difference would it make if nursing and other health supports were more visible at Tarāpuka Beach:

> *We'd definitely do more referrals! I guess there's something about having to print out a form, fill it out and then leave it at the office and wait rather than having a conversation first. That puts you off, doing that sort of thing…*Cassie

Gaining access to support from health services was clearly challenging for the staff working at Tarāpuka Beach. Teachers' experiences of making referrals for funding support for students who had complex health needs involved filling out a multitude of forms which they found time consuming and which often held no guarantee of acceptance, Fran mused *"It makes you think twice, is this really necessary..."*

During my observation of the Interagency meeting, I had noted a similar sentiment in relation to the making of referrals. Despite being reluctant to close cases where students had made progress with an intervention, and where there was no further funding was available to keep going, there was sometimes a reluctance to re-submit a referral for continuing funding support. This was particularly evident if they felt the student was unlikely to meet the criteria. Participant 5 (in the interagency meeting)

remarked: *"I don't want to make a full referral [for a teacher aide] because it means I have to go through that whole long process…"* This comment was made in reference to making a particular referral for more teacher aide[16] support that would be largely based on the collation of school and behaviour reports rather than a diagnosis.

This raised a concern for me in relation to the potential for children to be disadvantaged by this seemingly complex and timely referral process. If a referrer was having to weigh up the time taken to complete a referral against the chances of being successful, this could mean that a child may not even have the opportunity of being considered for support.

As far as awareness of what health services were available to the school, the reason staff may lack such knowledge could be because any concerns or issues about student health were relayed by a series of conduits, with teachers not directly making contact with health providers themselves. Kate illustrates this point well in her comment: *"It might just be me but I am not aware of the services available and what I can do as a teacher. It could be down to me to make myself aware of what I can do to refer a child or get a nurse to come in…"*

This was further confirmed by Fran who said: "At the moment I don't know what is supplied to us and what the process is. I have heard that there is a public health nurse out there but I don't know if we can access this or not". Interestingly, in relation to making health referrals, it was the Principal who demonstrated the most knowledge about what was available to the school. I considered the potential impact of him holding this information in light of the other interview participants evident lack of knowledge about who they can refer to and for what.

In this interview excerpt Neil describes his role as the 'interface' between the school, family and health services:

> *I may direct a child that I've seen via the teacher with for example, impetigo or sores and say to my secretary, "can you please ring the public health nurse" or sometimes we just bypass the nurse and go straight to the parent and say, "you need to take the child to the doctor". I'm the sort of, interface between the outside medical support that some children need. It doesn't tend to happen internally (by the teachers) …Neil*

It is not uncommon at Tarāpuka Beach Primary for the Principal or deputy principal to visit parents and caregivers at home when they have concerns about a student's health and wellbeing and want to raise this with the family. Often, the purpose of these visits

[16] A teacher aide works under the direction of a teacher to support children with their learning https://parents.education.govt.nz/assets/Documents/Special-Education/The-role-of-the-teachers-aide.pdf

is to suggest to families that they take the child to the family doctor to receive treatment or advice. I determined that the decision to home visit was essentially pragmatic given that they perceived the relevant health services as not available to the families through school. In addition, it allowed encouraging families to interface directly with their health care provider, potentially removing the onus of responsibility from the school. However, Fran commented that she would prefer to deal with a health professional first before talking with the family primarily based on confirming that concern or treatment was warranted: *"If I could, I might not talk directly to the parent, I might seek advice from the nurse first".*

Supporting Student Health and Wellbeing; Is this a Teacher's Role?

There was a remarkable similarity in how each participant responded to what they perceived their role to be concerning supporting the health and wellbeing of their students. Most felt that it was an integral part of their responsibility as a teacher, but not necessarily from a 'hands on' provision of care perspective. They described their role in this as mainly educational, involving health promotion activities and improving health literacy.

> *I think probably our role is really educational and you know, talking, getting resources or little programmes of work around looking after your teeth and healthy eating and fruit and vegetables. I think teachers do have a role in that… But sometimes you don't know because I'm not the expert with health things…Fran*

Teachers saw their role in addressing immediate health issues at school as similar to that of a parent. This perception was coupled with an assumed dilemma; if the teacher didn't intervene in a similar way that a parent might in a given scenario, they would be questioned as to why not. If they did intervene, they risk being deemed by parents as overstepping their role. The proposed intent when the interviewees adopted a parental-like stance was to support the family and be seen as working in partnership with them. Cassie and Fran provided helpful insights about this in the following interview excerpts:

> *I do think society has put a lot of pressure on us in the fact that we're pretty much the parents as well. I'm not personally a parent myself, but I do hear from cousins and family members when they're like "oh, the teacher's trying to act like the parent and telling the child what to do". I don't like hearing that. For me, my why is my students, and if me helping a parent out helps a student, I'll do it. For example, just to help mum I might say, "oh look you need to listen to your mum dah, dah, dah, dah" and that made mum happy, it's kind of helped at home. But I think I should have said, "no you're the mother, you*

> *parent your child, she's not my daughter" But I do feel that was part of my role…*Cassie

Regarding supporting their student's health and wellbeing, there was an ill-defined boundary between what the study participants at Tarāpuka Beach Primary felt they could and should do, and what they could and should *not* do. This was further complicated by a sense of obligation and duty of care some felt for their students. It was as if there was a wobbly, rather vague line in the sand and overstepping this line was at times associated with a degree of burden and uncertainty:

> *I think that it's a big ask for teachers to do all that kind of work, but I personally need to connect to a child and I don't feel I care about them if I'm just like "Hi, public health nurse, "can you go deal with that". I feel like I have to be involved because that child is with me during the day and if I don't understand what's happening, I can't have that holistic idea of how to care for them…* Cassie

> *I do think sometimes, the issues may be too big for us. We need someone else to step in, in their professional role and take on the health and social welfare issues - maybe it's not so much my role...* Fran

I noted that these sentiments of duty and obligation reflected the expectancy the Principal had of his teachers in relation to student health and wellbeing:

> *I think it's an expectation I have for all my teachers, because you can't sit in a classroom and ignore them (*health needs*). If you're looking at teaching, learning, academic achievement and supporting wellbeing and all of those things, then that's part of what we do, that's our job…*Neil

I reflected on how the attitude at Tarāpuka Beach, in the context of their relationship with health and health services, is strongly influenced by the Principal's leadership and expectations in this area. I observed that his firm and committed leadership contributes to a very student-focused ethos at the school.

Managing Without

In the absence of a visible and sustained interface with health services at the school, the staff at Tarāpuka Beach Primary work cohesively and conscientiously to meet the health needs of their students. This did not come as a surprise to me given their shared philosophical view that upholding student wellbeing played a key part in all of their roles:

> *It's not one teacher that fixes it. It's a group of people who are trying hard, to make it work... Starting with the team meetings, I ask them (the staff) to write down children causing concern and then that comes to the management meeting and we'll talk about it. At the Friday admin meeting if there's a child that's been stood down or there's been a health issue or these children are at risk at the moment, we all need to be aware of this. I say, "can you please all watch out?". The idea is to communicate across the school the needs of various children, so that we all look out for them…*Neil

Working together at Tarāpuka Beach includes engaging families and the community. The staff indicated their willingness to talk with families about health concerns; however, as previously mentioned, this was often clouded by their perception that they were not the 'experts' and that a health professional was likely to have more authority and influence to speak on health matters.

> *If there's school sores, we'll ring the family to take them home and take them to the doctor. But I think the message is stronger to a parent if it's coming from a health professional rather than a teacher saying, or the office lady saying…*Jennifer

> *You've got to create that relationship and you've got to do it together. I'm remind them (the parents) because I'm part of it, I'm part of the whole circle that's looking after the kid…* Kate

Working together in a collegial, supportive sense, as opposed to a formal interdisciplinary one, was a theme that was identified from my observation of the Interagency meeting. During the meeting, the participants spoke about how best they could support individual students on the Learning Support register from a resourcing perspective. Many references were made to the lack of funding available to run programmes that might support small groups of students or invest in more intensive one-on-one interventions. In light of the lack of funding, meeting attendees often had to think creatively and allocate leftover funding from specific individualised student care packages to students who had not reached the threshold on their own. However, this way of allocating resources was frustratingly piecemeal and unreliable, plus there was no opportunity to plan long-term goals for the student.

> *I'm not saying you need to break rules, but I do think you need to be innovative sometimes around individual cases of children who don't always fit. I know for resourcing they need criterion and I know they need to be able to do this, this and this. But actually, it begs the question, is it working? And if it's not working, why are we doing it? Why can't we just say, actually it doesn't work, let's try it another*

> *way, let's redistribute the resource in a slightly different way. But it's all managed by bureaucracy…*Meeting Participant 6

Returning to the notion of professionals working more collaboratively across professional disciplines, I contemplated whether being able to draw on discipline-specific expertise may help school staff navigate some of these perceived bureaucratic barriers impacting access to certain types of support.

Commitment, collaboration and innovative thinking were required from teachers to ensure that students with identified health and learning needs at Tarāpuka Beach Primary can have these needs addressed, even if this is in a stop-start way. There is a sense from those I spoke with that anything is better than nothing and that the school would always find another way to meet these needs should a particular resource become unavailable.

Cultural Perspectives

As the only non-NZ European interview participant, Cassie offered valuable insights into how Pasifika[17] families relate to education staff and consider teachers as leaders. In doing so, families often have a reluctance to question teachers. Cassie commented that it was similar for health professionals:

> *I see this a lot when you work with the Pasifika families, they see the teacher as the leader. They don't question them…you go to school you listen to your teacher. Then you come home and you listen to me as your mother. It's just that kind of relationship. When it comes to health, it's the same too. They've got their own spiritual ways, when they go to the doctor, they listen to them and when they return home, they also have to listen to their spiritual leaders…* Cassie

Cassie went on to explain that this somewhat hierarchical way of thinking was part of the day-to-day Pasifika family functioning too:

> *The mums are usually frontline. You see them but behind them are the dads, and the father at home will have the final say. Mum may come home and say, I am getting medicine and dad will say no...* Cassie

In light of Cassie's cultural insight, I considered how stressful it could be for some families to navigate the different requests and advice from people with whom they had both personal and professional ties. Potentially this could include their doctor,

[17] Pasifika is a term used by the MoE and MoH to describe people living in New Zealand who have migrated from the Pacific Islands or who identify with the Pacific Islands because of their heritage.

their child's teacher, spiritual leaders, elders and spouses. I suspected this could be overwhelming at times and potentially impact engagement with services such as health.

Kate, a first-year teacher, offered insights on her practice and how she needed to carefully consider how she communicated any concerns about a student's health and wellbeing with their family, particularly with those from another culture than her own. Drawing on previous experiences in another non-teaching role, Kate was careful that her conversations were not misinterpreted as blaming the family or being seen as superior. This was difficult in regards to Pasifika families, who hold teachers in high regard in terms of superiority, and this created a level of unease for Kate:

> *I'm always very careful to not be accusatory or not be disgusted you know. I'd never think like that anyway, but I'd never want it to come across that way, especially to Island families. I think it's just risky ground as a white woman, to be all high and mighty about health…*Kate

Kate went on to explain:

> *I feel it as a tension, I have to navigate it, but I find it a good challenge because I really enjoy working with Pasifika families. I used to work as a GP secretary and a specialist secretary so, I know the history and the difficulties of getting Pasifika and Māori families to engage with health services. I kind of understand their reservations. I understand that, how some organisations or people can come across and it can be very accusatory or very derogatory. I think it stops people from engaging and so, I'm very, very sensitive to that. I try and bring up any issues in a way that's, concerned and understanding…*Kate

The way these insights were described to me, it felt as if the teachers were spending as much time navigating how to work effectively with their Pasifika families as these families who were doing the same with them and potentially other services. In my interpretation, I likened it to a respectful 'dance', with each party being careful not to tread on one another's toes.

Based on her own experiences and cultural background, Cassie emphasised the importance of teaching staff to understand how families from different cultures function and openly acknowledging different cultural perspectives and language barriers.

> *Some Pasifika that I know, are very shy and easily intimidated and there could be a language barrier there. If they go in to the doctors*

> *and the doctor say's do this, do this, do this, they just go yeah, yeah, yeah, but they don't always understand what they're getting themselves into. For example, we're sitting down in a meeting and I knew the mother had limited English language as a Tongan, and I heard everyone talking about her son and that he had ADHD, he had just been diagnosed and been prescribed Ritalin medication. The doctor asked "do you want it?" (there was no interpreter), and said "it's good for your son and it will help you". "Okay, okay" she said and agreed to it. When she came back a week later you could see she was quite upset and she was like "no my family is very angry with me because I shouldn't give him medicine. We need to pray for him" I just thought wow! Even having an interpreter there would have helped…*Cassie

It was evident from what Cassie and Kate had shared that there was potential for a power imbalance in the relationship between Pacifika parents and the teachers; this was bought about mainly by the unanticipated consequences of this complicity, communication difficulties, and conflict with spiritual values.

Cassie identified that having access to culturally appropriate health care professionals in schools could support engagement with families:

> *I find that's a barrier within schools. I haven't ever come across a Pacifika public health nurse. That just could be where I've been based, but I think having one would help. It would be the same with any, not just Pacifika, we've got a lot of the Indian community represented here too, and Chinese…*Cassie

Following this statement, Cassie and I discussed the possibility of using Community Health Workers of the same culture in the absence of a culturally appropriate health professional such as a nurse. Cassie thought this would be a good idea and added that it might be helpful for some of the solo or stay-at-home fathers at the school to have a male health worker that they could be referred to.

Summary

Tarāpuka Beach Primary is a culturally diverse and very inclusive school; The Principal leads by example, and there is a strong sense from the school staff that the student is at the heart of decision making. Classified as Decile 4, Tarāpuka Beach Primary received minimal visible health service resources from the DHB. However, the school goes to considerable lengths to ensure no child is disadvantaged. The expectation of staff regarding the relationship between schools and health services was shaped by their experiences working with the public health nursing service.

Barriers to accessibility, such as the referral system, considered unnecessarily lengthy and complex, impeded teachers from engaging and sustaining a relationship with health providers. In addition, opportunities for engaging with health services at Tarāpuka Beach Primary were limited due to a lack of visibility.

In this report, I have presented my findings based on an analysis of the data collected through different sources. My findings have aligned with, and further informed, all five issue statements outlined at the start of the study to a lesser or greater extent. To assist the reader, these issue statements are included in Table 3. The findings have also informed and confirmed some of the sub-issues presented at the outset of this study. However, it is essential in case study research for the researcher to remain open to new and unique findings, not just seek confirmation. As such, the insights around working with Pacifika families, particularly the cultural influence on their relationship with teachers, was new information, as was the apparent lack of health content in the current New Zealand undergraduate teacher training syllabus.

Table 3. Issue Statements relating to Tarāpuka Beach Primary

	Issue Statements
1	Good health is necessary for effective learning
2	Individual experiences shape teachers' perceptions of health services both professionally and personally
3	Organisational and individual culture will shape school staff's perception of health
4	Accessibility of health services will shape relationships between school staff and health services
5	The opportunities for collaboration between school staff and health service providers influence the quality of the relationship

As suggested through the subheadings provided in this report, four main themes were identified from the data. Some of these themes have relational sub-themes that provide additional context. The first theme relates to issue statements two, four and five; the findings expose the minimal health service support offered to the school and identify a relationship with health that is considered external, separate and invitational. I entitled this theme *'Reduced visibility of health services'* Is anybody out there' to reflect this.

Second theme: *'Filtering of teacher referrals'* pertains to the internal systems and processes for enacting a referral. Teachers refer children who have health or behavioural issues of concern to another person to activate the necessary help and support formally. However, some teachers articulated that they wanted to be able to access health services themselves, not necessarily via another person or system. This second theme aligns with issue statements one, three, four and five.

The third theme focused on the often-conflicting tensions at play when teachers reflected on their role in relation to their student's health and wellbeing. This theme is

named '*Supporting student health and wellbeing; is this a teacher's role?'* and aligns with issue statements one, two and three.

In the fourth theme, I highlighted the school's pragmatic stance in dealing with health-related issues without any other external support. At times this stance seems to throw up challenges for the teaching staff, which they continually navigate with care and consideration. I named this theme *'Managing without'*; this theme correlates with issue statements one, three, four and five.

The final theme was identified from the valuable insights provided about the need to consider different cultural perspectives when engaging with children and their families. I named this theme '*Cultural perspectives'* and relate this section to issue statements two and three.

Tarāpuka Beach school case findings highlight certain barriers to accessibility, such as the referral system, were sometimes considered lengthy and complex, impeding teachers from engaging and sustaining a relationship with health providers. Likewise, there were fewer opportunities for engagement with health services due to a lack of visibility. The findings also provided new insights on engaging and working more effectively with Pasifika families, particularly how culture can potentially influence Pasifika people's relationship with teachers directly. In addition, an apparent lack of health content in the current New Zealand undergraduate teacher training syllabus.

Appendix AA. Case Report 3: Ranguru Cove Primary School

Case Report Three: Ranguru Cove Primary School

Ranguru Cove School was the third and final case to be included in my study. Ranguru Cove is a large, decile ten[18] school in a city in New Zealand, with a school roll of over 600 students. The school is situated in a cosmopolitan, residential suburb close to the inner city. Historically, the suburb was a working-class area with a mixture of state and private housing however, it is now a highly sought-after, residential location with extensive redevelopment. Ranguru Cove School sits in the heart of this leafy, expensive suburb and is classified as a co-educational, state funded, contributing school, encompassing school years 1-6. The school has a Māori medium education[19] unit where students who attend, are taught in Te Reo Māori for many of their subjects.

Twenty-one percent of students at Ranguru Cove identify as Māori and learn in either the main-stream setting or in the Māori medium education unit. A further sixty-six percent of students identify as NZ European with the remaining thirteen percent identifying as Samoan, Cook Island, other European and other. Children are taught in class groups within a Modern Learning Environment (MLE)[20] and the school usually has a designated SENCO[21]. At the time of my first visit to the school did have a SENCO but she was about to leave and the school was in the process of employing a new person to this position.

When I first met with the Principal of the school, I was asked to wait in the school reception area. This was the first time I had visited the school and my initial impression was that of a highly organised environment; this was signalled not only by the order and neatness of the physical space in which I was waiting, but also in the efficient manner with which my visit was acknowledged. The school's trophy cabinet was in the same reception space and I was struck by the neatness of the display, particularly the way in which it was illuminated from within, and the trophies and shields beautifully polished. When I enquired, I was advised by the school receptionist that the school values centre on excellence, respect, care and inclusion.

[18] School deciles are used to target funding for state schools, the lower the decile, the more funding the school receives. Deciles indicate the extent the school draws their students from low socio-economic communities https://www.education.govt.nz/school/funding-and-financials/resourcing/operational-funding/school-decile-ratings/#sh-Decile

[19] Māori medium education is where students are taught all or some curriculum subjects in the Māori language for at least 51 percent of the time (Māori Language Immersion Levels 1-2). https://www.educationcounts.govt.nz/data-services/directories/maori-medium-schools

[20] A Modern Learning Environment encompasses flexible classroom spaces with integrated technology aimed at providing teachers and learners with the tools and spaces they need to optimise learning https://cdw-prod.adobecqms.net/content/dam/cdw/on-domain-cdwg/industries/k-12-education/a-modern-learning-environment.pdf

[21] The Special Educational Needs Co-ordinator. (SENCO) has the responsibility of managing and coordinating the well-being, learning and education of students identified with special educational needs (SEN). The SENCO meeting brings together other professionals involved in supporting children with SEN both from within the school and external agencies such as health and social services.

My first contact with the school Principal was warm and welcoming. I was taken into the staffroom, provided with a hot beverage and given time to explain my research and why I felt it important to include a Decile 10 school as a case. The Principal was new to the school and listened with interest, offering her own insights and sharing her professional experiences of working with the health system. The Principal was quick to agree for the school to be involved, and I was granted the opportunity to present information about the study at a staff morning tea the following week. At the morning tea, I spoke with the staff about the study and left my contact details should they wish to become a participant. Over the following ten days I received five registrations of interest to take part in the study, all of which were subsequently confirmed through further email contact.

Interview Participants

Participants initially included the Principal, three classroom teachers plus the individual who had previously held the SENCO role and who had recently left the school although was retaining close links whilst a replacement was found. During the course of the individual interviews, I recruited a sixth participant who held an administration role at the school and who was responsible for manning the sick bay as well as interfacing with families when there were health issues with students. The five participants currently employed by the school requested to be interviewed in the school environment during their non-teacher contact time. The participant who was now no longer at the school, requested to be interviewed in her home.

Based on the information gathered in the pre-interview questionnaire, an overview of the interview participants from Ranguru Cove school is included in Table 1. All six participants interviewed were female, with five identifying as NZ European and one as Other European. Five of the participants were experienced teachers, with a minimum of 20 years in the role, and they ranged in age from 44 to 61 years. The sixth participant, Kendra, a support person at the school, had worked at Ranguru Cove school for over nine years and held a wealth of institutional knowledge about the school and its community.

The information gathered from the interviews spanned an array of topics and sentiments, which provided an abundance of rich, informative data. The length of each interview ranged from 35 to 45 minutes.

Table 1. Interview Participants Ranguru Cove Primary School

Name	**Age Bracket (yrs.)**	**Ethnicity**	**Position**	**Teaching experience**	**Knowledge of available health services**	**Attendance at SENCO meetings?**	**Attendance at school PLD Sessions**
Kate	40-45	NZ European	Senior Teacher	20 years	*"Within school; there's First Aid, dressings, creams"*	Yes	Yes
Suzie	50-55	NZ European	Part-time Class Teacher	25+ years	*"There's bugger all offered"*	*"Only if I have a student being discussed"*	*"Yes, if I am working that day"*
Tanya	45-50	Other European	Principal	30 years	*"Limited knowledge of what might be available to us"*	Yes	Yes
Jodie	60-65	NZ European	Class Teacher – Māori Medium Unit	20 years	*"Institutional knowledge of what might be available to us"*	No	Yes
Saskia	45-50	NZ European	SENCO	28 years teaching, 1-year SENCO role	*"There are minimal services available"*	Yes	Yes
Kendra	50-55	NZ European	Administration staff	9 years	*"There's nothing now; used to have a public health nurse"*	No	*"No – I attend a 2 yearly First Aid Update"*

The SENCO Role at Ranguru Cove

At the time of conducting the individual interviews at the school, the designated full-time SENCO, Saskia, had recently left the school and a new person yet to be appointed. As a result of not currently having a SENCO in position, the Principal informed me that the educational needs meetings were not currently happening routinely. The senior management team and teachers were sharing some of the previously assigned SENCO work informally between themselves. One teacher in particular, was assigned to most of the student behaviour concerns and held pastoral care responsibilities. The lack of SENCO meetings presented a challenge for me as I had planned to observe one as part of my data collection plan; following a conversation with the Principal about this she agreed to forward the study information sheet to Saskia, the previous SENCO, in the event that she may be interested in participating in the study. Saskia subsequently contacted me via email and I was able to engage her as an interview participant. I used this opportunity to focus my interview with Saskia on the SENCO role at Ranguru Cove. I constructed a suite of questions based on the original SENCO meeting observation tool, to elicit how the SENCO meetings had been run in the past and to gain an insider perspective.

Saskia requested to be interviewed at her home one afternoon. When I arrived, I was greeted warmly and shown to a seat at a table. Saskia made me a cup of tea and produced a large homemade chocolate cake. Saskia chatted openly as she cut me a large slice of cake, asking me about my background and how I had chosen my research topic. I felt welcomed into Saskia's home, and her warm, friendly personality enabled us to quickly build a rapport. Saskia provided a valuable insight into the SENCO role and functioning at Ranguru Cove, and was eager to share her experiences of accessing support for children with education and health needs and of the relationship the role had with health services.

> *It is a massive job. The role is about special education needs but it's bigger than that. Any child that has a learning difference or a behavioural difference or a need, you are the go-to person and then your job is to work out is it teacher capability? Is it because the teacher needs to be upskilled? If so, it would be my job to do that and to work out whether it's something medical, is it a health issue? Is it family capability? Is it family and parenting that needs support?* ...Saskia

The way in which Saskia spoke these words, gave me a sense that the role of the SENCO was at times very busy and stressful. Curious, I asked Saskia why she had left the role and she explained that she had become unwell: *"nothing serious but I have never been sick like that in my life and I just couldn't get better; I thought to myself that I might not even be alive if I keep working like this"* Asked whether she attributed her ill health to the stressors of the SENCO role, Saskia again alluded to the heavy workload,

but felt that she had been offered sufficient support. Saskia expressed her feelings about leaving the school mid-way through the year when I enquired what it would be like for the school not having someone in the role:

> *Horrendous, and I feel very bad about that. That was my hardest thing, basically they'll prioritise. You know what's it's like from the medical profession. You have to focus on the acute need and not what we would call the prevention stuff…*Saskia

Saskia described there being no access to health service support at Ranguru Cove school, it was something in her role that she had to *"fight for"*. Saskia also reminisced about how she perceived the health and wellbeing needs of students had changed over recent years, and how accessing the right kind of help was frustrating and difficult.

> *It's a tenfold change, kids used to come to school, played with their mates, ate their lunch and ran around. You'd have one or two children that were a little bit anxious or clingy but now it's big. I would say autism is another increasing issue; you would maybe get one or two in the school when I first started teaching, now you are getting one to three per class – that's huge and we are not resourced sufficiently to support these children…Saskia*

SENCO meetings were run weekly at Ranguru Cove when Saskia was in the role, and meeting participants included the Principal, two deputy Principals, a senior teacher (who was designated the responsibility of children with behavioural and pastoral care needs), and Saskia. The meeting was run as part of the Senior Management meeting, not exclusively as a SENCO meeting. No external health or education representatives were present, and class teachers were only invited if a particular student of theirs was being discussed and further information was required. Saskia regularly met with the allocated Resource Teacher of Learning and Behaviour (RTLB)[22] to discuss what resources might be available to support individual students with their learning. The school had no regular interface with health services at these meetings despite the fact that health issues were frequently discussed.

Saskia led the section of the meeting that related to her designated SENCO role, based on a report that she had prepared at the end of the week prior. The 'live' report, situated on Google Docs[23], contained a list of the students and people working with them. The report also recorded the actions needing to be taken or discussed going forward. Saskia shared the report with the leadership team weekly, to which they

[22] Resource Teachers: Learning and Behaviour (RTLB) are funded to work together with teachers and schools to support the achievement of students in Years 1-10 with learning and/or behaviour difficulties. https://rtlb.tki.org.nz/The-RTLB-service/What-RTLB-do

[23] Google Docs: A free Web-based application in which documents and spread sheets can be created, edited and stored online. https://www.google.com/docs/about/

contributed comments. The updated report formed the agenda for the next meeting. Given that, on the whole, class teachers did not attend the SENCO meetings, I felt concerned that in the process of 'handing on' and not consistently involving the teacher, valuable information and/or nuances of a situation could be lost. To add further insight into this practice from a classroom teacher perspective, Suzie described the process of referring on in the following quote:

> *We as classroom teachers are expected to hand it over to the SENCO and to the senior management. We refer it to senior management, one of them said that she was looking after it, it was under her umbrella and to kind of, as a classroom teacher, step back and they were going to deal with it. We have to assume that they will follow up and do stuff…* Suzie

Suzie is suggesting here that she felt a little discomfort with the 'handing on' and of excluded from the next stage in the process. This activity also suggests there is a degree of 'ownership' of health issues by senior management and the person holding the SENCO role

A senior teacher at the school had the assigned role of behaviour support and pastoral care, and Saskia, as the SENCO, the role of learning support. From Saskia's perspective, the two functions had been separated for pragmatic reasons, based on the senior teacher having established relationships with families and the wider school community. These relationships had been developed over the senior teacher's long tenure at the school. The teacher would co-ordinate getting children and families to health appointments if needed, and would home visit if concerns about a student's physical health and/or behaviour existed. However, Saskia alluded to some challenges and tensions she felt about separating out these roles, she coped by only referring children to the senior teacher if they were discrete behavioural issues.

> *It was a little bit like the SENCO role had been separated into two, that's how Ranguru Cove ran it, and so that person's role was, well, she worked a lot in the classrooms and she was more about behavioural support. My role was more about learning but then behaviour and learning are really linked so… I really just called on X when I felt it was just a stand-alone issue or something….* Saskia

Tiered System of Needs

Explaining how children on the SENCO report list were presented for discussion, Saskia described a three-tier system by which she ranked children based on need. Tier one applied to children who had manageable needs within the classroom, with the provision of a little extra teacher and/or parent support. Tier two applied to children requiring an intervention from within the school, such as literacy support or a supportive reading programme. Tier three remained reserved for children who Saskia

described as having *"extreme needs"* where many agencies external to the school may have involvement. The children listed on the SENCO report had the tier category applied against their name and details of what supports were in place. Also listed, was the provider of the support, and who held overall responsibility; Saskia, or the teacher responsible for behaviour and pastoral care. This offered a practical way to prioritise the children and their needs but it seemed a very 'blunt' instrument and potentially overlooked an opportunity to consider the child and their needs in a more holistic way.

SENCO Meeting Construct

Saskia described the SENCO meeting as occurring *"around a table"* with all members of the meeting contributing freely. The dialogue centred on resources, time frames and who might oversee the intervention if Saskia felt she did not have time. The meetings lasted for up to an hour, with, on average, seven cases discussed in some depth. Collaborative discussions occurred around possible strategies and solutions for supporting students:

> *It was a very open, very honest meeting, if people disagreed, they would definitely say, "I disagree", and then we would come to some kind of arrangement…*Saskia

When concerns or queries about the health of students were raised, Saskia explained that she took on the responsibility of following up with external health providers. Saskia described this as often challenging and of the need to be persistent and tenacious:

> *You've got to be aggressive but not in a negative way. I had to be aggressive with the local hospital, you don't take no for an answer. If you don't hear back, you ring again and again, and again and again. I would just have a list on my wall and I would date how many times I've rung or emailed; you have to fight for those kids you really do...* Saskia.

As Saskia described these challenges of accessing health services, she spoke with emotion and exasperation; why did this have to be such a difficult process? I wondered how much of the difficulty Saskia was experiencing, may be being caused by the internal operating systems, protocols and polices of the health sector itself?

Despite not being able to observe the Ranguru Cove SENCO meeting first hand, Saskia provided me with a valuable insider insight. Over the course of Saskia's interview, I had deduced that health support was not visible or easy to access at Ranguru Cove and this added an additional burden to the SENCO role.

Professional Learning and Development

Professional Learning and Development (PLD) opportunities were offered to staff weekly, at Ranguru Cove school, and lasted for approximately an hour and a half. Two of these meetings per term were reserved for planning and general school business. The senior leadership team at the school were responsible for planning and choosing the education offered. The focus for staff over the previous twelve months had been on student or learner agency[24]. Prior to this, group education opportunities had focused largely on pedagogical topics. The opportunity to learn about health conditions that might impact on educational outcomes for children to date had been minimal as referenced in Table 2. However, Tanya the new Principal was only able to provide minimal retrospective detail on the PLD offered in the previous two years.

Table 2. Ranguru Cove Primary: Professional Learning and Development (PLD) Topics 2017 - 2018

Topic	**Health Related?**	**Additional Information**
Student/ Learner Agency	*No*	Focus for 2018 Student Agency
First Aid	*Yes*	Two yearly updates
Staff Planning	*No*	Curriculum and general school planning

Suzie, a class teacher confirmed the lack of PLD relating to student's physical, behavioural and mental health:

> *We do a lot of PD but it's nearly always about, teaching, learning or enquiry. We're doing lots of enquiry stuff but it's very little about health. Every second year we have, first aid training and every year we get retrained on how to use an epi pen. But, as far as health issues with children go, I can't think of any…* Suzie

PLD was offered on an "as needs" basis for teachers who had a child in their class with a long-term health condition. It was the SENCO's role to look for where that support and education might come from, and to arrange for the teacher to be released from their class to attend:

> *My job would be to give support if the teacher came to me and said I've got this child in the class with diabetes, I know there is an action plan but I'd like to know more. My job then would to support them (the teacher), to say right, let's look for a course together or you look*

[24] Student or Learner Agency is having the power or capacity to act and make choices. In a learner-centred environment, learners have agency over their learning and classroom systems serve the needs and interests of the learner. http://elearning.tki.org.nz/Teaching/Learner-agency

> *for one and I'll try and get the funding for you or I'll take your class while you go…*Saskia

I explored the targeted PLD approach to health with Tanya the Principal who explained that the cost of providing PLD to all staff on health issues that may only pertain to one or two students, a minority, was prohibitive. There was also a notion that teachers who were not interacting with that particular student would consider attending training as not a good use of their time. It was expected that whoever was released to attend targeted training, would feed back to their teaching colleagues in the individual studios.

When asked about providing general education on topics such as Attention Deficit Disorder (ADD) or Autism (ASD), Tanya agreed that it would be ideal but that there were too many competing priorities. The pragmatic approach was to offer it to teachers who had students in their class with conditions such as these. Tanya talked about the amount of money the school invests each year in offering such targeted education opportunities:

> *Yeah, and we as a school invest a lot of money into that. You know that's $350 a day for a reliever. So, we would maybe release that teacher, they'd have some time with the experts, they'd have time to play. You roll that out a couple of times a year for that teacher over maybe 10 children that's a lot of money…*Tanya

Overall, there was a sense from the participants that they would have liked more health-related topics included in their PLD programme, particularly mental health. Many alluded to the increasing number of students who started at the school with existing anxiety and other mental health and behavioural issues. Mental health was classified by many of the participants, as a health issue that significantly impacted on learning, but finding help and support was challenging. Saskia found mental health needs in the student's distressing, but felt that the team lacked expertise, and that staff knowledge in this area was an issue that would need to be addressed:

> *The increase in mental health is really, very, very upsetting; to see those young kids coming through is so sad. It's something that schools are spending a lot of time on and we feel that it is a health issue but we don't have the support or training to know about those things. Everyone is just doing the best they can but it's not necessarily, the right thing to do. That's something going forward, especially in higher decile schools, that it's just going to have to be properly addressed…*Saskia

Although identified as impacting on learning, the participants did not consistently link mental health and behaviour to physical health and vice versa. Discussions seemed to

consider these as separate entities. The new Principal, Tanya was aware of this and described the current practice situation to me:

> *Before I came here behaviour and learning were separate responsibilities in terms of the SENCO. The 'behaviour DP', well she was a DP has now gone into what we call a pastoral care role. We have a person allocated for pastoral care and behaviour; they manage that specifically…*Saskia

The default for considering including PLD content about health issues, was to start from a health and safety perspective; knowing how to prevent and treat accidents, rather than knowing about identify and manage students with long term health conditions.

Individual Interviews

Health Services Are Not Visible or Accessible to Us

One of the questions contained within the participant pre-interview questionnaire, provided an early insight into the participants knowledge of what health services were available in and to the school. Consistent across the participant questionnaires, was the assertion that minimal or no visible external health support was available to the school:

> *Bugger all health services are offered here...*Suzie

In addition, some participants lamented the past when health services were more visible to them and how much they had valued this, particularly in relation to public health nursing. There was a perception that previous services had been withdrawn from the school on the basis of their decile ranking, and this had impacted on their ability to access support for health issues promptly:

> *The nursing service was withdrawn from us probably five or six years ago due to us being a decile 10 school. A health nurse used to come in regularly… we desperately need it back in this school, just because we're a decile 10 it doesn't mean that the children don't get sick or don't get injured or that we don't need support...*Kendra

Suzie and Tanya acknowledged that a higher decile school may not need as much health support as that of a lower decile. However, they also spoke about the challenges of accessing support for a percentage of Ranguru Cove students and their families who were clearly struggling to cope with managing long-term health conditions, economic hardship and social problems in their lives.

> *I'm sure a decile 10 school doesn't need quite as much as the lower decile schools but there's still a real need for a small percentage of*

> *our kids. We are decile 10, but there are still kids in social welfare, there are refugee families, there are kids with high anxiety levels…*Suzie

The public health nursing service was the most referenced health service, with all participants having an understanding and knowledge of this service despite it not being perceived as visible or accessible to them. Much of this knowledge had been gained through previous experience of working in schools where the service had been more readily available. The participants who had been at the school for a longer length of time, reminisced about the time when they did have access to the service and the perceived value it had brought to the staff and students. Saskia reflected on how nursing meant she had felt more supported in addressing health needs of her students:

> *It was a really lovely environment to work in, to have a health person supporting us. It's just another hand because basically health needs are huge in schools. It's another person that can bring expertise, you don't have to constantly upskill yourself or try to make contact with somebody who knows…*Saskia

The external relationship that existed with health, whether visible or invisible, rested predominantly with the public health nursing service. The conversations frequently defaulted to the nursing service, with this appearing to be the preferred way of interfacing with health on a regular basis. This may be because it was a familiar service that in their view, had worked well in the past. Jodie expressed how she thought the nurse could bring value but also the importance of that person knowing and understanding the school and local community.

> *The nurse would be the practitioner that we could, refer to first of all as long as it's someone who has also a good local community knowledge of what are the services out there. I'd see that person as also someone who is informing us when we have questions, like how can we help this child? They can tell us where this child could go…*Jodie

In addition to the nurse knowing and understanding the community, other desirable attributes were discussed by the participants. These included the nurse being approachable, caring and understanding, as well as being visible and accessible. Having a conduit to health in the form of a nurse was seen as another benefit, potentially streamlining decision making and timeliness to accessing the right support for a child:

> *There wouldn't need to be so many people involved, if I needed to contact certain people, I could just go to the one person and she would advise us but as it is now, I'm dipping into lots of different piles to find the right help and this takes time...*Kendra

In addition to the lack of visibility (coupled with perceived availability), another barrier for staff to access health support for students who were eligible, was securing the necessary funding for students. This largely fell on the SENCO at the school to navigate and took up a huge amount of her time. The amount of paperwork involved in completing an application was considered hugely prohibitive and not worth doing unless one was confident of a positive outcome:

> *You've just got to be creative with all your funding applications. Applying for ORRS funding is like a marriage and divorce all in one. It's a like a full-time job to do it. And I would not recommend it unless you thought you had higher than a 90% chance of getting it. You'd be much better off yourself, with the time taken to do it, sitting one on one to support that child and the teacher. It's hugely time consuming, very specialised, and labour intensive. You've got to know the language; you've got to know how to do it…* Saskia

I detected a huge sense of frustration about how hard funding was to get for students who needed it, with the school often self-funding initiatives that could be utilised across groups of students. Many of the other teachers that I interviewed, conferred with Saskia, often alluding to having to 'balance' their decision (based on the time they had available) to complete a referral for health service support if a child was borderline in meeting the acceptance criteria:

> *You're so damn busy trying to get the educational side of things done and just running the classroom, looking after the kids and teaching them as well as the normal meetings and PD and everything. You run out of time to search for healthcare…* Suzie

Kate talked to me about the acceptability of having an accessible health service at the school, she spoke about this in the context of the public health nursing services. Kate was concerned about how families might perceive this and how those who did choose to engage, may be stigmatised. Kate also doubted how useful it would be from a practical perspective, given that many parents and caregivers worked during the day:

> *A barrier might be how it* (the health service) *was perceived. We do have a diverse range of families so, whether it was seen as something that certain families went to but certain families wouldn't use…. Most parents are working, part time or full time so that would make it hard, even to come, I mean it's hard to go to the doctor so it's also hard to come to the school during the day. Also, I don't know how easy it would be for the teacher to access. If a teacher was concerned about a child, it would be easiest for us to email the nurse because we only have a certain amount of time during the break and I guess the nurse may or may not be here at the time…* Kate

Kate offered solutions to the issue of accessibility in terms of timing, suggesting that health service support could be offered before and after school and on set days, that could be diarised in the school calendar. Suzie also alluded to this too, advocating that staff would need upskilling on what service was available, by whom and when. However, Suzie thought parents and caregivers at the school would most likely prefer to see their own GP rather than a visiting health service at the school. When I enquired further, I sensed that a visiting nursing service was considered of a lower standard compared with that of a GP and in addition, families would not want their health information to potentially be accessible to the school. Not only was health considered external by those interviewed, but from what was being reported, by members of the wider school community too.

Managing Learning and Health Needs

Throughout the individual interviews the participants discussed, deliberated and questioned their role and responsibilities in managing the health and wellbeing of the students at the school. This was done in the context of their existing workload as well as the supposed boundaries of responsibility and expertise between themselves, the families and the health sector. Many viewed managing the health needs of their students as an additional burden, but at the same time acknowledged the interrelatedness of health and learning.

> *You can't teach a kid that's not at school through truancy or, is unwell or unhappy. You've kind of got to look at the holistic nature of the child. They can't learn if they can't hear or if they can't see properly. They can't learn if they're in pain so are always having to look for that…*Suzie

Some of the participants likened their role to being a parent, of needing to set behavioural expectations and boundaries. This was in addition to tending to basic physical needs such as reminding the child to wear a warm jersey, change wet clothing, drink more water or go to the toilet.

> *They are all my babies and I wouldn't treat them any differently as I would my own children …*Kendra

Participants spoke about taking care to foster good relationships with families so conversations around the health and wellbeing of the child were received in the way that was intended. I noted that in my interviews with participants, much reference was made to the tenuous nature of parental and teacher relationships and of parental wellbeing. Parental anxiety and parental expectation on children were also alluded to frequently. Being diplomatic and discreet when discussing student health concerns such as headlice, toileting and food, was seen as essential so as not to cause offense or embarrassment to families and risk harming the teacher-parent relationship.

Maintaining an open and positive relationship with families was considered important in supporting student health and wellbeing both at school and in the home:

> *It's very grey isn't? We have to be really careful, you have to tread really, really carefully, because you don't want to ruin your relationship with the family. You've got to earn that trust and build that relationship first so that you can talk about the things that you're worried about like the nits or the skin infections or the child's behaviour…*Kate

In addition to having a pseudo parental role, those interviewed also saw themselves as role models to the children in promoting the school values and behavioural expectations:

> *I definitely liken my role to that of a parent especially in teaching about behavioural expectations, boundaries, how to relate to other children and how to relate to adults. You are modelling the whole time, the type of behaviours you would expect…*Jodie

The teachers that I interviewed at Ranguru Cove gave an impression of being highly professional and of taking their teaching roles and responsibilities very seriously. There was a genuine sense of concern and frustration that accessing health support for children was unnecessarily time-consuming and difficult. The response to this was to develop ways to 'get by' and do what needed to be done in both a pragmatic and efficient way.

Getting by Without Access to School Health Services

Being a large, busy school, affected how Ranguru Cove interfaced with health and had led them to develop their own systems for reasons of both efficiency and consistency. Informative descriptions were provided by the interview participants as to how the school currently manages the health needs of students in the perceived absence of health service support. 'Getting by' without health service support involved utilising the office staff, the wider school and local community, national health lines and websites, in-house referral system and divvying up of roles and responsibilities across senior members of staff.

Kate spoke about 'flagging' issues of concern (health) to the office staff at the school who then deal with the issue via liaison with the appropriate external service and the parent/caregiver. This somewhat pragmatic approach sat comfortably with most of the class teachers who were preoccupied with the lack of time they had to deal with their student's health concerns and were confident in the relationship the office staff had with the families. Kate explained to me that she passes the concerns on and doesn't generally deal with health issues herself:

> *Me being able to send a child that I'm concerned about the to the office and the office staff to take care of that for me, is fantastic. Because that means I don't have to necessarily call the family or write a note and send it home or send an email. The office staff just tends to do that for us, but that's not really their job, but it's all we have you know…*Kate

Suzie supported this, explaining that on a day-to-day basis, the office staff were usually the first point of call for a minor health issue or treatment. Suzie commented that the teachers were too busy to have to deal with this themselves, and that the office staff often knew the families really well and were used to dealing with them. Suzie described the office staff as the 'face of the school' and that their relationship with the families was often better than that of the class teachers. This reliance on the two office ladies to deal with health issues was referred to by all of the interview participants and appeared to be the accepted norm.

> *We go and see our office person initially, and then it's up to the office staff to phone the parents or to treat the child as well as they can. Occasionally it goes through one of our DPs but she's less medical and more behavioural. So, if it's medical it would go to the office staff and they either tape and bandage or phone home to try and get help. If there wasn't help then I know that they sometimes take the child to a GP or a medical professional…*Suzie

I was curious as to what the office ladies thought about their role in supporting the health needs of the students. One in particular, Kendra, was referred to as someone the children and families were fond of and who had an abundance of knowledge of the school community having been at Wallis Gove for over nine years. Kendra had agreed to be interviewed and offered a valuable insight into her role and responsibilities. When I first met Kendra, I was struck by her warmth and openness; she had a bright smiley face and a cosy, caring manner about her. I sensed that children of all ages would feel very comfortable and safe in her presence. Kendra emitted an air of calm, confidence and trustworthiness, this demeanour I imagined, would bode well for interacting with parents and caregivers. Kendra explained that her ever increasing role in supporting health needs of students at the school was borne largely out of necessity following the withdrawal of the public health nursing service six years prior. In the comment below Kendra described her role:

> *I'm the enrolments officer and receptionist plus I am number one in the sick bay. Some of the children call me the doctor at the school! I actually deal with that side of it plus the health and safety side of things, you know I follow up after injuries. I also have a lot of children that do just come in and just need to have a chat. So, you know, I'm that sort of in-between person between parents and pupils and that…*Kendra

The more we spoke; it became clear that Kendra in particular, was the main default for the teachers in supporting the everyday health needs of students at the school. In addition, she was often regarded as a substitute parent during school hours, by many of the students. As our interview progressed, it was apparent that Kendra took this responsibility very seriously, but was not always comfortable with some of the things she was being asked to do or the ensuing accountability:

> *It's in my job description that I am the first aider. There's two of us plus the teachers. We all do the same training every two years but I seem to have ended up being the number one go-to person. When the health nurse was withdrawn from us, a lot was asked of me to like help train the staff in certain things like epi pens and the likes of that, and I wasn't comfortable with doing that. We were very lucky that we had, a staff member whose partner was a doctor so she would come in and do the training for us. Same with talking about asthma and the likes, I'm not trained to do that sort of stuff and that's what I said, I'm actually not going to do that because I wasn't comfortable to do that. I just felt that was, it was a little bit too much pressure to do it...*Kendra

I enquired about the training and resources that had been made available to Kendra to support her in this role; Kendra told me that she attended first aid training every two years. Kendra added that she utilised the national 0800 Health Line[25] to access additional guidance and support as well as a local GP practice. Kendra also alluded to spending time on the internet updating herself on common conditions such as asthma, allergy and skin infections; she reminisced about the time when there was a visiting nursing service and how they had provided this level of knowledge and expertise:

> *Having the health nurse was great, I could just pick her brains with things and she would just, feed me lots of information. I'm not a professional you know and that's first and foremost. I'm not a professional. I've had basic first aid training, that's it. As much as the kids call me the doctor at the school, I'm not a doctor and I'm not a nurse…*Kendra

Kendra described the difficulty she had in navigating where her role began and ended in supporting the health needs of the students and figuring out the key supports 'in the moment'. Kendra relayed an incident that happened at the school that had caused her to reconsider her role, her boundaries, and how well she was supported.

The incident had involved a parent becoming angry with Kendra over what she perceived as an unacceptable delay in getting help for her child who had fallen at school and had a suspected fracture. The day after the incident the parent and the

[25] Healthline is funded by the Ministry of Health and provides free health advice and information to the public 24 hours a day, 7 days a week. https://www.health.govt.nz/your-health/services-and-support/health-care-services/healthline

Principal at the time, had questioned Kendra's actions and had accused her of not being assertive enough on the phone with the ambulance service. Kendra was tearful and angry as she reflected on the incident:

> *I felt like I had let that family down which was dreadful. There were a couple of comments that were passed around school; someone said to me "maybe you should have been a bit more forceful on the phone" I felt like they didn't trust me anymore because they said to me "well, we need to get a doctor on board so if you ever have any questions about whether you're doing the right thing you can ring the doctor". I'm like, you know I've done this now for 8 years, you've trusted me for 8 years to do this, now all of a sudden, I actually feel like you don't trust me to do the job and to do the right thing. It was not a good feeling and it did take me a little while to work through it in my head that you know it's actually okay. I didn't do anything wrong…*Kendra

Kendra spoke about the erosion of trust that had subsequently ensued between herself, the families and the school leadership team at the time; she described being ignored by the affected mother and the "paralysing" effect this had on her. This had influenced how safe she felt in her relationships with the children too:

> *I actually said to my boss, "because I'm in the back room with children alone a lot, I actually don't want that anymore; all I need is one child to say, one thing like, Kendra did this or Kendra did that, I want someone else to be working in there with me". I said I needed more support in there. I did feel like there was, way too much responsibility put on me in that role because I'm not trained in that. Anyway, it just ran its course you know, everything got swept under the carpet. The support didn't ever eventuate…*Kendra

The expectations of Kendra being perceived as the 'go-to' person by the teaching staff extended to the parents and caregivers. A child with a long-term health condition requiring regular monitoring and/or follow-up at school was most often tended to by Kendra:

> *We have some children that have very specific health needs, and there is a certain level of expectation from the families. I always meet with them before their child starts school, any child that is anaphylactic, diabetic anything like that., I have a very close relationships with these families and I do manage all of that side of it too, like medical kits and the likes of that. Our diabetic girls come to me, I'm their go-to person, they come and communicate with me about their specific needs...* Kendra

This dependency on one person is in itself a burden for Kendra, who articulated the need for further support and back-up. The following comment illustrates why this was so important:

> *I had one of our little fellas who comes to me to take medication in the middle of the day. I wasn't here one day and I said to him the next day "oh buddy you didn't come and take your medicine yesterday" he said "no you weren't here". So, this is where it falls down, because the children get so used to me…*Kendra

Adopting pragmatic solutions to 'get by' in the perceived absence of external health service support is part of everyday life for the staff of Ranguru Cove school. Solutions have been developed with good intent and my interpretation was, that these are generally effective, but the responsibility lies heavily on a small number of people and ultimately this may not always be in those individuals', or the students' best interests.

Culture Matters

Throughout my data collection, it became clear that culture from both an ethnic and ethos perspective, influences how Ranguru Cove and the school community, relate to, and interact with, health services. There is a belief which has manifested over time and related to decile ranking, that they are unique, this uniqueness lies in the types of health needs experienced by the children attending the school, the belief that they are ineligible for external health service support and of the school having a Māori Medium unit operating within it.

The staff value the known, in-house system of referral and support for children with health needs. The current system is seen to be effective and there is an assumption that the school, because of its decile ranking, would not be eligible for any additional, external assistance. This not ideal from the school's perspective but they were at a loss to know how to change things; there was resignation that the situation was what it was. Consistent with this, the ethos of the school had become about managing themselves:

> *In my time here we haven't accessed the health services; my experience is that there is a culture at the school that we are decile 10 so, we should not expect help and support. I'm trying to change that culture to say that actually there is help and support out there, and our children are as entitled to it as anybody else…*Tanya

This was also evident when I interviewed Jodie, who was sceptical about what benefit an external service would be to the school and students. From her viewpoint, the school staff already had some knowledge themselves and knew how to access help with most common physical health concerns:

> *You know we know what the services are out there…. We know how to use an epi pen. We know where the epi pens are, we know what to do when we go on trips. We know the children who are diabetic and what they require. We know what to do with the asthmatic children and that you have to be considering them all the time when you're doing physical activities blah de blah… We have all that information and we know what to do…. Jodie*

Earlier in our interview, Jodie had discussed the importance of supporting health and wellbeing from a holistic perspective, however, the emphasis in this comment seems to rest solely on an ability to address and manage physical health needs rather than on prevention or early identification. It was as if Jodie had given up on an external health service being able to offer anything other than what they (the school) had now learned to manage themselves. Jodie described supporting a child with vision problems:

> *I can think of a case two years ago where I had a child for whom I was sure it was an eye tracking problem. I helped the family who couldn't afford a behavioural optometrist, we found ways of working through WINZ to get the funding, to get an appointment for one of those tests to be done and then as a school we provided half of the, costs for the child to get glasses…*Jodie

In contrast, Kendra appeared to understand there was a benefit to being able to work alongside health services in order to address a variety of issues from attendance, social needs and physical ill health over choosing to favour an autonomist culture. Kendra perceived a visiting health service positively in that they could act as a conduit to accessing a variety of specialist supports such as developmental and behavioural assessments for children and their families:

> *I mean with us being a decile 10 school, we do have children that come from very low-income families. We get low income to very, high income families. I think we would really benefit from having a health professional come along, be it a health nurse or someone like that. Just because it's decile 10 doesn't mean children don't get sick or they don't have other issues with things you know...*Kendra

Most of the interview participants considered the school to be unique in relation to its health needs, with some students and their families coping very well but others (a minority) struggling on both poverty and emotional health fronts. However, due to the perception that visiting health services were not available to the school, this further reinforced the 'culture of managing alone'. Being 'outside the norm' poses an additional layer of health need that was not easily addressed with their existing resources. Jodie, Kendra, and the remaining staff that I interviewed, had expressed concern about the increase in anxiety levels amongst students and their families, the

perception being, that this was an issue likely to be more prevalent because they were a higher decile school.

> *The needs of this school are really different. We have, I would say, a high degree of anxiety amongst our families in terms of being a failure, that's students and parents… It's difficult to be different here, to wear clothing that isn't brand new and shiny. To have lunches that are unhealthy puts you outside of the norm here...*Tanya

When asked what they thought precipitated the increase in anxiety disorders observed at Ranguru Cove, the participants commented on the lack of resilience and acceptance of difference, by many of the students. Tanya attempted to sum this up in the following observation:

> *Children in lower decile schools don't need the resilience, they have that. They have to draw on that every day. They need safety, they need aspiration, they need self-belief, but they have resilience. Our children here need resilience, they need perseverance, they need to understand the value of collaboration and achieving in a team. That it's not all about you…*Tanya

Tanya's comments were drawn on comparisons of the time she had worked in a lower decile school; her recent move to Ranguru Cove had highlighted some stark comparisons about which she spoke candidly, particularly in relation to culture around practice and understandings related to health issues. These perceived differences were also mentioned by other participants during the individual interviews. Jodie, in comparing the issue of anxiety between children who attended the Māori medium unit and those attending mainstream classes, felt that anxiety was more prevalent in the main-stream students. Jodie proposed that this was due to the application of a Māori model of health and wellbeing in the units.

> *The mere fact of establishing immersion units meets that pillar of what Mason Durie calls Te Whare Tapa Whā, you know so that whanau help build spiritual wellbeing; just the way we operate under tikanga Māori I think helps to build spiritual wellbeing…*Jodie

Jodie described how families of children attending the Māori Medium unit 'wrapped around' each other in times of hardship, providing whatever they could to support each other. In addition to nurturing their child's identity as Māori, Jodie also understood that families chose to have their child educated in an immersion unit so as to build and support their own connections with other Māori from the community, sharing experiences and building friendships. Jodie had observed that this had a very positive impact on student wellbeing.

However, when it came to accessing external help and support specifically for children attending the unit, Jodie lamented that there were few, if any, Māori health providers operating in central Auckland:

> *If I had a family who was gravely in need of support, I'm not sure at the moment where I would, go straight away. I can't think of one specifically, culturally responsive, Māori health service in the inner city. I can't think of one, or a clinic…*Jodie

This was considered as a significant challenge when trying at access wraparound support services specifically for Māori children and their whānau. Jodie also expressed caution in utilising mainstream health service providers, suggesting that the level of cultural competence in some clinicians, could negatively impact both initial and sustained engagement.

Staff adopting a culture of them 'knowing what to do' and the habit that had developed over time of 'managing alone', was a strong sentiment across all of the interviews, often described in a way that suggested they didn't need to be told by an outsider. Many participants confidently described to me how they manage health related conditions and scenarios at the school. Coming from a health background myself, I was concerned that those I interviewed, didn't know what they didn't know, but neither had they been afforded in-house opportunities to build on this. For example, in their PLD and in providing opportunities for class teachers to work *directly* with health providers rather than passing their students health needs over to another designated person in the school to follow-up on.

Summary

The staff at Ranguru Cove want to be able to connect with health service providers, both mainstream and Māori. However, the school staff do not believe that they are eligible for a visiting health service due to their decile ranking. The lack of external visiting health support has prompted the school to develop ways of working to address the health needs of their students in a way they consider best. This has resulted in a referral system whereby teachers pass on their concerns to a designated individual. This individual is allocated a specific and separate responsibility relating to either behaviour, pastoral care, learning or physical health. Those interviewed, implied that if access to health services, particularly public health nursing, was improved and became more visible, it would be imperative the provider understands the specific needs that arise in light of this diverse, and culturally unique setting.

My findings from this case study closely align with and inform issue statements 2,3,4 and 5 (refer Table 3). It is evident that individual and organisational culture and experience, has helped shape and influence interactions with health services over time. In addition, decreased visibility of health services at the school and the

consequent lack of opportunity to work alongside health service providers, has directly influenced the quality of the relationship.

Table 3. Issue Statements relating to Ranguru Cove Findings

	Issue Statements
2	Individual experiences shape school staff's perceptions of health services both professionally and personally
3	Organisational and individual culture will shape school staff's perception of health
4	Accessibility of health services will shape relationships between health services and education personnel
5	The opportunities for collaboration between the health service provider and school staff influences the quality of the relationship