
Building Collaboration and Balancing Stakeholder Needs in Comprehensive Health and Guidance Programming

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ABSTRACT

Comprehensive Health and Guidance initiatives highlight the need for increased involvement of various stakeholder groups in identifying and meeting the emotional, social, academic, and physical needs of children and adolescents. The integration of multiple perspectives in program planning facilitates an understanding of differences and opens the door to collaborative decision making about program priorities as well as coordinated investment in program initiatives. Active involvement of students, in particular, beginning at the planning stages, fosters personal and collective empowerment and ensures that the programs created are relevant, responsive, and that they find the support they need to achieve optimum impact.

RÉSUMÉ

Des initiatives en matière de services complets de santé et d'orientation [*Comprehensive Health and Guidance*] ont souligné la nécessité d'une participation accrue des divers groupes intéressés, ceci afin d'identifier et de satisfaire les besoins affectifs, sociaux, éducatifs et physiques des enfants et des adolescents. L'intégration de perspectives multiples, lors de l'élaboration d'un programme, favorise la compréhension des différences et ouvre la porte à des prises de décision collectives concernant les priorités de programme. Elle permet également une meilleure coordination des efforts et ressources investis dans les diverses initiatives de programme. L'engagement actif des élèves, en particulier, et ceci dès le stade de la planification, encourage une prise en charge personnelle et collective. Il garantit que les programmes conçus seront appropriés et adaptés aux besoins particuliers des élèves. C'est également la meilleure façon d'obtenir le soutien nécessaire aux programmes pour qu'ils aient un impact maximum.

Over the past several decades, attention has increasingly been drawn to the mental and physical health needs of Canadian children and adolescents. As a result, the role of schools has expanded to address guidance and health needs in a more systematic and comprehensive manner. Mental and physical well-being are essential to the success of children at every point in their development and form a necessary prerequisite to learning (Symons, Cinelli, James, & Groff, 1997). It is during the school years that life-long behaviour patterns are developed. If early deficits are not addressed, adolescents are ultimately at risk of dropping out of school or becoming involved in other self-defeating or self-destructive behaviours (Cameron, Mutter, & Hamilton, 1991).

A growing body of research indicates that Comprehensive School Health and Comprehensive Guidance and Counselling approaches typically are accompanied by reduced absenteeism, reduced alienation from school, increased school satisfaction, increased academic performance, and an increased sense of the

relevance of school on the part of students (Hughey, Gysbers, & Starr, 1993; Lapan, Gysbers, & Sun, 1997). These initiatives in schools are an attempt to address the whole person needs of students (Diachuk et al., 1995) rather than focus on crisis issues from a remedial perspective (Cameron et al., 1991).

Common to these approaches is the recognition that people are inseparable from their environments. The school and community are a complex web of interdependent and interacting elements (Henderson, 1994). Thus, the goal of facilitating optimal student functioning and well-being is reached through a wide range of processes implemented at the school, family, community, or provincial/territorial levels (Canadian Association for School Health [CASH], 1990; Davis & Allensworth, 1994). Personal lifestyle changes are balanced with broader structural changes at the family, community, organizational, political, social, and economic levels (Allensworth, 1994; DeGraw, 1994; English, 1994). The synergistic effect of involving multiple stakeholders, integrating and coordinating efforts, providing multiple sources of reinforcement and support, and targeting multiple points of intervention, enhances the positive educational/health outcomes (Cameron et al., 1991; Wilbur, 1994).

While there is agreement on the guiding principles outlined above, there is less agreement in practice on the nature and degree of involvement that various stakeholder groups should have in program planning, implementation, and evaluation. An argument will be presented in this paper for the importance of developing Comprehensive Health and Guidance programs through a collaborative process that ultimately encourages active participation of all relevant stakeholder groups.

NEEDS ASSESSMENT: AN ESSENTIAL STARTING PLACE

The traditional focus of accountability in education has been on the means rather than the ends of programs or curricula. Program planners relied on insight, expert judgment, and the whims of administrators and community members to determine program objectives (English & Kaufman, 1975). Little attention was given to whether the program objectives were appropriate or justifiable. However, there is growing agreement that program objectives themselves must be systematically linked to the needs of the target client population.

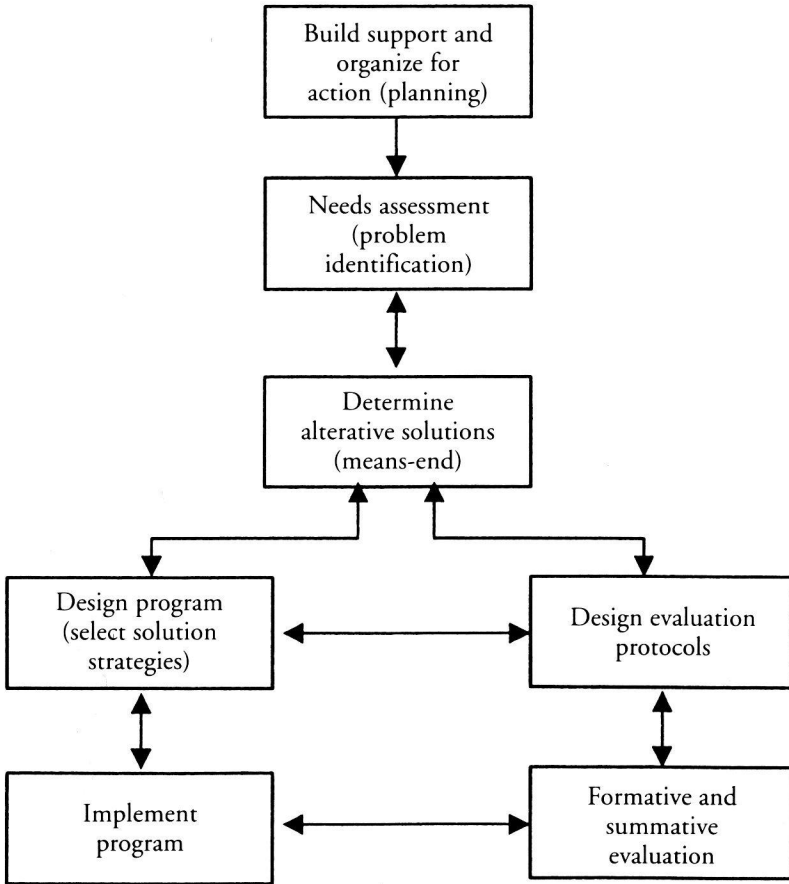
As a result, needs assessment is emerging as a more integral part of program planning. Needs assessment is a process for identifying and defining valid or needed outcomes, products, or results that become the impetus for program planning and intervention. It essentially parallels step one of the scientific method: problem definition. (See Figure 1.)

The Role of Needs Assessment in Comprehensive Health and Guidance Programming

The Comprehensive Health and Guidance literature recognizes needs assessment as an essential prerequisite for responsive programming (Hiebert, Collins, & Robinson, 2001). In practice, however, the amount of importance placed on the needs assessment process and the way in which it is implemented varies.

FIGURE 1

The role of needs assessment in the program planning and evaluation processes.



Acknowledging the necessity of needs assessment in the program planning process does not necessarily translate into a bottom-up, student-driven process. In practice, students often are the ones least likely to be directly involved in defining their own needs and establishing priorities for health and guidance programming (Berkin, 1994; Wang & Lawton, 1995).

In the literature, there is debate regarding the use of a normative versus a felt or perceived approach to define needs. Normative needs represent gaps between current conditions and established standards as defined by experts, professionals, government policy, etc. Felt needs are the phenomenologically based or perceived needs of particular individuals or groups. A normative approach suggests that needs can be objectively defined and assessed (Slade, 1994) and that educators and health professionals are in a better position to make that assessment (Berkin, 1994). A central risk in using a normative approach is that a program

will be designed for which students have no felt need and no investment. Currently, many writers place priority on the perceived or felt needs of target client populations, asserting that they provide a more sound foundation for effective program planning (Hiebert et al., 2001). Regardless of which approach is used, it is important to address the central question: "Whose reality is driving and being represented in the needs assessment process?"

STAKEHOLDER COHERENCE: GRASPING DIFFERENCES

One important implication of a dynamic and interactional definition of needs is that all stakeholders have an important role to play in identifying needs and establishing program objectives (Ames, 1994; Kane, 1994). Program failures are too often the result of top-down assessment and implementation strategies, which fail to meet needs specific to the target community. Many prevention efforts in recent years have missed the boat by targeting youth, by failing to include them in the establishment of needs or in the program planning process (Berkin, 1994). To remain responsive, an institution must avoid being captured by any one group, particularly those whose function is predominantly administrative. Stakeholder participation should include active involvement in all levels of the assessment and decision-making process itself (Berkin, 1994; Monette & Charette, 1995; Slade, 1994).

The Importance of Student Involvement

Student participation encourages interest in, commitment to, and ownership of programming and, subsequently, fuller participation therein. Students need to be empowered to take active responsibility in meeting their own needs instead of being passive recipients of knowledge, structures, or services. Kurth-Schai (1988) asserted that the ability of children and youth to actively participate in identifying and addressing personal and social needs is often underestimated. The end result is reinforcement of negative self-images rather than facilitation of a sense of empowerment. When educators or health practitioners assign needs to students under the guise of preparing them for the real world, the message students often hear is that their world is less real and less meaningful (Berkin, 1994).

Context-Specific Assessment of Needs.

There is strong empirical support for the assertion that the needs of children and youth vary across demographic areas (Collins, 1998; DeGraw, 1994). For this reason, program priorities cannot simply be transplanted from one school, community, or region to another, but must respond to specific individuals or groups. National assessments may provide useful information on trends, but are not necessarily reflective of local concerns (Kane, 1993).

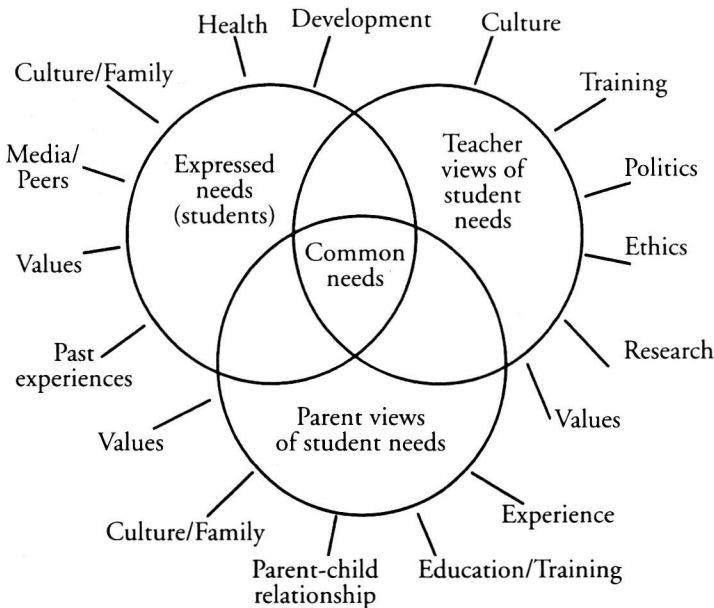
In addition, subgroups within a given population are likely to manifest differing needs profiles. Differences across gender, grade, and ethnicity have been well documented (Collins & Angen, 1997; King & Coles, 1992). For needs

assessment to be truly reflective of diverse needs, active involvement of all segments of the population must fostered.

The Role of Adult Experience and Expertise

There is considerable evidence that the priorities and expressed needs among adolescents may differ considerably from those ascribed to them by adults. Teachers and health practitioners may possess information about long-term risks and benefits of particular courses of action. For example, the emphasis by adults on smoking cessation and substance abuse programs is likely born out of their awareness of the connection between health choices and long-term wellness. However, adults may become locked into a particular view of children and adolescents which shapes their perception of student behaviour and needs (Guba & Lincoln, 1994; Mitchell, 1989). Some writers point out that the view in education, psychology, and popular media of adolescence as a time of turbulence has lead to a distortion in the needs, attitudes, and behaviours ascribed to adolescents by other members of society (Mitchell, 1989). Recent studies suggest that adults, particularly school personnel, place a higher focus on personality, crisis, or problem-focused issues like self-confidence and self-esteem, where as students seem to be more skill-based and solution-focused in their reports (Collins, 1998).

FIGURE 2
Factors influencing perception of need



Understanding and Balancing Differences

The life experience and expertise of teachers must be tempered with safeguards against bias or narrowness of vision. On the other hand, students may be limited in their conceptual framework and unable to see the complete range of potential alternatives (Montero, 1994; Nolte & Kane, 1990). What is being proposed in this paper, therefore, is the exploration of multiple perspectives and the use of collaborative decision-making models, not simply a reversal of roles with students now in the driving seat and teachers becoming passive recipients of bottom-up demands (Kane, 1993, 1994; Montero, 1994; Niles & Tiffany, 1990). Program development models which facilitate comparisons of the perceptions of various stakeholder groups provide a vehicle for exploring and understanding such differences.

Figure 2, adapted from Slade (1994), presents a useful model for arriving at a balanced decision about what defines needs for a particular individual or group. There may be some needs that all stakeholders agree are important (centre of figure), but other areas may require negotiation. This particular model highlights the influences of multiple, and often subjective, factors on the perceptions of stakeholder groups. Other program evaluation writers echo this call for pluralism in decision making (Montero, 1994). They suggest that instead of limiting the role of students and families to consumer or client (Nader, 1990), they should become full participants in decision making (Berkin, 1994).

PARTICIPATORY, COLLABORATIVE PARTNERSHIPS IN PROGRAM PLANNING

A case has been built for the importance of defining needs in a way that opens the door for students and other stakeholders to have an active voice. It is critical, however, to recognize that personal and collective values enter into the program planning and development process at numerous other points: prioritization of the emergent needs, decision making related to program planning, implementation of intervention strategies, and establishment of on-going evaluation criteria and processes. A dynamic and interactive process of negotiation and compromise among working partners forms an essential foundation for developing responsive programming. Involvement in the entire planning, implementation, and evaluation processes is needed to ensure that the goals and objectives are community-wide and community-owned and that control over health solutions is shared by all members of that community (DeGraw, 1994; Kane, 1994). Siri (1994) asserted that school-based efforts are doomed to failure without such family and community involvement.

Step one of the program planning and evaluation process outlined in Figure 1 points to the importance of building collaborative relationships from the very beginning of the planning process. Involving stakeholder groups actively in all aspects of the process will ensure that the programs created are relevant, responsive, and that they find the support they need for optimum impact. An increased sense of community is developed, communication and cooperation increased, and mutual

commitment to goals and programming heightened. The strengthening of these ties can have considerable influence on adolescent wellness and development (Price, Cioci, Penner, & Trautlein, 1993) and create increased community empowerment which is a core agenda in guidance and health promotion (Fetro, 1994).

Facilitating Multiple Stakeholder Involvement

In spite of the compelling arguments presented above, involving multiple stakeholders in health and guidance initiatives is a challenging endeavour (Allensworth, 1994; DeGraw, 1994). Isolated efforts need to be integrated and barriers must be broken down to allow for greater communication and collaboration (Wilbur, 1994). However, duplication and gaps in services can be eliminated, costs reduced, and effectiveness increased when participants share responsibility for the healthy development of the children and youth (Alberta Education, 1993).

A few practical guidelines have been established for fostering stakeholder collaboration and cooperation in health and guidance programming. The Comprehensive School Health literature and the Comprehensive Guidance literature suggest that a health and guidance coordinator be designated and a community/school health advisory council be established (Diachuk et al., 1995; Kane, 1994; Hamburg, 1994; Wilbur, 1994). This advisory group then becomes responsible for all aspects of programming.

Expanding the Target Base for Comprehensive Health and Guidance Initiatives

In keeping with the emphasis on broadening the stakeholder base, increased emphasis is being placed on targeting health interventions at the broader community, political, social, and economic levels. School-based interventions are seen as forming the hub of programming (Carlson, Tharinger, Bricklin, Demers, & Paavola, 1996), but ideally should be integrated within broader community, provincial, and national initiatives (Allensworth, 1994; DeGraw, 1994; English, 1994; Henderson, 1994). Change within any of these broader systems has the potential to impact the wellness of students at the local school level. The interaction between these systems is non-linear in nature and has wide ranging ripple effects.

To date, few attempts have been made in Canada to situate Comprehensive School Health and Comprehensive Guidance initiatives within the larger context of community, city, province, etc. (Raphael, 1996). To do so likely would involve building stronger links to the community to better understand community needs and values, and then creating partnerships with community members, organizations, media, and government (Birch, 1994; Hamburg, 1994; Jackson, 1994). Issues of cultural and economic diversity, in particular, need to be addressed by highlighting the needs of disadvantaged and ethnic minorities and building more open and more effective connections to cultural communities (English, 1994; Kane, 1993; Price et al., 1993; Raphael, 1996; Siri, 1994).

Another approach might focus on developing variables associated with levels of system change (Allensworth, 1994; DeGraw, 1994). Nicholas and Gobble

(1991), speaking of health promotion efforts generally, state: "New theories and conceptual models are needed that better account for the multitude of variables currently under investigation in health promotion" (p. 30). The Ontario Child Health Survey also suggests the need for building broader conceptual frameworks for understanding health-related needs in adolescence by looking at the linkage between societal factors and health status (Raphael, 1996).

A move towards treating systems as the units of measurement and intervention exists in family health research (Gillis, 1991). Some attempts have been made in the United States to assess programming on state, district, and school levels (Small et al., 1995), however, the same approaches have not been applied directly to the assessment of health and guidance needs. One of the areas for future research may be development of assessment instruments which view school or community as the unit of measurement, to facilitate comparison across local communities or larger geographic regions.

CAPITALIZING ON THE FULL RANGE OF STAKEHOLDER VOICES

The ultimate programming authority in schools clearly will continue to rest with school personnel and educational policy makers. However, there is evidence that actively involving relevant stakeholders can facilitate responsive, effective program development and empower community members to take an active role in enhancing their own development and overall wellness. There is a strong push in the current literature for allowing students, in particular, to have an active voice in all levels of the program development and evaluation processes. There are also an increasing number of studies that demonstrate a positive impact of bottom-up, student-driven processes. An additional challenge has been raised to expand the nature of current collaborative partnerships to include members of the broader community and to explore alternative approaches to enhancing the whole person through broader system-wide assessment and intervention strategies. The full potential of addressing the guidance and health needs of school children and adolescents through such comprehensive approaches remains to be tested.

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