Reflecting and Informing Health and Wellness: The Development of a Comprehensive School Health Course in a Bachelor of Education Program

SHELLY RUSSELL-MAYHEW
ALANA IRELAND
KERRI MURRAY
ANGELA S. ALBERGA
SARAH NUTTER
TINA GABRIELE
GAVIN PEAT
DIANNE GERELUK
University of Calgary

ABSTRACT: We present a case study articulating a process by which the University of Calgary created a health and wellness course for the Bachelor of Education (BEd) program. This course will now be a mandatory degree requirement for all students in both the elementary and secondary specializations. We focus on the essential conditions in the university environment that occurred over eight years and enabled the course preparation, such as leadership from a health champion, student involvement, support from administrators and faculty-wide awareness building, innovative teaching practices, information access and evidence/research, allocation of resources and written policy, and campus relations, an interdisciplinary team, and community outreach. Within the comprehensive school health framework, there are four distinct but related components, including social and physical environment, teaching and learning, healthy school policy, and partnerships and services. Through the case study, we illustrate how the development of this CSH course in a BEd program both reflected and informed the wellness culture of our educational institution.

Keywords: comprehensive school health, health-promoting universities, teacher education, education policy, wellness

RESUMÉ: Nous présentons une étude de cas qui explique la création d'un cours de santé et bien-être pour le Baccalauréat en Éducation (BEd) à l'Université de Calgary. Ce cours sera désormais obligatoire pour tous les étudiants qui visent à compléter le diplôme en éducation, soit en spécialisation élémentaire ou secondaire. Nous

soulignons les conditions dans l'environnement universitaire qui ont contribué pendant huit années au développement du cours, telles que le leadership d'un mentor de santé, la participation des étudiants, le soutien des administrateurs, la sensibilisation des membres à travers la faculté, les pratiques innovatrices d'enseignement, l'accès à l'information, la preuve et la recherche, l'allocation des ressources et d'une politique écrite, les relations sur le campus, une équipe interdisciplinaire, et la sensibilisation communautaire. Au sein d'un cadre complet de la santé en milieu scolaire, nous identifions quatre composantes distinctes mais étroitement liées : l'environnement social et physique, l'enseignement et l'apprentissage, une politique d'écoles saines, et partenariats et services. Au moyen d'une étude de cas, nous montrons comment ce cours sur la santé en milieu scolaire dans le programme BEd a reflété et informé la culture de bien-être dans notre institution.

Mots-clés : la santé en milieu scolaire, la promotion de la santé par les universités, la formation des enseignants, la politique éducative, le bien-être

Educational institutions at all levels may benefit from approaches such as Comprehensive School Health (CSH) that consider the health and wellness of all stakeholders. There is growing recognition across educational institutions (i.e., K–12 and university settings) that what matters is producing students who are both academically strong and living well in the world. In Canada, no existing BEd program provides mandated wellness education, yet school professionals (i.e., teachers, principals, school counsellors) are expected to contribute to school wellness once employed in school communities; this situation reveals a critical education-practice gap. In a nation where the importance of CSH has been advocated, surprisingly little has been done to address how universities educate future school professionals.

There is rising awareness regarding the importance of health and wellness on university campuses, as well as influences from broader public discourses. Unhealthy behaviours and mental, physical, and social health stressors have been identified among students, faculty, and staff in higher education (El Ansari et al., 2011; Hartman & Darab, 2012; Polat, Ozen, Kahraman, & Bostanoglu, 2015; Shaheen, Nassar, Amre, & Hamdan-Mansour, 2015). The pressure of 'work intensification' and "efficiency, productivity, and excellence" on faculty as well as students

(Hartman & Darab, 2012, p. 52) has garnered more attention in recent years. Previous notions of health and wellness in the academy have commonly been relegated to that of (a) grievances to faculty associations if workload was unjust or imbalanced, (b) medical leave for those who indicated mental or physical health issues, and/or (c) a shift out of prominent roles in administration or large academic portfolios. High rates of mental health issues amongst university students (UCalgary Mental Health Strategy, 2015), as well as burnout amongst faculty members (Watts & Robertson, 2011) has lead to a call for health and wellness to be conceived more centrally in universities as well as in K–12 school communities.

Health Promoting Universities

The World Health Organization (WHO) defines health as the "state of complete physical, mental, and social well being and not merely the absence of disease or infirmity" (WHO, 1948). Health promoting behaviours (i.e., regular exercise, nutrition, stress management, and positive relationships) have been consistently associated with reduced risk of disease and premature mortality. The WHO "Health for All" initiative (WHO, 1998) and the Ottawa Charter for Health Promotion (WHO, 1986) identified *healthy settings* as important considerations where "health is created and lived by people within the settings of their everyday life; where they learn, work, play and love" (WHO, 1986, p. 4). The Health Promoting Universities (HPU) movement later adopted this settings-based health promotion approach within higher education to incorporate the health and wellness of the whole university system. Previously, HPU programs have focused on themes of alcohol, smoking, healthy eating, mental health, and sexual health within higher education settings (Dooris & Doherty, 2010). Although higher education is garnering more interest in health-promoting frameworks recently, future research and policy agendas need to focus on systematic investment in university health and wellness programs (Dooris & Doherty, 2010; Okanagan Charter, 2015). The importance of a whole-university approach to a healthy academic culture centres on students, staff, community, curriculum, research, structures, and policies (Dooris, 2001; Dooris & Doherty, 2010).

Comprehensive School Health Framework (K–12 School Communities)

Comprehensive School Health (CSH) is an empirically supported international framework for school health and wellness

(Basch, 2011; Veugelers & Schwartz, 2010) that "address[es] school health in a planned, integrated, and holistic way in order to support improvements in student achievement and well-being" (Joint Consortium for School Health [JCSH], n.d., p.1). The CSH framework is built on evidence that healthy children are better learners and that a student's educational success impacts lifelong wellness (Bassett-Gunter, Yessis, Manske, & Gleddie, 2015). Provincial education departments are increasingly recognizing that to improve student well-being, comprehensive school health approaches are required (McIsaac, Hernandez, Kirk, & Curran, 2016).

Within the CSH framework, there are four distinct but related components including (a) social and physical environments, (b) teaching and learning, (c) healthy school policy, and (d) partnerships and services. "[W]hen actions in all four pillars are harmonized students are supported to reach their full potential as learners and as productive members of society" (Bassett-Gunter et al., 2015, p. 239). The CSH approach has been shown to support the health and wellness of all members of the school community (students, parents, and school professionals), thereby improving education outcomes for students (Allensworth & Kolbe, 2009; Fung et al., 2012; Stolp et al., 2014).

CSH is a foundational concept nationally but contextual differences exist provincially. For example, Alberta's Health Action Plan (Alberta Health Services [AHS], 2012) proposed promoting health and wellness in schools through initiatives such as Alberta Healthy School Community Wellness Fund, Ever Active Schools, and Health Promotion Coordinators. These initiatives emphasize health and wellness education in schools, university curriculums, and across sectors of government. National consensus holds that CSH is a best practice (Canadian Association for School Health, [CASH], 2006), with endorsements for CSH by the Canadian Teachers' Federation and the Canadian Association of Principals, among others (Stolp et al., 2014).

A Way Forward?

While research has highlighted that school professionals (i.e., teachers, principals, school counsellors) play a significant role in the success of CSH (Grossman, McDonald, Hammerness, & Ronfeldt, 2008), few have endeavoured to change how school professionals are prepared to address CSH. In a nation where the importance of CSH in schools has been advocated, surprisingly little has been done to address how BEd programs educate future

school professionals (Bostock, Kitt, & Kitt, 2011; Lunenberg, Korthagen, & Swennen, 2007).

Most educators feel uncomfortable and/or unprepared to address health and wellness (Hamming, Ogletree, & Wycoff-Horn, 2011; Russell-Mayhew, Peat, & Ireland, 2012; Vamos & Hayos, 2010; Whitley, Smith, & Vaillancourt, 2013). In a study designed to determine the needs of teachers responsible for health classes, Vamos and Zhou (2009) reported barriers to teaching about, and discomfort with, health and wellness topics. For example, teachers experience considerable uncertainty about how to respond to the mental health concerns of students (McIsaac, Read, Veugelers, & Kirk, 2013). Personal values, attitudes, behaviours, and experiences regarding health and wellness impact comfort and efficacy in teaching or modeling school health (Morgan & Bourke, 2008; Piran, 2004; Speller et al., 2010).

It is not enough for the academy to simply teach health and wellness; they must also create learning environments that enable and model health and wellness in university settings. For example, teachers' involvement in school wellness may be impacted by their own attitudes and beliefs (Piran, 2004), as well as their educational training experiences (Yearwood & Riley, 2010). Grossman and Schoenfeld (2005) wrote that "teachers need to understand deeply not only the content they are responsible for teaching but how to represent the content for learners of all kinds" (p. 202). In order for teachers to learn how to effectively teach, they need to consider the context, the students, the materials, and the approach (Grossman & Schoenfeld, 2005; Grossman et al., 2008; McCaughtry, 2004).

Despite mandatory K–12 health curricula across the country (Bates & Eccles, 2008; Belmont, 2014), there is a surprising silence about the pedagogies necessary to deliver such curricula. In addition to providing learning experiences consistent with those outlined in provincial health curricula, school professionals, regardless of the subject taught or administrative position held, are socially positioned to influence school health and wellness and provide positive role modeling in schools (St. Leger, 2000; Storey, Spitters, Cunningham, Schwartz, & Veugelers, 2011; Veugelers & Schwartz, 2010). However, most BEd students in Canada are not provided with any school health and wellness education in their BEd programs (Russell-Mayhew, Ireland, & Alberga, 2015).

Given this previous research, it is clear that school professionals (i.e., teachers, principals, school counsellors, school nurses) need to be better prepared to address school health during their university education. University BEd programs have not yet adequately responded to the contemporary and complex needs of

students in K–12 schools (Westen, Anderson-Butcher, & Burke, 2008), as few, if any, BEd programs take up school wellness as a focus in curriculum or professional learning. However, school professionals who receive school health and wellness education tend to be more invested in, and have a more comprehensive understanding of, school health (Byrne, Almond, Grace, & Memon, 2012; Sirakamon, Chonan, Akkadechanum, & Tuale, 2013). Thus, research is needed to elucidate the best ways to prepare school professionals to address CSH. Universities, professional institutions, and school communities need to collaborate (Greenberg et al., 2003) to address this lack of quality and provision of health and wellness education in BEd programs (Smith, Potts-Datema, & Nolte, 2005). In the spirit of addressing this need, annual professional learning opportunities were offerred to BEd students at the University of Calgary. This training was entitled "Health Champions Conference" and involved a variety of CSH learning opportunities.

The purpose of this article is to document how the process of working towards a CSH course in a faculty of education (a) revealed the importance of health and wellness in both universities and K–12 school communities, and (b) shifted over time to highlight the notion that academics can no longer espouse principles of health and wellness without reflecting on their own practices. Figure 1 portrays a visual representation of this process.

Method

A Descriptive Case Study Design

A descriptive case study design was employed in order to explore how the culture in a faculty of education shifted to support the development of an undergraduate CSH course. Descriptive case study was employed to analyze the complex political and social factors that give rise to a particular social phenomenon (Yin, 2014). Specifically, descriptive case study "traces the sequence of interpersonal events over time, describes a subculture that had rarely been the topic of previous study, and discovers key phenomena…." (p. 1). The intent of descriptive case study is to "illuminate how a decision or set of decisions were made: why they were taken, how they were implemented, and with what result" (Shramm, 1971, as cited in Yin, 2014, p. 5). Reflecting case study design recommendations made by Yin (2003), boundaries of time and place were placed on the case, such that it would account for shifts occurring in the Werklund School of Education (WSE) from 2009 to 2017. We entered the research with four propositions

based on both the personal experience of the researchers, as well as literature (Baxter & Jack, 2008). These propositions included (a) health and wellness are important constructs to consider on university campuses, (b) health and wellness have not been traditionally prioritized in BEd programs, (c) parallel to teachers in the application of CSH in K–12 schools, the academy is an integral part of the implementation of CSH in universities, and (d) a priority of health and wellness at a programmatic level requires a shift in the academic culture. The propositions and their sources are summarized in Table 1.

Timeline

Although we did not employ a time-series analysis, we provide a timeline depicting the student-based interventions with BEd students that contributed to the creation of the CSH course (see Table 2). This timeline provides important context in support of our propositions.

The shifts towards increasing emphasis around health and wellness at the post-secondary level suggest growing awareness of the need to integrate health and wellness both informally and formally at the post-secondary level. The timeline above notes the parallel movements at the faculty and campus level, and suggests a shift in ethos and awareness towards health and wellness.

At the faculty level, greater discourse about health and wellness has emerged since 2014. In 2014, a Quality of Life Committee was struck and endorsed by the Dean of Education, following perceptions that work–life balance among faculty and staff was strained. The terms of the committee were to provide opportunities to increase personal health and collective wellness among faculty and staff as well as to address areas that were creating undue stress. The initial activities focused on creating awareness through a sponsored wellness week. By 2014, the Quality of Life Committee had moved from an informal ad hoc committee to a standing committee comprised of support staff and faculty. Most recently, the move toward awareness and addressing more systemic forms of health and wellness at the faculty level has emerged as part of the key pillar in the proposed WSE Faculty Academic Plan 2018–2023 (in press). The shift from informal and ad hoc processes at the faculty reflects the increasing emphasis on health and wellness across the campus. Traditionally, wellness was commonly approached through student support services (for academic supports), wellness centres (for health and counselling services), activities organized and sponsored by the Students' Union (for fostering increased student engagement), and

intervention strategies (through campus security and risk assessment teams for those students who have been deemed in crisis or at-risk to oneself or others). Following a major task force in 2014 and consolidating the research from macro studies on health and wellness, the University of Calgary responded by developing a comprehensive wellness framework that is outlined in the results below (UCalgary Mental Health Strategy, 2015). In 2015, the University of Calgary formalized the Mental Health Strategy to promote mental health and well-being and to reduce stigma for those students who needed support (University of Calgary, 2015). With the recent rise of mental health awareness in the public sphere, universities have responded with more holistic approaches that consider how to cultivate health and wellness in higher education (http://www.ucalgary.ca/staffwellness/wellness). Alternate initiatives have included increased wellness activities and workshops for academics, quality of life committees, or becoming part of the faculty or university strategic direction (UCalgary Mental Health Strategy, 2015). At both the faculty and institution level, there has been a palpable and purposeful shift of considering health and wellness beyond the informal and personal recommendations to foster positive well-being, to that of more systemic identifiers and recommendations to better support individuals within the broader university environment. These macro shifts in thinking about health and wellness at the institutional level helped to make explicit the ways in which curricular and programmatic changes were required within a faculty of education to support BEd students as future school professionals.

Data Sources

Multiple sources of data, a benefit of case study research, were included in the current study (Baxter & Jack, 2008; Yin, 2003). Sources of data included: direct observations (1200 hours of in-kind contributions from the interdisciplinary team planning annual Health Champions conferences), policy documents (i.e., CASH, 2006), Health Champions core committee meetings (approximately 10 meetings per year since 2009), qualitative participant data from Health Champions conferences (131 completed qualitative evaluation forms 2015–2016), workshop content, and qualitative interviews with educational professionals (n = 6; 3 males and 3 females; Russell-Mayhew, Ireland, & Klingle, 2016b).

Analysis

Analysis was conducted by linking data back to propositions and determining whether propositions were supported (Yin, 2003). The CSH framework was used as a guide for data interpretation.

Results

Results are organized according to the four propositions that guided our analysis: (1) health and wellness are important on university campuses, (2) health and wellness have not been traditionally prioritized in BEd programs, (3) there is a parallel between the application of CSH in K–12 schools and HPU in universities, and (4) a priority of health and wellness at a programmatic level requires a shift in the academic culture.

Health and Wellness Are Important on University Campuses

HPU approaches advocate that it is necessary to approach health and wellness within the context of the whole university system (Dooris & Doherty, 2010). Efforts to incorporate health and wellness in larger systemic ways, such as the 2015 UCalgary Mental Health Strategy, reflect the importance of health on campuses. Data from the 2014 task force also provided evidence that it was essential to make greater efforts to take health and wellness into account at the University of Calgary. The report noted that "a majority of our students expressed feeling overwhelmed (90%), lonely (64%), very anxious (58%), or very sad (67%) at some point in the year to completing the survey" (University of Calgary 2015, p. 1). Similarly, the report noted that 33% of employees had taken long-term disability due to mental health issues. Given these startling statistics, the University committed to develop a comprehensive HPU framework that would focus on six interconnected strategic focus areas; (1) raising awareness and promoting well-being, (2) developing resilience and self-management, (3) enhancing early identification and response, (4) providing direct service and support, (5) aligning institutional policies, processes and procedures, and (6) creating and sustaining a supportive campus environment (University of Calgary, 2015, p. 2).

Although this was a reactive response, the university's commitment to developing a multifaceted HPU framework was a demonstration of the perceived significance of health and wellness on the university campus. Additional recommendations and key action items emerged from this report, including (a) a UFlourish Week through the Wellness Centre that hosts a number of events,

activities, and workshops to promote positive well-being and resilience on campus (University of Calgary, 2016a), and (b) a Thrive Priority Support Network was implemented in 2016 that sends email alerts to students when marks that are reported on the Desire2Learn (D2L) sites note a decrease or pattern of declining marks (University of Calgary, 2016b). The indicator is sent to a student with the suggestion that they meet with an individual to provide academic support, but also as a way to initiate a conversation about wellness, which commonly features as a root to the declining academic achievement.

Specific to BEd programs, pre-service and practicing teachers shared beliefs that health and wellness were of extreme importance in relation to themselves personally, as role models for students, and within K–12 schools (Russell-Mayhew et al., 2015, 2016a). In reference to universities, one interview participant suggested "we are making inroads into health promotion, but what's disappointing is that we're still struggling, even at the university level. We can talk about health and wellness and things like that, yet the big problem is changing culture, changing thinking, changing the way of belief" (Russell-Mayhew et al., 2015; Russell-Mayhew, Ireland, & Klingle, 2016a).

Health and Wellness Have Not Been Traditionally Prioritized in BEd Programs

A review of 880 BEd course descriptions across Canada in the 2013–2014 academic year revealed that only six courses included health or wellness content in required courses (Russell-Mayhew, Ireland, & Alberga, 2015). The CSH course in the WSE BEd program that resulted from this case study and that will be implemented in Winter 2018 will be the first mandatory course to systematically address health and wellness with pre-service teachers in Canada. This speaks to the paucity of health and wellness related preparation and prioritization in BEd programs. Furthermore, students who participated in the Health Champions workshops shared beliefs that greater CSH training "should be mandatory in Ed. classes," and that "this should be a course instead of just a conference. I feel that a lot of this kind of information is lacking in our courses, but is vital to teaching and working in schools" (Russell-Mayhew et al., 2016b). Data collected over three years of Health Champions workshops indicated a significant decrease in weight bias and an increase in self-efficacy to address school health-related initiatives (Russell-Mayhew et al., 2015; Russell-Mayhew et al., 2017).

Initial efforts to provide health and wellness related training in the faculty of education were met with limited interest (one faculty member, and 18 BEd students), demonstrating a lack of prioritization of health and wellness in 2009. In contrast, participation in Health Champions in 2017 included 110 second-year BEd students, as well as seven faculty members (across two faculties), and over 20 community partners. Greater interest was also mirrored in the WSE academy in 2014 when the profile of health and wellness had expanded to include the whole faculty and staff in a "Health and Wellness Week" where more than 50% of the academic and support staff stepped away from their desks and took part in noon-hour activities including yoga, campus walks, tai chi, geocaching, and indoor cycling as well as discussions on work–life balance and mindfulness. In the upcoming WSE Faculty Academic Plan 2017–2022 (WSE, in press), the notion of collective well-being has been identified, with three key priorities: (1) value and support opportunities and structures that enable healthy living and well-being, (2) value and support a culture of ethical actions and respectful collegiality, and (3) value and support a culture of scholarly and professional engagement (p. 5). The inclusion of collective well-being as a key priority is the first time that the notion of wellness has been made explicit and prioritized within a strategic plan in the Faculty of Education (WSE, in press).

There is a Parallel Between the Application of CSH in K–12 Schools and HPU in Universities

Similar to CSH in K–12 schools, striving for health and wellness in a university requires a commitment to each of the four component areas (1) social and physical environment, (2) teaching and learning, (3) healthy school policy and (4) partnerships and services. Reflecting an understanding that promoting health and wellness in schools and on university campuses is about more than just providing instruction, a BEd student emphasized the importance of understanding "how to change the structure of universities so that healthy lifestyle can be promoted all the way through schooling, [but] feeling stuck at a barrier with this" (Russell-Mayhew et al., 2015). In order to see a shift in wellness in the WSE, each component of CSH was addressed. Specifics of how the components can be applied to this case study are outlined in the discussion section.

A Priority of Health and Wellness at a Programmatic Level Requires a Shift in the Academic Culture

As outlined in the results related to the above propositions, a shift in the academic culture in the WSE was essential to prioritizing wellness. The importance of the academic culture was articulated by a WSE educator who noted the "inroads" to wellness but also the difficulty of "changing culture" (Russell-Mayhew et al., 2015). Thus, shifts in (a) policies (i.e., WSE Faculty Academic Plan 2018–2023, in press), and (b) programing (i.e., CSH course) only followed once there was also increased interest from faculty members, staff, and students (i.e., Quality of Life Committee 2014 and Health Champions Conference 2014–2017). Further details of this shift are provided in the description of essential conditions required for health and wellness.

Discussion: Essential Conditions Over Eight Years

In order to prioritize health and wellness under the framework of CSH within an institution, the following are the required essential conditions that we identified. This case study demonstrated that a shift over time toward health and wellness in the culture of the faculty contributed to and resulted in the development of a mandatory BEd course in CSH. This outcome exhibits reciprocal influence in relation to a series of essential conditions, which are described within the conceptual framework of CSH. The four interrelated components of CSH are social and physical environment, teaching and learning, healthy school policy, and partnerships and services. Observations and recommendations (i.e., essential conditions) are offered within each of the components of CSH in order to facilitate ease of application of this internationally supported framework within other BEd programs.

Social and Physical Environments

Social and physical environments within the CSH framework encompass both the quality of relationships occurring within and between stakeholder groups (i.e., staff and students), as well as the way in which the physical space influences behaviour (i.e., gathering spaces, adequate lighting, food and water availability, etc.). The essential conditions observed within this component area are (a) leadership from a health champion, (b) student involvement, (c) support from administrators, and (d) faculty-wide awareness building.

- Leadership from a health champion. Sustained commitment from a faculty member was required to bring attention to the issue of wellness, coordinate action in the academy, and engage partners in the work. This faculty member was able to mobilize human and financial resources as required and remained in a leadership role throughout the eight years of the case study.
- Student involvement. Students represent a key stakeholder group in the university, and are contributors to and beneficiaries of both a shifting culture and the implementation of an undergraduate course. All levels of students, from undergraduate to doctoral, were engaged in various aspects of the case study. Undergraduate students participated as peer mentors in the delivery of content during the Health Champions Conferences and assisted in the planning of the conference while earning credit in service learning projects. Masters and doctoral students and post-doctoral scholars were similarly involved in the planning and delivery of teaching and learning opportunities, as well as all aspects of research associated with the case study.
- Support from administrators. Support from administrators (i.e., dean, vice dean, and associate dean) included both moral and logistical. Moral support was provided through activities such as presence and/or speaking at teaching and learning opportunities and partner engagement events. Logistical support was provided to assist with mobilizing human and financial resources and with decision-making and scheduling of the course in the academic calendar.
- Faculty-wide awareness building. Awareness of health and wellness as a priority across the faculty progressed over time. This awareness occurred through an emphasis on faculty and staff wellness with initiatives such as a Quality of Life committee introduced by the dean and wellness week activities. In students, awareness-building activities for the Health Champions conference occurred annually at orientation to the BEd program.

Teaching and Learning

This CSH component area considers the totality of teaching and learning experiences occurring in a school environment, including formal classroom instruction, practicum and field study methods, and informal learning (i.e., through newsletters or online resources). The essential conditions observed in this component area are innovative teaching practices, information access, and evidence/research.

- Innovative teaching practices. Aligned with the academy's approach to teaching and learning broadly, innovative teaching practices were employed throughout the case study. Strategies included intensive block-week Health Champions conferences offered to students, peer-led content delivery, and the availability of service-learning projects. BEd students engaged in kinesthetic learning (learning through the body) and community engaged learning (community partners, health resource fair) during the Health Champions Conference.
- Information access. As the case study evolved, information was made readily available to BEd students through an online learning platform (i.e., D2L site). The site held all manner of resources to support self-directed learning and access to partner information.
- Evidence/research. Aligning the shifting wellness culture and development of the course to a research program within the lead faculty member's lab enabled allocation of human and financial resources and provided an evidence-base to continue work in the academic setting. Data collected informed the refinement and development of health and wellness content each year.

Healthy School Policy

This component of CSH refers to policies, guidelines, and practices within the school community, which collectively or individually contribute to the health and wellness of all members. The essential conditions in this component area are allocation of resources and written policy.

- Allocation of resources. As noted previously, this condition was enabled through support from administrators and alignment with research of the lead faculty member. Human resources were allocated from the academy, securing time and expertise from post-doctoral scholars to develop and implement teaching and learning strategies, and from graduate students to lead the collection of data to evaluate content and processes.
- Written policy. Campus-wide policy was born from a mounting need to address student mental health (UCalgary Mental Health Strategy, 2015), providing the academy with an opportunity to contribute to and enact that policy within the faculty. Additionally, the practices around faculty and staff health and wellness shifted over time away from a reactive approach (i.e., faculty members moving out of prominent academic roles and provision of medical leave) toward a proactive approach (i.e., health promotion).

Partnerships and Services

Partnerships and Services constitute the supportive relationships that exist between the school and the wider community, including organizations offering programming or resources that contribute to school health. This component area also represents inter-sectoral collaboration. Essential conditions here include campus relations, an interdisciplinary team, and community outreach.

- Campus relations. A key factor underpinning the shift in wellness culture was the partnership with another faculty, namely the Faculty of Kinesiology. This served to leverage additional resources, such as facility access for innovative teaching and learning opportunities, and also contributed subject matter expertise to the development of the course.
- Interdisciplinary team. To distribute workload, amplify importance, and provide sustainability in the case of staff turnover, a coordinating committee was developed. Members offered a range of skill sets and backgrounds, with cross-faculty and community participation.
- Community outreach. Intentional outreach to community partners working to support healthy school communities resulted in rich and unique partnerships. These partnerships brought a connection to the K–12 school health sector through government ministries representatives, school superintendents and practicing teachers, as well as a link to other post-secondary institutions in a potential community of practice. Opportunities to engage partners occurred through interdisciplinary team memberships, at teaching and learning workshops, as guest lecturers, in resource fairs for students, at staff wellness workshops, and in a community consultation on CSH course content during the development phase.

Summary

Over time, these essential conditions came together to allow for a mandatory course. If an education faculty takes action in these four components of CSH, it is possible to move health and wellness from the peripheries as an optional add-on in a BEd program, to essential curriculum of the teaching profession.

Outcome: A Mandatory Course in Comprehensive School Health

A healthy school community supports the wellness of all its members and healthy students make better learners. Within the broader evidence-based CSH framework, this case study described a process by which essential conditions were created for the

development of a course that supports future teachers to be health champions.

These essential conditions resulted in the development of a mandatory course entitled "Creating Healthy School Communities." Beginning in 2018, all Bachelor of Education students in the WSE will be required to take this course as part of the core curriculum. Teachers and administrators are role models responsible for creating environments that foster the health and wellness of students in K–12 schools. Correspondingly, the university is integral to establishing a culture that promotes the health and wellness of pre-service teachers who will later contribute to CSH in their roles as school professionals. This case study has demonstrated the essential conditions that together allowed for the development and implementation of a mandatory CSH course.

Conclusion

A healthy school community is one where all members, including teachers, staff, and students are supported in a culture of wellness. Though well understood as foundational for both academic success and healthy growth and development of students in primary and secondary educational settings, a CSH approach is rarely applied in higher education. As part of the continuum of education, universities and other institutions should be recognized for their influence on learning outcomes and the health and wellness of their students, faculty, and staff. This influence takes on amplified importance when one considers that faculties of education are preparing the teachers of tomorrow who are expected to positively contribute to a school environment that encourages health and wellness when they are employed. A CSH approach must be both modeled and taught at the university level for maximum impact. A shift in the culture of wellness in programming, faculty, and university contexts has resulted in the development of the first mandatory CSH course in Canada. This course will be one step towards positively impacting wellness environments in K–12 schools and universities. Healthy students made better learners and we contend that it is the responsibility of post-secondary institutions to prepare teachers to do their part in school health and wellness. We hope that outlining the process of developing a mandatory CSH course in a BEd program will serve as a model for the adoption of wellness in university culture and BEd curriculum.

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Table 1: Propositions and Corresponding Sources

Proposition	Source
(a) health and wellness are important on university campuses	Literature Dooris, 2001; Dooris & Doherty, 2010
(b) health and wellness have not been traditionally prioritized in BEd programs	Literature and Personal Experience Russell-Mayhew, Ireland, & Klingle, 2016b Russell-Mayhew, Ireland, & Alberga, 2015
(c) there is a parallel between the application of CSH in K–12 schools and HPU in universities	Literature and Personal Experience Bassett-Gunter, Yessis, Manske, & Stockton, 2016
(d) A priority of health and wellness at a programmatic level requires a shift in the academic culture.	Literature and Personal Experience Story et al., 2016

Note. Four propositions were identified in the current research. Propositions and corresponding sources were based on the personal experiences of the researchers as well as the literature.

Table2: Timeline

Academic Year	Bachelor of Education Students/Program	Faculty	Institution
2009/2010	18 BEd students – physical education specialists participated in 3-hour in-service during class	2 faculty members from the WSE involved	
2011/2012	30 self-selected BEd students participated in 3-hour in-service during voluntary 1-day training	2 initial faculty members continued Recruited involvement from 1 additional faculty member from the Faculty of Kinesiology, as well 1 community partner from Ever Active Schools (i.e., Health	

		Champions Committee was formed)	
2013/2014	110 self-selected BEd students-elementary specialization participated in 2-day voluntary Health Champions Conference	Health Champions Committee organized first Health Champions conference for BEd students (conference focused on CSH framework) WSE introduced Health and Wellness Week for Faculty and Staff	
2014/2015	80 self-selected BEd students (~29%) participated in 2-day voluntary Health Champions Conference	Quality of Life Committee was introduced by the Dean of Education and included faculty and staff members from across WSE	University of Calgary initiated the Mental Health Strategy task force and UFlourish activities UCalgary Strong introduced as a strengths-based approach to celebrate year end
2015/2016	120 self-selected BEd students – 2 year only (~37%) participated in 2-day voluntary HEALTH CHAMPIONS conference	Health Champions Committee proposed CSH Course	Thrive Priority Support Network established to reach out to students in need. UFlourish Week offered by the Wellness Centre to promote positive well-being and resilience on campus.
2016/2017	110 self-selected BEd students (~35%?) – 2nd year only signed up (plus waiting list) participated	Collective health and wellness identified in the new Faculty Strategic Academic Plan	CSH course as a mandated part of core curriculum approved through

	in 2-day voluntary HEALTH CHAMPIONS conference	(Faculty Academic Plan 2018-2023) in 2017	university committees University of Calgary launched the Mental Health Strategy

Note. Timeline depicting the student based health and wellness interventions at the University of Calgary that contributed to the creation of the CSH course. Interventions are indicated for three different levels, the BEd program level, the faculty level, and the institution level.

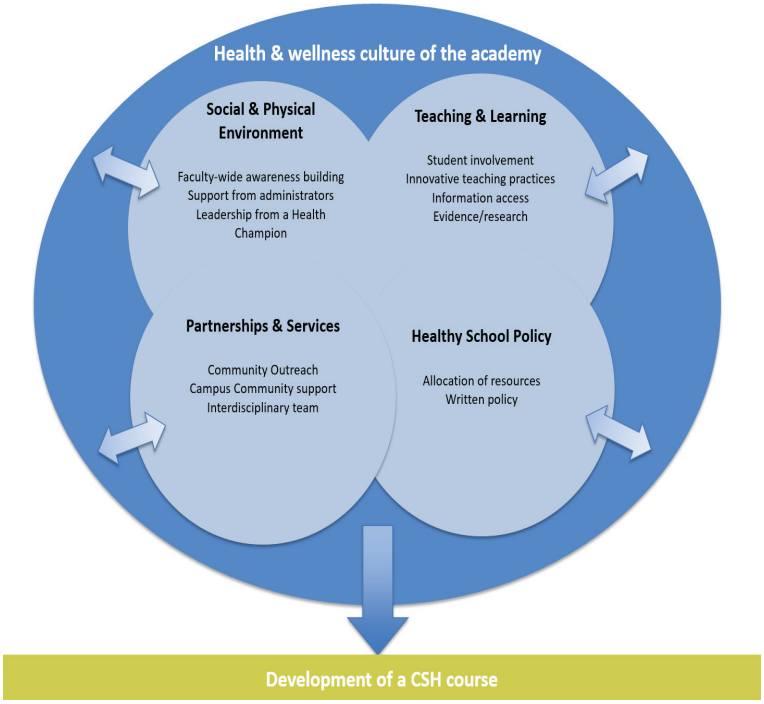

Figure 1. A visual representation of the process by which the development of a CSH course in a BEd program reflected as well as informed the health and wellness culture of the academy, utilizing the CSH framework.

Address for Correspondence
Shelly Russell-Mayhew, Werklund School of Education, University of Calgary;
Alana Ireland, Werklund School of Education, University of Calgary;
Kerri Murray, Ever Active Schools, Calgary, Alberta;
Angela S. Alberga, Department of Exercise Science, Concordia University;
Sarah Nutter, Werklund School of Education, University of Calgary;
Tina Gabriele, Faculty of Kinesiology, University of Calgary;
Gavin Peat, Werklund School of Education, University of Calgary; &
Dianne Gereluk, Werklund School of Education, University of Calgary.