TEACHING TOGETHER AS TAPESTRIES

Teachers’ Experiences of Partnering with External Providers to Facilitate School-Based Drug Education

by

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Abstract

This dissertation examines the nature of the partnership between Life Education Victoria (LEV) and three primary schools in facilitating drug education programs. Employing the woven construction of tapestries as a metaphor, this study examines the interweaving of two occupations: external specialist teachers of drug education and generalist classroom teachers, both of whom have a role in facilitating school-based drug education.

Generalist classroom teachers are commonly considered the best providers of health and drug education in the primary school context (Meyer, 2004). However, their capacity to deliver effective programs has been questioned (Faucette & Patterson, 1989; Morgan, 2008; Morgan & Bourke, 2008). Consequently, schools have sought to establish partnerships with external organizations, such as LEV, to facilitate school-based health and drug education programs.

To date, there is no available research that examines the nature of the partnerships between generalist teachers and specialist LEV educators. Therefore, the purpose of this research was to contribute to that understanding through (1) an examination of the nature of the partnerships between schools and LEV (i.e., the context of the partnerships between generalist teachers and specialist educators) and (2) an examination of the generalist teachers’ experiences working together with specialist educators, particularly in the unique setting whereby specialist educators are invited into the school setting, yet not into the actual classrooms. The primary research question was: How do primary school teachers and external specialists partner together to facilitate school-based drug education programs?

Through a qualitative approach, this study investigated the experiences of teachers from three primary schools that engage with LEV. Each school amounted to a particular case; hence, a case study methodology was applied. The data were collected through interviews, nonparticipant observations, and questionnaires in order to elucidate principals’, drug education coordinators’, and teachers’ perceptions of their experiences with LEV.

Based on the framework espoused by Weiland and Akerson (2013), the nature of the partnerships between LEV and the three schools under study was classified as cooperation, which is the least level of commitment, risk, negotiation, and involvement. Three divergent types of this partnership were recognized. These included LEV-faced, school-faced, and school/LEV-faced partnerships. Each partnership was distinguished by the school’s provision
of drug education, the role LEV played in the program, and the support afforded generalist teachers.

Within the context of these three types of partnership between LEV and the participating schools, five divergent yet repeated forms of teachers’ experiences were identified as they worked with specialist educators. Teachers’ ways-of-being were categorized in order of ascending levels of engagement: (1) being-a-disengaged-teacher, (2) being-an-observing-teacher, (3) being-a-takeover-teacher, (4) being-a-learning-teacher, and finally (5) being-a-collaborative-teacher. Teachers’ ways-of-being in the Mobile Learning Center (MLC) were shaped by a combination of their school environment, their relationships with other colleagues (ways-of-doing outside of the MLC), as well as their perceived competence (ways-of-knowing) to facilitate a school-based drug education program.

Findings in this study expand our understanding of the “passive” verses “active” role of generalist teachers working together with specialist educators. The more elaborate spectrum of engagement presented in this study ranged from “disengagement” to “over engagement” to “partial engagement” and finally “full engagement” with external providers. This expanded classification can address the recommendations of previous research that has called for a mutual understanding between classroom teachers and informal educators concerning their respective roles (Weiland & Akerson, 2013).

These findings contribute to the drug education literature by providing a clearer description of the nature of the partnerships between schools and LEV, as well as the roles encompassed by the two occupations: generalist teachers and specialist educators. This may inform future decisions and practices of external providers (including LEV) as well as school administrators, leadership teams, and classroom teachers.
Declaration of Originality

This is to certify that:

The thesis contains my original work only. No material has been submitted for any other degree in any university.

To the best of my knowledge, this thesis comprises no material previously published or written by any other person. Due acknowledgments have been made in the text to all of the material used.

The thesis is less than 55,000 words in length, exclusive of tables, bibliographies, and appendices.

Signature:

Peter Botross
Acknowledgments

I embarked on this study journey furnished with an inflated sense of confidence and an undeniable passion for education. I reach this junction with a rather deflated sense of competence and a fresh appreciation for the power of endurance. Every tapestry comprises two sides and this project was no exception, displaying the beauty of possibility (interest) and the power of endurance (effort). Through this project I learned that endurance is not defined by the confidence to never “give up,” but rather by the courage to “get up” one more time for-the-sake-of-which.

Along the journey, I encountered circumstances, challenges, and people who enriched the tapestry with their contrasting and colorful threads. I am grateful for the many individuals who intentionally or unintentionally weaved within me the courage to overcome obstacles and to complete this project.

I’m grateful to my “super-visors” Dr. Julianne Moss who encouraged the commencement of this project, and Dr. John Quay who invested a significant amount of time and energy, challenging, and expanding my understanding of education through occupation, as well as encouraging me to persevere. Thanks for staying the course.

I’m thankful for the many teachers, drug education coordinators, and principals who voluntarily contributed to the data. Further, I’m appreciative for the partnership I enjoyed with the team of LEV educators and staff members for several years. Thanks for your trust.

I’m also thankful for Pam Firth who provided copyediting and proofreading services, according to the guidelines laid out in the university-endorsed national Guidelines for Editing Research Theses (Institute of Professional Editors, 2010).

I’m indebted to my wife Suzie, my children Luke, Jirah, and Kanan for their unconditional love, unrelenting support, and unceasing encouragement even when quitting seemed the better option for our family life (and my sanity). Thanks for always being there.

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<th>Full Form</th>
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<tr>
<td>BCE</td>
<td>Brisbane Catholic Education</td>
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<td>DARE</td>
<td>Drug Abuse Resistance Education</td>
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<tr>
<td>ICSEA</td>
<td>Index of Community Socio-Educational Advantage</td>
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<tr>
<td>ICT</td>
<td>Information and communication technologies</td>
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<tr>
<td>LEA</td>
<td>Life Education Australia</td>
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<td>LEC</td>
<td>Life Education Centres</td>
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<td>LEV</td>
<td>Life Education Victoria</td>
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<tr>
<td>MLC</td>
<td>Mobile learning center</td>
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<tr>
<td>NCETA</td>
<td>National Centre for Education and Training on Addiction</td>
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<tr>
<td>PD</td>
<td>Professional development</td>
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<tr>
<td>SHAHRP</td>
<td>School Health and Alcohol Harm Reduction Project</td>
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<td>TAM</td>
<td>Transparent anatomical model</td>
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<tr>
<td>US</td>
<td>United States</td>
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<td>VELS</td>
<td>Victorian Essential Learning Standards</td>
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CHAPTER 1: Drug Education as a Teaching Partnership

This chapter introduces the initial threads of an investigation into the various partnerships that exist between Life Education Victoria (LEV) and the many primary schools throughout the state who collaborate with LEV in efforts to teach drug education.

Life Education is the largest nongovernment provider of drug and health education in Australia, reaching approximately 600,000 primary and secondary school students annually. Operating since 1979, in excess of 4 million students have participated in its program over the past 30 years. In 2010 alone, Life Education Australia (LEA) partnered with more than 3,200 schools, catering for 610,000 students in their care (Astbury, 2011).

As a registered national charity, LEA is independent of both government and religion. Its mission is to empower young people to make the best choices for a safe life, which is achieved through leading school-based drug and health education programs. Accordingly, LEA partners with schools to provide positive and preventative programs to encourage young people to make informed healthy lifestyle decisions, free from the harms associated with drug misuse. LEA has branches throughout all states and territories to serve the needs of each state. In Victoria, LEV services over 680 primary schools, annually.

Employing the woven construction of tapestries as a metaphor, this study examines the interweaving of two occupations: external specialist teachers of drug education and generalist classroom teachers, both of which have a role in facilitating school-based drug education. Ideally, these two occupations come together as warp and weft, reflecting the nature of partnerships as “richly woven tapestries” which “represent a collection of unique and complex images” (Mullinix, 2000, p. 12).

The partnerships between LEV and primary schools in Victoria are developed with the aim of building on the strengths of both parties in order to provide effective school-based drug education programs. My interest in researching these partnerships began with my recruitment as the education manager at LEV in early 2010. My role involved leading a team of 25 specialist educators, facilitating professional development (PD) programs for these educators, and improving the partnerships between primary schools and the organization.

In order to convey the essence of my introduction to LEV and the basic question I have concerning the program, I share the following vignette.
I had been working for LEV for only a couple of weeks when my wife and I were invited to the organization’s annual fundraising event: the Gala Night. We arrived at a glamorous city hotel venue to dine with over 500 business executives, each guest having invested $200 merely to attend the evening. The food, the speeches, the silent auction (which included hundreds of items), and the classy entertainment provided a warm and exciting atmosphere for all guests. But nothing prepared me for the main event of the night: an epic fundraiser auction. As each item was displayed on two large data projectors, I learned how generous and passionate people could be in their support of health and drug education. The guests outlaid tens of thousands of dollars to secure many donated items. Additionally, substantial donations were made to refurbish an LEV mobile learning center (MLC) for a rural region in Victoria.

At the conclusion of the evening, my wife and I lined up in the hotel foyer to pay for the items we had successfully bid for in the silent auction. The queue was lengthy. We stood beside a middle-aged business executive and his two teenage children, all dressed stylishly and beaming with contagious smiles. They clasped 14 invoices for 14 significant silent auction items that they had bid on. The father appeared calm. I heard him ask his daughter, “Why do you need two of the same hand cream packs?” Her response was simple: “I don’t know!” The father grinned. His unflappable approach to the expense almost convinced me that he had had just a little too much to drink. A few minutes later, I discovered the reason for his unreserved investment in “the cause” by listening to his candid conversation with the person standing behind me. It went something like this:

My daughter went to a party a few years ago and she got together with the wrong crowd and took a pill of some sort. She was naïve. We got a phone call in the middle of the night advising us to collect her from a nightclub. She was knocked out, her eyes rolled back and she was out. We were terrified, wondering if she was going to survive the incident. Some days later as we discussed what had happened as a family, my son, who was only 11 years old at the time, began to explain the dangers of unknown pills. “Do you know what’s in those pills?” he probed his sister. My wife and I were shocked at the extent of his knowledge on the subject. We asked him where he had learnt all he knew about drugs. We discovered that the source was the Life Education program. Since then we have been committed to supporting this cause. We have become passionate about ensuring that no child experiences what our daughter experienced as a result of her ignorance.

On this Gala Night, I learned firsthand about the generosity and commitment of supporters who believe in the impact of LEV. Acutely aware of my role as an education manager, this
experience led me to ponder the actual efficacy of the Life Education program, from which a basic question emerged, one that others before me have also considered: Does Life Education make a difference, or is this anecdotal evidence only a rare experience for select families?

**Interwoven: A Question of Partnership**

Despite its reported popularity among teachers, parents, and supporters—as apparent in the Gala Night—LEV has been criticized, as evident in an evaluation conducted by Hawthorne, Garrard, and Dunt (1992) and Hawthorne (1996). Another example is the report produced in 2010 by the National Centre for Education and Training on Addiction (NCETA) titled *The Role of Schools in Alcohol Education*. This report was commissioned by the Australian Government Department of Education, Employment and Workplace Relations. It reviewed, assessed, and graded 64 alcohol education programs. This report judged the effectiveness of the Life Education program as “not conclusively established,” asserting that “the evaluation evidence for the efficacy of LEC [Life Education Centres] work is mixed” (Roche, 2010, p. 74).

The “mixed” evidence reported by Roche (2010) was drawn from several studies on LEV. However, the NCETA report appeared to underscore the evaluation conducted by Hawthorne et al. (1992). The Hawthorne et al. study sought to assess the value of the LEV drug education program by evaluating the LEV syllabus, its impact on a school’s drug education curriculum, and its short-term effects on participating students. At the heart of the study was a comparison between the LEV program and more traditional school-based drug education programs. The study sampled 86 schools and their Grade 6 students (3,019 participants) from the Melbourne metropolitan area, 42 of which had participated in the LEV program for five years or more, the other 44 schools having been exposed to more traditional school-based drug education programs. Hawthorne et al. (1992) reported that students who participated in the LEV program gained knowledge without any positive impact on their attitudes or behaviors toward drug use and misuse.

Although LEV students possessed greater health knowledge, at this stage there was no evidence that participation positively affected students’ attitudes, delayed student experimentation with or initiation into smoking, persuaded students to avoid drinking or to drink less, or that it reduced students’ use of analgesics. Indeed, there was some evidence that, compared with NLEV- [non-LEV] students, LEV-students’ drug use and misuse were marginally higher. (Hawthorne et al., 1992, p. vi)
As an external provider, LEA was established to partner with teachers in the facilitation of a whole-school drug education program. The program was essentially designed to be a joint undertaking between the schools and LEV in order to achieve objectives that concerned knowledge, attitudes, and behavior (Astbury, 2011). The evaluation by Hawthorne et al. (1992) highlights the capacity of the Life Education program to convey important knowledge related to drug education (with this partnership operating in a minimal way), but that addressing further goals associated with attitudes and behavior requires a much more developed form of partnership. This complication was highlighted in the NCETA report:

> Overall, the evaluation evidence does not decisively answer that question of efficacy of the LEC approach, as the very nature of the LEC model makes it difficult to subject to formal evaluation, since teachers cannot be made to follow up or apply Life Education’s resources in any particular way. (Roche, 2010, p. 75)

As documented by the report, the very nature of a “support” model cannot be evaluated as a stand-alone program. The partnerships between LEV and the schools are central to the achievement of the educational aims. Consequently, further investigation ought to examine LEV’s partnerships with teachers. However, informed by investigations I conducted within and outside LEV, I was able to ascertain that no such research had been conducted.

An earlier review commissioned by the Australian Government Department of Health and Ageing did provide some insight into the partnerships between LEV and teachers in schools, although it did not specifically investigate the efficacy of the partnerships. This review intended to provide LEV with an overview of current activities in order to refine its drug education models and, if necessary, adapt programs in line with identified best practice (Carbines, Wyatt, & Robb, 2006). The evaluation team positively commented on Life Education’s materials and resources, its holistic perspective on drug education, and interactive pedagogy. However, while the review documented the high level of teacher satisfaction with the program, it did not evaluate the partnerships between LEV and the participating schools. Carbines et al. (2006) recommended that LEV must revise its strategies and role in order to adequately support teachers in facilitating whole-school drug education programs. Consequently, the aim of my research was to further investigate the partnerships between classroom teachers and LEV educators in the conduct of school-based drug education programs.
Warp or Weft: Life Education Educators and School Teachers

There are two basic ways of portraying the partnerships between schoolteachers and LEV educators, which draw on the tapestry metaphor. One way positions schoolteachers as the weft thread in a weft-faced weaving (the front and visible face of the tapestry), with all the warp threads (LEV educators) hidden in the completed work. Often the case is seen the other way, however, with schoolteachers hidden as the warp and LEV educators (weft) being the prominent deliverer of drug education, as the LEV educator is assumed to be the specialist.

Specialist educators

Astbury (2011) identified five main components of the Life Education program: (1) specialist educators, (2) mobile learning centers, (3) the suite of student and teacher resources, (4) parent information sessions and family forums, and (5) the Healthy Harold mascot and website.

In 2011, the LEV program was delivered by 25 full- and part-time educators utilizing 20 MLCs. While the great majority of the educators were qualified teachers upon their recruitment, they undertook an extensive LEV induction training for a period of 10 weeks. Their training incorporated both theoretical and practical teaching components in order to develop specialist expertise in health and drug education. As outlined in the Life Education (2011) Initial Training Manual, the “Professional Standards for Life Education Educators” guides the design, structure, and content of the Initial Training Program as well as the ongoing educators’ professional development. These standards revolve around five components: (1) professional practice, (2) professional knowledge, (3) professional engagement, (4) professional partnerships, and (5) professional reflection (see Appendix i).

Astbury (2011) describes the extensive training undertaken by the LEV educators succinctly:

Life Education’s Educators are considered specialists in the delivery of health education programs . . . They undertake an extensive initial training program including the provision of in-field experience which involves either observing their individual trainer in action, or practicing whilst being observed, guided and supported by their trainer. Once initial training is complete, Educators thereafter participate in regular internal and external professional development related to drug and health information and teaching and learning strategies.

(Astbury, 2011, p. 15)

An MLC is akin to a classroom. It is a sizeable van equipped with high-tech audiovisual equipment, a transparent anatomical model (TAM), and electronic modules that illustrate the
various body systems (e.g., digestive and nervous systems) taught throughout the LEV modules. The primary school program consists of 10 modules, each with defined educational outcomes that align with the curriculum framework of each state and territory. The modules for the junior primary school years broadly focus on the functions of body systems, nutrition, exercise, safety, and social skills. The modules for the middle and upper primary school years focus on advanced body knowledge, communication, friendships, and decision-making skills. Moreover, the modules explore how medicines, tobacco, and alcohol affect the body.

The LEV modules are designed to be age appropriate and sequential, delivered annually, and consistent with the partnership approach that LEV desires to promote to the schools it services (see overview of the LEV modules in Appendix ii). Each of the 10 modules is intended to be facilitated in part by the LEV educator on the school grounds inside the MLC (with the support of the generalist teacher), and in part by the teacher alone in the classroom. Since Life Education’s drug and health education program is intended to integrate into the curriculum, generalist teachers are provided with a document that outlines the links between each of the 10 LEA modules and the Australian Curriculum—Health and Physical Education (see an example in Appendix iii).

Sessions in the MLC are designed around intriguing narratives, interactive computer programs, and different activities to cater for various learning styles. Healthy Harold is a giraffe mascot used to help educators facilitate the MLC session. He is employed to introduce the narrative of each module and to share interesting tips, ideas, and jokes with the students. Furthermore, LEV supports schoolteachers with both print- and web-based materials (up to 20 hours per module) to conduct, at their discretion, pre and postvisit learning activities.

**Generalist teachers**

Much drug education literature has consistently substantiated the central role of schoolteachers in the facilitation of drug education programs. Generalist classroom teachers in primary schools are considered the best providers of drug education in the school context (Midford, Munro, McBride, Snow, & Ladzinski, 2002). Familiarity with the school and community locates these teachers in the best position to tailor a drug education program to meet their students’ needs. Generalist classroom teachers have the opportunity to integrate drug education within an ongoing health or social skills curriculum, ensuring that it is embedded in other elements of the school curriculum. Furthermore, generalist classroom teachers develop relationships with their classes, including individual students and their
families, which enable them to monitor and further support those who require additional assistance (Meyer, 2004).

Complicating this picture, however, some researchers question the capacity of the generalist classroom teachers to deliver effective school-based health education programs. Whipp, Hutton, Grove, and Jackson (2011, p. 68) assert that the delivery strategies employed by generalist classroom teachers often “present substantial barriers to quality student learning outcomes.” Other researchers concur, highlighting how the generalist classroom teacher’s lack of time, knowledge, energy, training, confidence, and experience results in a reduced capability to design and facilitate effective lessons (Faucette & Patterson, 1989; Morgan, 2008; Morgan & Bourke, 2008).

Consequently, schools have engaged the services of external specialists in order to facilitate school-based drug education—ostensibly in partnership with classroom teachers. Astbury (2011, p. 14) underlines that “many schools choose to bolster their efforts by partnering with a third party provider of a complementary program such as Life Education.” In a systematic review, Buckley and White (2007, p. 57) concluded that external specialists can be effective in providing school-based drug education. However, in order for the program to be effective, they recommended that “external contributors should be used in a supplementary role in drug education in a manner reflecting their expertise, when that expertise maps onto the aims and content of the drug education planned by the school” (p. 57).

**Woven Partnerships: Life Education and Schools**

Partnerships between schools and LEA are believed to be indispensable in order to achieve the common goals pertaining to health and drug education. Hence, Astbury (2011) asserted that LEA should be viewed as a resource that complements the efforts of its partnering schools. However, he acknowledged the challenge that Life Education faces “to ensure that schools, in choosing to work with it, take full advantage of the opportunities provided by this resource to support the learning and development of the students in their care” (p. 12). This is a challenge that relates to the nature of the partnerships between both organizations.

However, the nature of the partnerships between schools and external providers has not been adequately assessed to date. In fact, there has been little empirical research on the outsourcing of health education programs in general and drug education in particular. In examining the provision of physical education in New Zealand primary schools, for example, (Petrie, 2011, p. 15) asserts that there is a “paucity of research into the role of outside
providers.” The research available is narrow in scope and the collected data is partial and fragmentary. Often, outsourcing has not been the primary focus of the research but rather a topic to which passing reference is made (Davis & Clennett, 2006; Lynch, 2007; Smith, Fotinatos, Duffy, & Burke, 2013; Webster, 2001; Williams, Hay, & Macdonald, 2008).

Similarly, there is also a dearth of research on partnerships between schools and external providers in facilitating school-based drug education. Stead et al. (2009), via their review of drug education practice in Scotland, ascertained the necessity of further research to examine the best use of external providers in schools. Included among their recommendations was that “schools need help in making best use of the drug-education support provided by external visitors” (p. 18). In particular, they identified the need for better guidance on “how to use outside visitors more effectively, covering understanding of visitors’ particular strengths and expertise; what areas of drug education should be more appropriately covered by teachers; and ensuring that visitors’ inputs support and are integrated better with school provision” (p. 18). As a result, they argued for the “development of mechanisms that bring schools and agencies together to plan a consistent approach to drug education” (p. 18).

Unexamined partnerships can foster ambiguity that undermines their functionality and effectiveness. Tsou, Haynes, Warner, Gray, and Thompson (2015), through their exploration of interorganizational partnerships in the context of Australian Aboriginal organizations and mainstream agencies, acknowledged that “partnerships are particularly undermined and collaborations weakened through lack of clarity about respective roles resulting in confusion about the partnership’s purpose, its objectives and how to measure its success” (p. 2). Partnerships between LEV and primary schools, as well as generalist classroom teachers and external specialists, can similarly be weakened by role confusion.

Unlike health and drug education, examination of partnerships among educational institutions, including generalist classroom teachers and specialist educators, is not new to science education research. The relationships and roles of groups of teachers and specialist educators have been predominantly examined in the museum and/or field trip setting (Kisiel, 2005; Tal, Bamberger, & Morag, 2005; Tal & Steiner, 2006; Tran, 2007). Partnerships between the schools and museums can positively affect both institutions (Bevan & Dillon, 2010; Kisiel, 2010).

However, Bevan and Dillon (2010) called for a deeper understanding of how formal and informal educational institutions partner together to support teachers’ and students’ interests and capacities for engaging in science. They specifically advocated an examination
of how varied settings can provide different opportunities for these partnerships.

Furthermore, Weiland and Akerson (2013) found no research that examined the nature of the partnerships between classroom teachers and specialist science educators when they were invited into the classroom. Correspondingly, I was unable to locate any research that assessed the nature of the partnerships between LEV and the schools, including the collaboration between generalist teachers and drug education specialists when they were invited into the classroom.

Accordingly, I aimed to investigate the nature of the partnerships between LEV and primary school teachers in facilitating school-based drug education programs. The primary research question was: How do generalist teachers and external specialists partner together to facilitate school-based drug education programs?

Therefore, the purpose of this research was to contribute to that understanding through (1) an examination of the nature of the partnerships between schools and LEV (i.e., the context of the partnerships between generalist teachers and specialist educators) and (2) an examination of the generalist teachers’ experiences working together with specialist educators, particularly in the unique setting whereby specialist educators are invited into the school setting, yet not into the actual classrooms.

Through this investigation, I aimed to contribute to the drug education literature by bridging the research gap underscored above. A clearer description of the nature of the partnerships between primary schools and LEV, as well as the roles encompassed by generalist and specialist educators, may inform future decisions and practices of external providers (including LEV), as well as school administrators, leadership teams, and classroom teachers.

In Chapter 2, I present the twining of the tapestry in a literature review, which weaves together the underlying threads of the investigation: the approaches and goals of school-based drug education, and the partnerships between primary schools and external providers. In Chapter 3, I explore the roles of generalist and specialist drug educators, the nature of their collaboration, as well as the rationale, benefits, and challenges of recruiting external providers to facilitate drug education in primary schools.

In Chapter 4, I describe the methods used to conduct the investigation, including a rationale of the qualitative methodology and an outline of the comparative case studies method. A methodological framework is adopted to explicate the two roles—classroom teacher and specialist educator—that sit at the heart of the partnership. These are not merely
identities as they also encompass both skills and knowledge that each brings to bear in conducting drug education.

In Chapter 5, I describe the context of the partnerships between the schools and LEV. Three divergent types of partnership between LEV and the three schools under study are presented. Each partnership is characterised by the school’s provision of drug education, the role LEV plays in the partnership, and the support afforded the generalist classroom teachers.

These schools’ partnerships provide the context for teachers’ experiences in teaching with LEV to facilitate a school-based drug education program. Such stories are portrayed in Chapter 6 based on my findings from the questionnaires, observations, and my conversations with 12 teachers at the schools examined. I depict four divergent, yet repeated sets of experiences of teachers working with LEV. Chapter 7 concludes by summarizing the main features and findings of the investigation.

Summary

In this chapter, I have presented a brief overview of the partnerships between LEV and primary schools in facilitating school-based drug education programs. In tapestry terms, these partnerships are analogous to the weaving of two primary threads: the role of the external specialists (warp) and the role of generalist teachers (weft) in school-based drug education.

LEA is the largest nongovernment provider of drug and health education throughout Australia. As a not-for-profit organization, LEA partners with schools to provide positive and preventative programs to encourage young people to make informed healthy lifestyle decisions. Generalist teachers are considered the best providers of drug education in the primary school context. However, researchers question the capacity of classroom teachers to deliver effective school-based health education programs.

Consequently, schools have engaged external providers to partner with classroom teachers in order to facilitate school-based drug education. Yet, the nature of the partnerships between external drug education specialists and generalist teachers has not been assessed, particularly in the unique setting whereby specialist educators are invited into the school setting, yet not into the actual classrooms. Hence, this investigation sought to respond to the primary research question: How do primary school teachers and external specialists partner together to facilitate school-based drug education programs?
CHAPTER 2: Schools and Drug Education

This literature review weaves together the conceptual and empirical threads that underpin the investigation by addressing previous work that informs understanding of the approaches and goals of school-based drug education, as well as the nature of the partnerships between schools and external providers, in order to facilitate drug education programs.

Approaches to conducting drug education have evolved through quite diverse phases since beginnings that can be traced back to the late 1800s in the United States (US). Since this time, in a number of countries, including Australia, the goals of drug education have shifted significantly, from advocating for total abstinence campaigned for by the temperance movement to harm minimization (noting that in the US, vestiges of abstinence remain). However, regardless of the espoused goal, an underlying purpose of school-based drug education has been to address students’ behaviors concerning drug use and/or misuse. Yet the capacity of generalist classroom teachers to achieve more than mere knowledge acquisition remains questionable. Consequently, the partnerships between primary schools and external providers are examined, elucidating the context of the collaboration between generalist teachers and specialist educators in order to facilitate school-based drug education programs.

Approaches to Drug Education

Formal school-based drug education dates back to the 1880s in the US. In his examination of the history of drug education in the US, Beck (1998) identified the period between 1880 and 1930 as being dominated by the temperance movement. During this time, Mary Hunt and other leaders from the Woman’s Christian Temperance Union began to promote the establishment of educational programs in every school in order to inform children of the “evils of alcohol” (Baggott, 1990; Mervinsky, 1961). They gained political support for compulsory temperance education in schools. This movement advocated total abstinence and considered any use of alcohol, tobacco, and illicit drugs as abuse (Beck, 1998).

By 1901, every state and territory in the US had passed legislation mandating compulsory temperance education in public schools (Mervinsky, 1961). It was presumed that students would not use drugs as a result of education that informed them of their dreadful physiological consequences (Ballard, Dawson, & Kennedy, 2002b). Beck (1998) credits the contribution of the temperance movement for the complete prohibition of alcohol that came about in the US in the 1920s. While the temperance movement had a significant influence in
many countries (Gershman, 1987; Midford, Pettingell, & Stothard, 2006), it had minimal impact in Australia, although it did have its champions.

What influence the temperance movement had in Australian schools in the late 19th century was achieved through the activities of diverse groups. These groups included the New South Wales Temperance Society (Dillon, 1985), the Woman’s Christian Temperance Union in Victoria (Hyslop, 2006), and the Department of Public Instruction in Queensland (Mammino, 1993). However, the movement had to contend with public support of alcohol consumption and succeeded only in the closing of hotels during World War I (Grant & Serle, 1983; cited in Midford et al., 2006), along with restrictions placed on the availability of narcotic-based medicines (Lonie, 1979). Drug education in Australia was not pursued immediately postwar, although temperance groups offered education in schools concerning the dangers of alcohol and tobacco. These endeavors were limited to optional examinations and competitions (NSW Department of Education, 1969; cited in Midford et al., 2006).

The period between 1952 and 1969 ushered in a new era of drug education in Australia. For example, upon its formation in 1952, the Queensland Health Education Council took the leadership role in drug education, replacing the temperance movement. This change culminated in the launch of a new health education syllabus in Queensland schools by 1966 (Mammino, 1993). The inclusion of specific drug education in the health education curriculum of schools in an Australian state was achieved following a widely reported incident in 1967 concerning three teenage girls using drugs at their teacher’s home in Kings Cross, Sydney. As a result, the Sydney Morning Herald reported (“Reassurance by Wyndham on Drug Taking,” 1967, as cited in Midford et al., 2006) that the NSW Director General of Education had announced the expansion of the health education curriculum to incorporate drug education to prevent young people from drug use.

Addressing societal problems was the fundamental reason for the introduction of school-based drug education programs. Instead of attempting to tackle the “problem” of drug abuse merely from a criminal justice perspective, progressive governments became proactive and funded school-based drug education programs. Schools were conceptualized as a frontline in the war against drugs. Drug education was considered a key component of the government’s drug control strategy aimed at impacting students’ behaviors (Ballard et al., 2002b; McBride, Farringdon, Midford, Meuleners, & Phillips, 2003). It was believed that students who participated in school-based drug education would grow up to be adults who abstained from these substances (Muller, 2006).
**Information-based approaches**

The drug education models of the late 1960s in Australia were patterned upon those designed in the US. Information-based drug education programs were assumed to impact students’ behaviors (Dielman, 1994). This approach was contrary to approaches that used scare tactics that aimed to shock young people with legal consequences and other horror stories. Cahill (2004, p. 2) suggested that scare tactics were founded on the premise that “if we could just show how risky it is—they wouldn’t do it.” And yet, confronting students with the most severe harms did not deter them all from using drugs (Tobler & Stratton, 1997). The tendency of some students to believe in their own invulnerability, along with the contradiction between their observations and the corollaries communicated in the scare tactics programs, may have contributed to the ineffectiveness of these programs. In addition, scare tactics have been shown to be counterproductive because they glamorize risky behaviors (Cahill, 2004) making certain behaviors more compelling, particularly for adventurous students or individuals who, for myriad reasons, may be driven to cause themselves harm.

Information-based approaches, however, sought to provide basic information on drugs and their repercussions: physical, psychological, legal, and social. It was assumed that providing information on the harms of drug use would prompt students to make the rational choice not to use them. However, knowledge *alone* did not significantly impact student behavior in the direction assumed. Evaluation of these programs produced mixed results, with some demonstrating positive effects, others having no impact, while others yielding a negative influence on student behavior (Hansen, 1993; Tobler & Stratton, 1997). While these school-based programs improved knowledge retention, they had little or no impact on attitudes and behavior (Goodstadt, 1986; Schaps, DiBartolo, Moskowitz, Palley, & Churgin, 1981; Tobler, 1986).

Furthermore, Berberian, Gross, Lovejoy, and Paperella (1976) asserted that this information-based approach could alter students’ knowledge and attitudes in a counterproductive way by stimulating student interest in drug experimentation. In effect, students could gain high levels of accurate knowledge on the deleterious consequences of drug use, yet hold attitudes favorable toward drug use (Hawkins, Catalano, & Miller, 1992). Consequently, information-based approaches by themselves (in the 1950s to 1960s) were considered to be a failure by the late 1970s (Kinder, Pape, & Walfish, 1980).
**Affective approaches**

In Australia, the launch of the National Drug Education Program by the Commonwealth Government in the 1970s ushered in a new era for drug education. The integration of drug education into the health education curriculum in schools was now premised on the perceived need for a low-key approach. “The overall aim was ‘education for living’: teaching young people to live without the need to use drugs” (Midford et al., 2006, p. 24).

This approach to drug education in Australia resembled that of the affective programs designed in the US (Gorman, 1996; Tones & Tilford, 2001). The affective approach sought to reduce the use of alcohol and other drugs by focusing on students’ personal development. These programs were based on the premise that drug use is a result of deficiencies in an individual’s development, moral values, or social, coping, and general life skills. The assumption was that students would avoid drug use if they were emotionally stronger and better decision makers (Gorman, 1996; Rundall & Bruvold, 1988).

School-based programs adopting this approach focused on “self esteem, decision making, values clarification, stress management, and goal setting” (Midford et al., 2006, p. 24). Self-esteem programs emphasized helping students to recognize and appreciate their personal uniqueness, self-worth, and value. Students were encouraged to accept and positively frame their failings and challenges. These programs also provided strategies to support students in making informed and rational decisions. Students were skilled to create solutions, discover alternatives, and make wise choices (Dorn & Murji, 1992; Sutherland, 1979; Tones & Tilford, 2001).

Values-clarification strategies encouraged students to identify their existing values and negotiate positive values (Hansen, 1993; Lewis, 1993). Through examination of the relationship between one’s values and the consequences of one’s behavior, it was assumed that individuals would develop beliefs and behaviors toward drugs that were consistent with their values. These programs equipped students with coping skills to manage their stress, including stress reduction and help-seeking strategies (Polich, Ellickson, Reuter, & Kahan, 1984; Tobler & Stratton, 1997). Furthermore, this approach taught students goal-setting skills. By clarifying their personal goals and setting a plan to achieve them, students would, it was believed, reject drugs as inconsistent with their goals (Hansen, 1993; Midford et al., 2006; Sutherland, 1979).

However, as with other approaches, affective approaches to school-based drug education impacted students’ knowledge without significantly changing their drug use
behaviors (Bangert-Drowns, 1988; Hansen, 1993; Moskowitz, 1989; Polich et al., 1984). Dorn and Murji (1992) asserted that affective approaches resulted in generally discouraging results in terms of reducing drug use. Tobler and Stratton (1997) emphasized that affective approaches are more effective when complemented by components associated with the other approaches, such as those addressing social influences, as described in the next section.

**Social influence approaches**

Not surprisingly, a social influence approach to drug education reflects the effect of social modeling theory on Australian drug education conducted in the mid-1980s (Dielman, 1994; Faggiano, Vigna-Taglianti, Versino, Zambon, Borraccino, & Lemma, 2005; Wragg, 1990, 1992). Such approaches considered social pressure as the reason young people use drugs. In order to resist this pressure, young people need to be inoculated by prior exposure to counterarguments, and have the opportunity to practice the desired coping behaviour in supportive classroom environments (McBride, Farringdon, Midford, Meuleners, & Phillips, 2004; Midford, 2009).

School-based drug education programs that adopted this social influence approach provided students with information, resistance skills training, and normative education (Dorn & Murji, 1992; Hansen, 1993; Midford, 2000). Normative education encompasses correcting student misconceptions relating to their peers’ drug use. Students are prone to overestimate the extent of their peers’ drug use; hence, programs that adopted the social influence approach sought to present the statistical facts in order to establish accurate group norms (Botvin, 2000; MacKinnon et al., 1991; Stead & Angus, 2002). These programs also supported students to identify social influences and pressures, and to develop resistance and refusal strategies. Resistance skills training sought to develop students’ skills to deal with social pressures to use drugs (peers, media, or family). Students practiced resistance strategies through role-plays in order to develop behavioral skills to resist social influences (Donaldson, Graham, & Hansen, 1994; Dorn & Murji, 1992).

Social influence approaches have been extended to incorporate a more general social skills component, such as in the Life Skills Training program developed by Botvin and colleagues (Botvin & Kantor, 2000). Life skills are broad social skills including communication skills, interpersonal skills, and conflict resolution skills. General skills are developed for a broad range of applications; they are not only targeted to resisting pressure to engage in drug use (Faggiano et al., 2005; Hansen, 1993).
There is some evidence that social influence approaches to drug education impact students’ behavior via abstinence or delayed drug use (Cuijpers, 2002; Dusenbury & Falco, 1995; White & Pitts, 1998). Wragg (1990, 1992) found that students who participated in these programs were significantly less likely to start using tobacco or cannabis, but did not differ from control groups in their alcohol consumption. He also found that students who participated in social influence programs demonstrated a lower level of use and a better ability to use drugs responsibly. However, other studies indicate that there is very little long-term impact for social competency models (Gorman & Conde, 2009; Lloyd, Joyce, Hurry, & Ashton, 2000).

**Ecological approaches**

School-based drug education programs have shifted from information-based to social influence approaches and more recently to multilevel ecological approaches (Aguirre-Molina & Gorman, 1996; Flay, 2000; Stigler, Perry, Komro, Cudeck, & Williams, 2006). The premise of this multilevel ecological approach rests on the assumption that health-related behaviors are the result of interplay between “person and environment, agency and structure, individual and society” (Astbury, 2011, p. 19).

Ecological approaches to prevention take into account the multiple spheres of social influence on young people, including family, school, peers and community. Using a classroom-based program as a base, adolescents’ social environment is addressed, including whole of school programs, family programs, mass media and community interventions. (Roche, 2010, p. 129)

Astbury (2011) summarized the three sets of behavioral change theories that are combined in a multilevel ecological approach: individual-, interpersonal-, and community-level theories. The individual-level theories are used extensively by health practitioners to understand the psychological and intrapersonal factors that influence an individual’s practical judgment. These factors include knowledge, attitudes, beliefs, skills, and motivation. The interpersonal-level theories focus on significant others who influence the individual’s perceptions and behavior. These include family members, teachers, peers, health professionals, coaches, and so on. Community-level theories examine the influence of groups, organizations, social institutions, laws, and policy makers upon an individual’s and a population’s health.

The multilevel ecological approaches vary in the components incorporated in the intervention programs. Consequently, it has proven difficult to ascertain their effectiveness. Stead et al. (2009, p. 3) asserted that multicomponent drug education approaches “are
possibly more effective than those that are single-component in nature and that primarily target the individual.” The marginal nature of these findings is supported by Flay (2000).

Goals of Drug Education

**From prevention to harm minimization**

Since the launch of the temperance movement, drug education has set out to encourage prevention. School-based programs were designed to reduce drug use and were evaluated using this measure. This goal has dominated drug education in the US in particular. By attempting to remedy an individual’s deficits in knowledge, values, and/or skills, drug education programs sought prevention as a goal. Midford (2009) questioned the appropriateness of this goal given that some forms of drug use are normative in Western society, interwoven into adult social activities.

Is it any wonder, then, that the young people of these countries seek to drink when they are on the threshold of adulthood? Should our prevention strategies be based on a conceptualization of this behaviour as deficient and in need of remediation? Ideally, parents, politicians, policy makers and prevention scientists alike would prefer to prevent all drug use because of the inherent risks involved, but this is not realistic and programmes with such a singular aim may be [sic] actually be counterproductive. (Midford, 2009, p. 1692)

Midford (2009) asserted that prevention programs need to acknowledge drug use as not necessarily drug abuse, and to set alternative and realistic goals focused on reducing harm. School-based drug education programs with the aim of harm minimization strive to develop strategies that can encourage students to make appropriate judgments that facilitate safe drug use in every situation. The evidence indicates that no drug use is completely safe; hence, harm minimization drug education seeks to prevent or reduce the harm associated with drug use. Harm minimization accepts that, despite the best efforts invested, some young people will use drugs, even some illicit drugs. Abstinence, therefore, becomes one of many varied outcomes to reduce harm associated with drug use.

Harm minimization has been a guiding principle of government policy in Australia since 1985. According to the Ministerial Council on Drug Strategy (2011), harm minimization encompasses the three pillars of: (1) demand reduction, (2) supply reduction, and (3) harm reduction. It involves a range of approaches including prevention, early intervention, specialist treatment, supply control, safer drug use, and abstinence. Harm minimization intends to reduce harm to drug users and the community as a whole.
(Pennington, 1999). Its strategies differ based on the type of drug, the individuals involved, and the context in which the drug is used.

The *Strategy for Individual School Drug Education Guidelines* (Department of Education, 1998) outlines the aims of the harm minimization approach, which are to: (1) develop personal, social, and cognitive skills that equip students to deal with drug-related issues in a variety of contexts; (2) increase student understanding of the impact of drugs on society; (3) increase student understanding of the continuum of risk associated with drug use (this continuum is determined by the drugs used, the context in which they are used, and the people involved); and (4) increase student knowledge and skills that will equip them to contribute to the public debate about drug-related issues.

The effectiveness of a school-based drug education program is determined by reduced harm regardless of consumption. Put simply, if a prevention program fails to convince teenagers to consume alcohol at a party, but persuades them to not drive home, it would be considered effective in harm minimization terms (McBride et al., 2003, 2004; Midford, 2009).

Those who oppose the goal of harm minimization in drug education warn that this approach can appear to condone or ignore the moral dimensions of drug use. Bush and Neutze (2000) outlined four diverse moral positions in the drug debate: (1) Drugs can be allowed so long as others are not harmed, (2) some drug use is fundamentally wrong, (3) addiction is inherently wrong, and (4) some drug use is undesirable since it negatively impacts the welfare of individuals and/or community.

Teachers may express concerns about the potential of the harm minimization approach to undermine their professional judgment, while parents may be apprehensive about the safety of their children (Midford, McBride, & Munro, 1998). Therefore, it is critical that an exploration of matters of concern, as well as an explanation of the harm minimization approach, is communicated to all stakeholders in the school community. Ballard, Dawson, and Jackson (2002a) confirm that when the rationale of the approach is clearly communicated and understood, both parents and teachers embrace harm minimization.

The National Centre for Education and Training on Addiction’s (NCETA, 2010) report on *The Role of Schools in Alcohol Education*, which involved investigation of the nature of drug education in Australian schools, concluded that the schools consulted almost universally adopted the more realistic goal of harm minimization. In fact, research suggests that 90% of a
national sample of Australian teachers were “very supportive” of having harm minimization as the primary goal of school-based drug education programs (Midford et al., 2002).

**Education as the goal**

Evans (2002) proposed an entirely different goal for school-based drug education. Rather than pursuing prevention or harm minimization, Evans argued that drug education programs should aim to educate the participating students. Drug education helps fulfill every student’s right to learn about the world, and to analyze, understand, and act within that world. Consequently, she argued that the quality of the programs ought to be examined based on education, rather than by the “whims, desires and informed choices” (p. 19) of the students.

Ballard et al. (2002b, p. 17) quote Wilson (1998), who suggested that “school is not about repairing all social evils. It is about repairing one: the evil of ignorance.” Consequently, Wilson emphasized that teachers cannot be expected to “fix homelessness or stamp out violence, or prevent AIDS or end drug abuse” (p. 17). Schools are warned not to set targets to change behaviors; otherwise, they risk becoming “deflected from [the] real educational task . . . [and] be blamed for failing to achieve targets which are not in their control” (p. 17).

Roche (2010) underlined that school personnel generally believe schools should not be held accountable or responsible for changing students’ drug use behaviors. In an extensive national report, teachers were quoted as saying, “we’re not the people to fix every problem a young person has” (p. 214). Rather, they asserted that a school’s main role is “to present information, provide options and alternatives and to help students make informed choices” (p. 214). Schools concede the untenable responsibility associated with independently bearing the burden of such imposing educational goals.

**Partnerships Between Schools and Life Education Victoria**

The attainment of educational goals pertaining to health and drug education necessitates partnerships between schools and external providers. Astbury (2011, p. 12), in reviewing the role of LEA, underscored the essentiality of fostering partnerships with schools in order to establish health-promoting environments:

A cross sectoral partnership approach is necessary, involving a diverse range of stakeholders, coordinating resources and effort, enlisting skills and expertise, and bringing people together to work collectively, delivering the wide ranging and broad based set of interventions across the whole community needed to achieve the common goal—the health and wellbeing of our children and young people. (Astbury, 2011, p. 12)
Defining partnerships

Schools engage in diverse interorganizational partnerships ranging from community groups and local businesses to school districts, universities, and national corporations. A report by the Australian Council for Educational Research (Lonsdale, 2011) delineated the wide range of groups who enroll in school-community partnerships. These include local government, state or federally funded partners, health-related organizations, sporting clubs or associations, charities, community support services, small local businesses through to large multinational corporations, universities, TAFEs, and apprenticeship centers. Furthermore, schools partner with art galleries, religious organizations, and fee-for-service programs.

Despite the diversified types obtainable, school-community partnerships commonly reflect a joint commitment and a shared responsibility to meet students’ needs intellectually, socially, and/or emotionally (Willems & Gonzalez-DeHass, 2012). Authentic partnerships are defined as “respectful alliances among educators, families, and community groups that value relationship building, dialogue, and power sharing as part of a socially just, democratic school” (Auerbach, 2010, p. 729).

LEV perceives its role and delivery of its program as a partnership with schools and generalist classroom teachers. Astbury (2011) reported that the Life Education program is designed to be delivered in part by the Life Education educator with the support of the class teacher, and in part, by the class teacher who is provided with resources to support the delivery of an additional 20 hours of follow up, complementary learning. (Astbury, 2011, p. 18)

Accordingly, LEV’s effectiveness in delivering school-based drug education is predominantly contingent upon its partnerships with schools, entailing the contributions of both parties. This is consistent with Barnett, Hall, Berg, and Camarena’s (2010) reported definition of partnership: as two or more organizations that share common goals, which cannot be reached by either party independently. However, Carbines et al. (2006) observed the challenges associated with such interorganizational partnerships between schools and LEA.

Life Education’s greatest challenge in working with schools will always come from the essential nature of the organisation as being independent from formal schooling structures and systems. As an ‘outsider’ it will never have the capacity to dictate the nature of its engagement with schools. It will never be able to demand that teachers follow up or apply Life Education’s resources in a particular way. (Carbines, et al., 2006, p. 22)
Notwithstanding these quandaries, Astbury (2011) asserted that LEA could foster partnerships with schools and classroom teachers that are beneficial to both institutions.

**Benefits of partnerships**

Partnerships between schools and external organizations benefit students, families, staff, schools, and/or their communities. While schools welcome the increased resources, support, and expertise, community partners are mutually compensated through the partnership. These include benefits to their business or program, personal satisfaction or growth, as well as enhanced knowledge of best practices (Sanders, 2006).

Meehan, Wiersma, and Riffle (2002) predicated that partnerships between educational organizations are not only desirable, but are increasingly necessary. In fact, Casto (2016) called on schools to embrace partnerships with other organizations in order to best serve their students.

In other words, there are so many pressures on schools, students, and families that schools cannot single-handedly do the job of educating children, but can maximize their efforts by reaching beyond their walls and partnering with other organizations to best serve the needs of children. (Casto, 2016, p. 141)

Distinctly interorganizational partnerships provide schools with unique expertise, support, innovative solutions to complicated problems, and resources to successfully meet students’ needs (Blank, Jacobson, & Melaville, 2012; Callahan & Martin, 2007; Casto, 2016; Epstein, 2011; Meehan et al., 2002; Sanders, 2006). The report by the Australian Council for Educational Research (Lonsdale, 2011) identified the main motivations for schools to set up these partnerships, which included improving student engagement, academic outcomes, and social well-being, as well as broadening vocational options and skills. The diversified benefits associated with interorganizational partnerships between formal and informal educational institutions are alluded to in the drug education literature (Ringwalt et al., 2009; Roche, 2010; Stead et al., 2009).

**Prevalence of partnerships**

The prevalence of partnerships between schools and external providers in order to facilitate drug education has been broadly documented. Buckley and White (2007, p. 42) emphasized the global prevalence of outsourcing drug education, with “over 80 percent of schools in the USA and the UK using external contributors to deliver substance use education.” These external providers may include “police officers, members of drugs and alcohol services,
specialist drug services for young people, community groups, school nurses and other health professionals, personal advisors from youth organisations, theatre groups, youth services, parents of former drug users” as well as “national charities such as Life Education Centres” (p. 43).

The increasing pervasiveness of outsourcing drug education in schools is exemplified through the growth of the Drug Abuse Resistance Education (DARE) program in the US. DARE involves the use of trained police officers in the classroom to teach a highly structured drug education program. It is a collection of age-specific programs offered to primary school students (usually in the fifth grade), middle school students (usually seventh and eighth grade) and senior high students (usually ninth or 10th grade). The programs range from a 17-hour curriculum in primary school to a five-hour curriculum in secondary school. The distinctive feature of this school-based drug education program resides in the increasing popularity of its use in schools globally.

Rosenbaum and Hanson (1998) reported that the DARE program was administered in about 70% of U.S. school districts reaching 25 million students in 1996. By 1998, DARE was considered the most frequently utilized school-based drug education program across the US (DARE America, 1998). By 2000, 36 million students around the world were involved in the program, which was facilitated in 80% of the nation’s school districts and in 52 countries globally (DARE America, 2000).

The global trend of outsourcing school-based drug education through DARE and Life Education programs is also evident in Australia (Midford, 2000; Smith, 1986). The report by Roche (2010, p. 6) states that “the majority of schools consulted also invited the occasional guest speaker as part of their strategy to educate students about alcohol.” The report further indicates that external providers ranged from experts in the field to recovering alcoholics and victims of alcohol-related accidents. Police officers, guest speakers, and external organizations were reportedly invited into schools to support the facilitation of drug education.

In 1996, the Victorian Government made funds available for drug education programs, particularly in schools, announcing Turning the Tide as a drug reform strategy. The strategy was the outcome of an investigation into illicit drug use conducted by the Premier’s Drug Advisory Council (PDAC). The council was tasked with investigating approaches to reduce the demand for illicit drugs in Victoria. As the PDAC report Drugs and Our Community (1996) articulates, they proposed approaching illicit drugs as a health care matter, addressing
it through education, prevention, treatment, and rehabilitation. As part of the strategy, the Government sought to incorporate drug education as a core component of the school curriculum, providing teachers with appropriate training and resources for effective implementation. To support this strategy, the Victorian Government allocated over $14 million toward drug education in Victorian schools over three years (Department of Education, 1998). Victorian schools were given access to a number of specific drug education programs (including those involving external providers). A number of major and minor drug education programs were funded: Get Real, Life Education, and DARE.

**Types of partnerships**

Educational partnerships have been categorized differently throughout the literature. Combining the types of partnership identified by Tushnet (1993) and Barnett et al. (2010), I distinguish four broad categories: (1) primary or limited or vendor partnerships, (2) coalition partnerships, (3) collaborative or symbiotic partnerships, and (4) spin-off partnerships.

Primary or limited or vendor partnerships are the simplest type, involving the provision of services to either an organization or its clients. Coalition partnerships exist when participating organizations interact based on mutual exchange or benefit, dividing the labor in order to seek common goals. Collaborative partnerships, on the other hand, occur when equal partners have mutually conceived goals and policies and divide both labor and decision making on a continuous basis. Finally, spin-off partnerships are highly complex, whereby two organizations may join forces in the creation of a new corporation to accomplish their stated goals. These types of partnership have been employed to explain school partnerships with universities specifically, as well as external providers in general. They resemble the types of relationship observed among schools and informal educational institutions.

The levels of interdependence between formal and informal educational organizations have been differentiated by three classifications: (1) cooperation, (2) coordination, and (3) collaboration (Callahan & Martin, 2007; Intriligator, 1986; Meehan et al., 2002). If viewed on a continuum, cooperation describes the least level of interdependence, while collaboration the highest level of interdependence.

Cooperation is considered the lowest level of partnership between organizations. It is characterized by collaborative activities toward a particular, short term and focused goal or a single task. Organizations remain autonomous and the roles of each partner in the relationship do not overlap, whereby the task can be completed either separately or together. Such partnerships are relatively easy to implement, requiring very little coordination,
planning, or cultural and structural shifts in school functioning. When well implemented, their impact is likely to be positive, albeit limited (Intriligator, 1986; Weiland & Akerson, 2013).

Coordination is a type of partnership between organizations grounded in a long-term relationship or project, and can be more formalized. Roles may overlap; however, the success of tasks achieved by the partnership is greatly enhanced by each party’s expertise. Similar to that of the cooperation partnership, the purpose of the coordination partnership remains rather focused and the organization’s function autonomous, yet they may relinquish some independence to accomplish their shared goals. They often predetermine operational outcomes, associated strategies, and procedures to resolve disagreements (Intriligator, 1986; Meehan et al., 2002; Weiland & Akerson, 2013).

Collaboration is a long-term relationship that supports the engagement of complex multiple tasks. Organizations agree to relinquish some of their autonomy to accomplish shared goals as a combined effort on all levels: staff, skills, and resources. The partnership of both parties can instigate the creation of a new separate entity. Collaboration requires more commitment, risk, negotiation, and involvement than in cooperation and coordination types of partnership (Intriligator, 1986; Meehan et al., 2002).

Weiland and Akerson (2013) examined the nature of a partnership between a fifth-grade teacher and an informal science educator as they facilitated a science unit in the classroom. The partnership was defined through a framework of cooperation, coordination, and collaboration. Their findings advocate that a partnership of coordination, which involves moderate commitment, risk, negotiation, and involvement, was sufficiently effective, achieving positive student outcomes.

Effective partnerships

Weiland and Akerson (2013) affirmed that investigating the characteristics of effective partnerships between formal and informal educational institutions can “aid in fostering similar partnerships to meet the needs of educators as well as promote student learning in the elementary classroom” (p. 1350). According to Sanders (2006), effective school-community partnerships command three essential factors: (1) a shared vision, (2) clearly defined roles and responsibilities, and (3) open communication.

Effective partnerships require the establishment of a common vision, one that directs, motivates, and aligns partners toward meeting their specified goals. Complex partnerships require a collaborative process in building consensus on scope, direction, and goals. All
partners require a clear understanding of their roles and responsibilities as well as the expectations surrounding their contribution. Clearly defined expectations limit misunderstandings that can jeopardize the partnership's effectiveness. Moreover, open communication necessitates a systematic process through which shared visions are created, and roles and responsibilities are articulated. This is a critical success factor in school-community partnerships.

Manifestly, unexamined partnerships can foster ambiguity that undermines their functionality and effectiveness. Tsou et al. (2015), through their exploration of interorganizational partnerships in the context of Australian Aboriginal organizations and mainstream agencies, acknowledged that “partnerships are particularly undermined and collaborations weakened through lack of clarity about respective roles resulting in confusion about the partnership’s purpose, its objectives and how to measure its success” (p. 2).

Unexamined partnerships between LEV and primary schools can similarly produce ambiguity and role confusion. Therefore, the purpose of this research was to contribute to that understanding through (1) an examination of the nature of the partnerships between schools and LEV (i.e., the context of the partnerships between generalist teachers and specialist educators) and (2) an examination of the generalist teachers’ experiences working together with specialist educators, particularly in the unique setting whereby specialist educators are invited into the school setting, yet not into the actual classrooms (see Chapter 3). A framework to examine the nature of the partnerships between LEV and schools was required for this study and adopted from Weiland and Akerson (2013).

Weiland and Akerson (2013) constructed their framework in order to examine and classify partnerships between formal and informal educational institutions (and educators), building on previous work conducted by Buck (1998) and Intriligator (1992). This framework was composed of eight dimensions and postulated a structure to interpret the relationships among partners based on pre-established definitions. These eight elements of partnership include communication, duration, formality, objectives, power and influence, resources, roles, and structure (Table 1).
Table 1. Weiland and Akerson’s (2013, p. 1338) Combined Framework of Partnerships

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Cooperation</th>
<th>Coordination</th>
<th>Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>Occurs only for the purposes of task at hand</td>
<td>Frequent communication that occurs outside of task at hand</td>
<td>Frequent and open communication; level of comfort allows for honesty and disagreements</td>
</tr>
<tr>
<td>Duration</td>
<td>Short term</td>
<td>Intermediate term</td>
<td>Long term</td>
</tr>
<tr>
<td>Formality</td>
<td>Informal (not institutionalized)</td>
<td>Slightly formal</td>
<td>Formal (institutionalized)</td>
</tr>
<tr>
<td>Objectives</td>
<td>Objectives may or may not overlap</td>
<td>Complex single task; common goal; shared rewards</td>
<td>Long term; complex multiple tasks; success dependent on partnership; common goals and mission; shared rewards</td>
</tr>
<tr>
<td>Power and influence</td>
<td>Locus of control rests with individual educators; disagreements about turf are not an issue</td>
<td>Locus of control rests with individual educators; disagreements resolved by “majority rule”</td>
<td>Locus of control rests within the partnership; disagreements resolved using consensus-building processes</td>
</tr>
<tr>
<td>Resources</td>
<td>Supported with discretionary funds controlled by of the individual agencies; provided on a one-time-only basis; resources kept separate</td>
<td>Supported with dedicated funds from the individual agencies that remain within control of the individual agencies; shared resources</td>
<td>Supported by pooled resources that are largely within the control of the collaborative interagency unit; resources provided for an extended period of time; shared resources</td>
</tr>
<tr>
<td>Roles</td>
<td>Roles do not overlap; each individual has specialized expertise that their partner does not or cannot offer</td>
<td>Roles overlap a bit; individual’s areas of expertise may overlap, but programming is greatly enhanced by partnership</td>
<td>Roles overlap significantly; each individual trusts their partner to successfully execute and reach goals and objectives</td>
</tr>
<tr>
<td>Structure</td>
<td>Can be done alone or together; separate entities</td>
<td>Cannot be done alone but still two separate, codependent entities</td>
<td>Separate entities unite to form a new structure</td>
</tr>
</tbody>
</table>
The partnerships between primary schools and LEV have not been examined through a defined framework as outlined above. Consequently, Weiland and Akerson’s (2013) eight-dimension framework will be used to classify the relationships between the schools and LEV, and the context of the partnerships between classroom teachers and external providers. However, another framework is required to examine generalist teachers’ experiences in partnering with specialist LEV educators to deliver school-based drug education. This is explored in Chapter 3.

Summary

In this chapter, I have presented a literature review of the approaches and goals of school-based drug education, as well as the nature of the partnerships between formal and informal educational organizations, to facilitate drug education in primary schools.

Drug education approaches have evolved through diverse phases since their inception in the 1880s. The various approaches comprised educating students about drugs, self, and social skills, as well as their environment. Contemporary school-based drug education programs have progressed from scare tactics, to information-based approaches, to affective-oriented approaches, to social influence approaches, and more recently to multilevel ecological approaches to health promotion.

In some countries, including Australia, the goal of drug education has metamorphosed over time, from total abstinence advocated by the temperance movement to harm minimization (noting that in the US, vestiges of abstinence remain). Regardless of the espoused goal, school-based drug education has sought to change students’ knowledge, attitudes, and behaviors concerning drug use and/or misuse. However, the capacity of generalist classroom teachers to deliver more than mere knowledge remains questionable. Consequently, schools often resort to external specialists to assist with the provision of school-based drug education programs. Partnerships with informal organizations are necessary if schools are to reach their stated goals of delivering effective health and drug education. They provide schools with unique expertise, support, innovative solutions to complicated problems, and resources to successfully meet students’ needs. The levels of interdependence between formal and informal educational organizations have been distinguished by three classifications: (1) cooperation, (2) coordination, and (3) collaboration. If viewed on a continuum, cooperation describes the least level of interdependence, while collaboration describes the highest level of interdependence.
Unexamined partnerships between LEV and primary schools can foster ambiguity that undermines their functionality and effectiveness. Therefore, the purpose of this research was to contribute to that understanding through (1) an examination of the nature of the partnerships between schools and LEV (i.e., the context of the partnership between generalist teachers and specialist educators) and (2) an examination of the generalist teachers’ experiences working together with specialist educators, particularly in the unique setting whereby specialist educators are invited into the school setting, yet not into the actual classrooms (see Chapter 3). A framework to examine the nature of the partnerships between LEV and schools was required for this study and hence, was adopted from Weiland and Akerson (2013).
CHAPTER 3: Teachers and Drug Education

In this chapter, I examine literature concerning the roles of generalist and specialist drug educators, the nature of their partnerships as well as the rationale, benefits, and challenges associated with outsourcing health education in general, and drug education specifically. Finally, a framework is adopted from Quay (2013, 2015) to explicate the two roles—classroom teacher and specialist educator—that sit at the heart of the partnership. These are not merely identities as they also encompass both skills and knowledge that each brings to bear in conducting drug education.

Issues of Curriculum, Pedagogy, and Relationships

Student–teacher relationships have been consistently reported as an instrumental factor in the degree of students’ receptiveness to drug education (Bangert-Drowns, 1988; Bishop, Giles, & Bryant, 2005; Lloyd et al., 2000; Meyer, 2004). A report by the NCETA (Roche, 2010) revealed that both teachers and students emphasized the importance of cultivating positive coaching/mentoring relationships that promote trust, honesty, and nonjudgmental interactions. In fact, it was found that the perceived suitability of teachers as drug educators was primarily dependent on their relationship with students. The common conception was that teachers who had a more open, trusting, and mentoring relationship with students (often younger teachers) were better alcohol educators.

Conflicting results regarding this conception were revealed in studies focusing on the All Stars program: a character education and problem behavior prevention program for schools, which included drug education. Harrington, Giles, Hoyle, Feeney, and Yungbluth (2001) argued that classroom teachers involved in the All Stars program produced more positive results than any other drug education curriculum implementers. However, this finding was inconsistent with research conducted on the same drug education program by Ringwalt et al. (2009, p. 707), who reported that “students whose classroom teachers administered All Stars generally manifested poorer outcomes than students taught by other types of school staff,” whereas “students taught by their regular teachers were significantly more likely to use marijuana and less likely to report positive changes in their normative beliefs concerning the extent of their peers’ use of substance.”

While Ringwalt et al. (2009) did not endeavor to explain the imminent reasons for their findings, they referred to other research which proposed that “students might respond more positively to a curriculum taught by someone whom they consider an outside expert” (p.
This suggests that the educator’s knowledge and skill (expertise) are significant factors in the effectiveness of a drug education program, not just their relationship with students.

Aldridge (2008, p. 185) highlighted that one of the key roles of health educators is to be “an expert source of information used by the vast majority of young people who both want and require this on their lifelong health and drug journeys.” However, many teachers believe that they lack the necessary confidence, knowledge, and competence to facilitate health education effectively (Goldman, 2010; Johnson, Marguerite, Sendall, & McCuaig, 2014; Ollis, 2005; Parker, Wellings, & Lazarus, 2009; Smith et al., 2013; Wight et al., 2002). Roche (2010) confirmed that health education teachers feel that they lack the required knowledge to adequately teach drug education, in contrast to the knowledge held by external specialists.

Based on their observations and interviews, Stead et al. (2009), as well as Roche (2010), acknowledged that students may also prefer to hear from experts who are more knowledgeable in this area than their school teachers seem to be. Roche (2010) reported that “Some students had similar beliefs about credibility, as one catholic school student from South Australia remarked, ‘better to get someone in who knows what they’re talking about’” (p. 185). However, school-based drug education involves far more than transmitting comprehensive subject content. Knowledge alone does not influence behaviors, as teachers’ pedagogical skills make a significant impact on students’ learning. Systematic reviews have indicated that the effectiveness of school-based drug education programs may be more dependent on the delivery method utilized than the program content. In other words, school-based drug education demands more than content knowledge expertise, in addition requiring a well-developed grasp of appropriate pedagogies.

Teachers’ pedagogical approaches have substantial implications for the effectiveness of school-based drug education programs. Tobler (1986) was the first to publish a meta-analysis of substance use prevention program evaluation studies. Tobler and her colleagues conducted a series of comprehensive studies to systematically examine how prevention programs are delivered (Tobler, 1986, 1992; Tobler, Roona, Ochshorn, Marshall, Streke, & Stackpole, 2000; Tobler & Stratton, 1997). They classified drug education programs into two types: interactive and noninteractive. Importantly, Tobler confirmed that delivery methods were more influential than content in determining program efficacy.

Teachers who employ a didactic approach assume that students learn best through knowledge transmission and acquisition. Programs are taught through a traditional lecture or
presentation with little interaction among students or feedback from participants. Teachers transmit information, provide answers to students’ questions, and communicate health solutions. Cahill (2007) referred to research in the field of motivational interviewing to explain the rationale behind the failure of this pedagogy, which suggests that “insistence” can promote “resistance,” and that students are likely to resist health solutions enforced upon them. Alternatively, when students are engaged in creating the solutions themselves, they are likely to implement them. This provides students with the ownership required to stimulate behavioral change. This can only be implemented through interactive pedagogy (Cahill et al., 2014).

Teachers who employ interactive pedagogies facilitate student-centered and collaborative teaching methods to develop students’ drug-related knowledge, skills, and attitudes (Meyer, 2004). Interactive pedagogies engage students in problem solving, critical thinking, and applying their learning to real-life situations (Dusenbury & Falco, 1995). Teachers facilitate small-group activities, discussions, and role-plays to develop students’ knowledge and skills.

Interactive pedagogies emphasize a collaborative teaching environment. Teachers who employ collaborative pedagogies understand that decisions on drug use are often made in social contexts. Collaborative learning provides students with opportunities to enhance their social competency, manage their relationships, and develop value clarification skills (MacKinnon, Johnson, Pentz, Dwyer, Hansen, & Flay, 1991; Rundall & Bruvold, 1988; Tones & Tilford, 2001). Cahill (2007) proposed that drug education programs should assist students to deal with the complex social influences exerted on decision making, without demonizing them.

Roche (2010) advocated teaching methods that empower students to take ownership of their learning and behavior. Instead of teachers presenting a moral argument about alcohol use and providing answers to their own questions, they simply frame the questions and allow the students to develop their own solutions and strategies to avoid risk (Cahill, 2007). In this way, students take ownership of their learning and develop their skills in negotiating and solving problems that may be applied across a range of different situations and other risky behaviors. The use of interactive teaching strategies has been consistently identified as a critical component of effective school-based drug education programs (Cuijpers, Jonkers, De Weerdt, & De Jong, 2002).
a high degree of student-to-student interaction and active learning—are nearly always more effective than non-interactive programmes” (Stead et al., 2009, p. 2).

Despite their importance, interactive pedagogies are recognized as the one area of breakdown in delivering effective drug education (Cahill, 2004, 2007; Faggiano, Vigna-Taglianti, Versino, Zambon, Borraccino, & Lemma, 2005; Meyer, 2004; Midford et al., 2006). Moreover, researchers assert that while teachers are best positioned to deliver school-based drug education, they often lack the knowledge, skills, and confidence to facilitate interactive school-based drug education. Roche (2010) suggested that teachers’ abilities to deliver quality drug education programs vary substantially. In fact, researchers in the US determined inconsistencies among teachers in terms of their knowledge, understanding, and skills in delivering drug education programs (Hansen & McNeal, 1999; Loxley et al., 2004).

Generalist primary teachers facilitate literacy, numeracy, science, social science, as well as drug education. However, they may not be sufficiently trained in the health and physical education domains. Dusenbury, Brannigan, Falco, and Hansen (2003) submitted that teachers are more inclined to deliver the knowledge-based components of a program and ignore the more effective interactive components. Furthermore, Roche (2010) highlighted three main barriers that schools encounter in implementing school-based drug education programs. These barriers include a crowded curriculum, lack of up-to-date resources, and divergence of opinion about who should deliver drug education. Consequently, schools often resort to specialist educators to assist with the provision of school-based drug education programs.

Specialist Educators and Drug Education

Schools engage specialist educators for a range of reasons. One of the most commonly cited is to provide students with unique experiences (Ardzejewska, 2009; Smith et al., 2013). It is believed that students’ motivation to learn increases as a result of exposure to the fresh experiences, enthusiasm, and expertise of the external providers (Ardzejewska, 2009; Evans, 1993; Stead et al., 2009). In research conducted by the NCETA (Roche, 2010, p. 8), teachers reported that external providers were “well-received by students who seemed more attentive and responsive during these sessions.” One teacher is reported commenting on an external program, saying that it “excites the kids” because external specialists “have got it down-pat” (pp. 185–186). This teacher concluded that students appreciate the involvement of external providers. Overall, teachers in the report believed that guest speakers were perceived as more
credible from the students’ standpoint and provided a good opportunity to break the monotony of routine classroom lessons.

The support offered by specialist educators ranges from “resource availability, professional development, collaborative learning, research opportunities and management of programs to target audiences” (Smith et al., 2013, p. 250). Access to resources is a major consideration when schools engage with external providers. In a systematic review of the role of external providers in school-based drug education, Buckley and White (2007, p. 43) found that, “in addition to their work directly with pupils in the classroom, external specialists may be involved in the development of resources for use in schools. These resources include interactive CD-ROMs, videos, games, leaflets and other printed material.”

One of the most frequently reported reasons for using outsourced health education was to access the external providers’ expertise, which may not be held by generalist teachers (Ardziejewska, 2009; Evans, 1993; Macdonald, Hay, & Williams, 2008; Webster, 2001). Access to this expertise assists teachers who lack confidence to teach in this area and fear the corollary of potential mistakes (Goldman, 2010; Harrison & Hillier, 1999; Leahy, Horne, & Harrison, 2004; Ollis, 2005; Parker et al., 2009; Smith et al., 2013; Wight et al., 2002).

Johnson et al. (2014, p. 359) confirmed that “in the absence of teacher confidence and competence, schools have often relied on health promotion professionals, external providers, and/or one-off issue-related presentations rather than cohesive, systematic and meaningful health education.” Such expertise may also be provided via PD opportunities for teachers, so that they may observe “expertise” in action (Ardziejewska, 2009; Evans, 1993; Lavin, 2008).

Schools perceive external providers to be “an effective strategy by which to up-skill their own staff while also providing variety and interest for students” (Roche, 2010, p. 6). Teachers believe that this expertise is particularly important when dealing with sensitive and possibly controversial issues. Teachers’ views were consistent with researchers’ recommendations to utilize credible people to “provide information that is unambiguous . . . accurate and balanced and that is appropriate to the audience's developmental level” (Rowling, 1995, p. 5).

Schools outsource health educational work in order to meet new outcomes that may add to an already overcrowded curriculum, demanding teacher responsibilities and time constraints (Goldman, 2010; Johnson et al., 2014; Leahy et al., 2004; Macdonald et al., 2008; Ollis, 2005). Petrie (2011) suggested that external health education providers offer a pragmatic solution for schools and teachers burdened by crowded curriculum. For teachers
who lack confidence or are inundated by the work expected of them, “the outside provider doing the teaching or providing teachers with a ‘takeaway’ resource with lessons and activities offers a ready-to-use solution” (p. 15).

The challenges of engaging with specialists

In spite of the numerous reasons schools employ the services of external providers, there are also challenges that accompany the outsourcing of health education in general, and drug education in particular, such as financial costs, narrow understanding of the learners and school context, as well as undermining teachers or overreliance on external providers. McCuaig (2005) argued that primary schools cannot rely on external specialists who facilitate “one-off” presentations “which are often topic-specific, rely on novel resources and involve professionals with limited knowledge of the school program, students or community” (p. 67).

Petrie (2011, pp. 13–14) acknowledged that external providers may possess content knowledge, yet “they may have narrow understandings of the learners . . . and the context of primary schools.” This limitation undermines the effectiveness of the program. In fact, the Principles for Effective School Drug Education, published by the Australian Government Department of Education Science and Training (Meyer, 2004), asserted that effective drug education programs need to be “appropriate to the school context” (p. 21). Furthermore, Petrie contended that it is difficult for external providers “to make connections with learning opportunities provided in other curriculum areas and with broader school initiatives” (p. 15). This constraint also undermines the effectiveness of school-based drug education programs. Schools are encouraged to “embed drug education within a comprehensive whole school approach to promoting health and wellbeing” (Meyer, 2004, p. 18).

Macdonald et al. (2008, p. 11) indicated that external specialists provide generic programs or services that often lack “fit” with the school ethos, curricula, or programs. These generic programs may not “provide culturally appropriate, targeted and responsive drug education that addresses local needs, values and priorities” (Meyer, 2004, p. 30). Correspondingly, Burrows (2005) questioned the appropriateness of national or international external providers in meeting the diverse needs and interests of learners in a multicultural context. Similarly, Petrie (2011) conveyed the undesirable consequences of utilizing standardized programs without adjustments to the specific local needs of individual students, classes, and schools. These include taking the place of curriculum, providing limited or superficial links to the curriculum, as well as being disconnected from broader school ethos. Lees-Amon (1999, pp. 42–43) singles out DARE and Life Education programs as examples
of the “danger that what is being taught is not consistent with school policy and does not take into account individual issues such as culture, gender and ethnicity factors.”

Ardzejewska (2009) denoted that prohibitive financial cost is the most prevalent reported reason behind schools’ refusal to outsource health education to external providers. Macdonald et al. (2008) submitted that the financial cost involved in outsourcing programs creates two problems: a lack of sustainability and a lack of equity. Fee-for-service programs are difficult to sustain over a period of time and the costs transferred to parents cause inequality, particularly with lower socioeconomic schools and families. When financial resources are directed elsewhere, the sustainability of health education outsourcing is likely to be determined by the relative dependency on external providers (Davis-Blake & Broschak, 2009; Vincent, 2005; Williams et al., 2008).

The negative impact specialists could have on classroom teachers is by and large the most disconcerting challenge associated with outsourcing health education. Macdonald et al. (2008, p. 11) claimed that external providers undermine and potentially “de-skill” the generalist teachers. This criticism has been directed specifically at LEA as an external provider of school-based drug education programs. Lees-Amon (1999, p. 42) argued that LEA disempowers schools “by the very fact that outside facilitators come in and provide students with an incursion about drugs . . . teachers are temporarily handing over power to outside individuals whose job is to come in for a one-off session.”

Roche (2010) underscored that while students and teachers enjoyed the one-off presentation delivered by external specialists, there is no evidence to support their effectiveness. Petrie (2011, p. 15) affirmed that “external providers offer a pragmatic, fast-fix, temporary solution, compared to the sustainable and contextually relevant solution offered by well-trained classroom teachers.” Consequently, guidelines accentuate the need for drug education to be led by classroom teachers so that they can provide “young people the knowledge, skills and attitudes to appreciate the benefits of a healthy lifestyle and to relate these to their own actions, both now and in their future lives” (School Curriculum and Assessment Authority; cited in Welham, 2007, p. 152).

The Partnership Between Generalist and Specialist Teachers

Meyer (2004) upheld that classroom teachers are best positioned to provide school-based drug education. Despite their lack of content knowledge, classroom teachers are better informed of their learners and the school context than many external providers. Petrie (2011) maintained that classroom teachers develop a strong connection to learners, form a caring
learning environment, and facilitate programs that better meet the needs of their students (Alton-Lee, 2003; Faucette & Patterson, 1990; Petrie, Jones, & McKim, 2007). However, while they may be best positioned in this regard, the capacity of the classroom teachers to deliver effective school-based health education programs has also been questioned (Hansen & McNeal, 1999; Loxley et al., 2004; Roche, 2010). Whipp et al. (2011, p. 68) asserted that the delivery strategies employed by generalist classroom teachers “present substantial barriers to quality student learning outcomes.” The classroom teachers’ lack of time, knowledge, energy, training, confidence, and experience result in a reduced capability to design and facilitate effective lessons (Faucette & Patterson, 1989; Morgan, 2008; Morgan & Bourke, 2008).

Consequently, schools have explored the opportunity to foster an environment where specialist educators and generalist teachers partner together to facilitate school-based health education. In a systematic review, Buckley and White (2007, p. 57) concluded that external providers can be effective in providing school-based drug education, should they assume “a supplementary role in drug education in a manner reflecting their expertise, when that expertise maps onto the aims and content of the drug education planned by the school.” They recommended that specialists “should be included as a part of the drug education planned by the school rather than as a stand-alone session.” Principally, their systematic review articulated the benefits of a partnership between specialist drug educators and classroom teachers:

Process data suggests that when combined with class teachers (i.e. when delivering specialist sessions supported by teacher-delivered education), external contributors can bring specialist knowledge and novelty, leading to high involvement and enjoyment for pupils. (Buckley & White, 2007, pp. 55–56)

Buckley and White (2007) proposed guidelines designed to maximize the benefit of the partnership between teachers and external providers in facilitating school-based drug education programs. These include a good fit between the school and the external providers in terms of curriculum, values, and educational approaches. External providers are to meet students’ needs that cannot be addressed by existing classroom staff, and complement the lesson plans facilitated by the classroom teachers.

The proposed guidelines promote meaningful collaboration, analogous of a mutually beneficial partnership between external specialists and classroom teachers. This partnership is enhanced through meetings between teachers and external providers to plan shared
responsibilities as well as to monitor and evaluate pedagogy. It is anticipated that effective partnerships will enhance students’ learning experiences, improve teaching resources, and improve classroom teachers’ capacity to facilitate school-based drug education.

Partnerships between generalist teachers and external specialists can be a complementary exercise, providing a comprehensive learning experience for students. In their research of primary schools in Ballarat, Victoria, Smith et al. (2013) found that two key external providers complemented the work of the classroom teachers in health education. Principals and teachers reported that although external providers initiated student discussions, “internal teachers would often provide related support and information to students informally, on an ongoing basis” (p. 254).

Welham (2007) appraised a school-based drug education program delivered in Northern England in collaboration between classroom teachers and external providers (a national charity). The research outcomes indicated that “the intervention with subsequent teacher support in-class affected positively children’s knowledge of how to stay healthy and the likely impact of drugs, alcohol and smoking on the maintenance of health and well-being” (p. 149). Notably, specialists’ interventions were designed “to stimulate and support school-based actions and not to replace them.” Consequently, Welham (2007, p. 171) concluded that the partnerships between specialists and generalists classroom teachers “did show clear gains in the short term and over a longer period.”

Johnson et al. (2014) conducted research in Queensland, Australia, where they uncovered that external health education specialists provided resources that assisted classroom teachers. The evidence-based, good-quality resources enabled teachers to feel more confident in facilitating health education programs. Accordingly, the continued provision of curriculum resources by external providers was recommended, “in order to provide greater guidance on topic selection and on the depth of exploration of potentially sensitive content” (p. 371). Externally endorsed curriculum resources supported the generalist teachers who “felt they had genuine recourse and were free to ‘pass the blame’ if they experienced parental objections” (p. 372).

In partnership with external providers, teachers have an opportunity to develop their teaching practices. Whipp et al. (2011, p. 68) cited existing literature to affirm that such PD “may substantively improve generalists’ beliefs in their own ability as well as their teaching practices.” The research reported diverse benefits to teachers’ PD as they worked together with external providers. Contrary to the one-off workshops, participation with external
providers over two school terms provided an opportunity for teachers to consolidate their own professional learning. Observing a specialist’s session delivered in the school setting provided a “real world” and transferable experience in teachers’ own teaching context. The activities, structure of sessions, and facilitation style provided by specialist educators resourced teachers with activities to complement their existing knowledge. In fact, teachers reported their intentions to adopt new approaches and to continue various practices observed of external specialists.

Whipp et al. (2011, p. 75) established that working together with external specialists may provide classroom teachers “with improved knowledge and skills in order to independently manage and deliver effective PE classes.” Working together with external providers, therefore, can have a positive impact on teachers’ knowledge and skills. However, as articulated earlier there is “paucity of research into the role of outside providers” (Petrie, 2011, p. 15). There has been little empirical research on outsourcing of health education programs in general and drug education in particular. The research available is narrow in scope and the collected data are partial and fragmentary. Often, outsourcing has not been the primary focus of the research but rather a topic to which passing reference is made (Davis & Clennett, 2006; Lynch, 2007; Smith et al., 2013; Webster, 2001; Williams et al., 2008).

The roles of the generalist and specialist teachers

The clarity of roles among generalist teachers and specialist educators have been examined by substantial literature, particularly in science education research (Gupta, Adams, Kisiel, & Dewitt, 2010; Kisiel, 2005; Tal & Steiner, 2006; Tran, 2007). Findings advocate that there is confusion and uncertainty surrounding the roles of both partners. Accordingly, generalist teachers assume a passive role in the programs, inconsistently engage their students in pre and post field trip sessions, as well as limit their participation to administrative tasks. These tasks involve keeping times, organizing small groups, and managing students’ behaviors (Tal & Steiner, 2006). Informal educators reported their frustrations with the generalist classroom teachers who do not adopt an active role in the partnership (Tran, 2007).

Weiland and Akerson (2013) argued that the role of a specialist educator is to provide students with expertise and resources not readily accessible to them. The role of the generalist classroom teacher includes making connections to curricula and classroom activities, clarifying novel concepts, as well as managing students’ behaviors. However, they asserted that there was little if any research that illuminated what classroom teachers ought to do during the specialist educators’ sessions. Therefore, in order to maximize the benefit of the
partnerships, they called “for a mutual understanding between classroom teachers and informal educators, which includes shared goals and appreciation for one another” (Weiland & Akerson, 2013, p. 1336).

Bevan and Dillon (2010) similarly appealed for a deeper understanding of how specialist educators and classroom teachers (and institutions) partner together to support teachers’ and students’ interests and capacities for engaging in science. They specifically recommended an examination of how varied settings can provide different opportunities for these partnerships. Correspondingly, while the study by Weiland and Akerson (2013) examined a partnership between generalist classroom teacher and an informal educator, they defined informal educators as those who frequently have little formal pedagogical training and focus more on affective outcomes. This is considerably different from the LEV educators who partner with generalist classroom teachers in the three schools under study. These LEV educators are all fully qualified teachers, as previously articulated. Consequently, my research sought to bridge the gap in the literature, by investigating the experiences of classroom teachers working together with external specialists to facilitate school-based drug education. But how is this to be understood?

**Ways of Being, Doing, and Knowing in Drug Education**

Investigating the experiences of classroom teachers as they work together with external providers to facilitate school-based drug education requires an understanding of experience. For this I draw on the work of Quay (2013, 2015) and Quay and Seaman (2013, 2016), which bring together the philosophies of Dewey and Heidegger in development of a theory of experience. At the heart of this theory is the notion of an “occupation,” where an occupation is a way of being, and a “way of being is a way of doing and a way of knowing” (Quay, 2015, p. 147). In other words, an occupation is being–doing–knowing (see Figure 1).
Figure 1. Quay’s framework of the interrelation of ways-of-being, ways-of-doing, and ways-of-knowing as occupation.

An important corollary of understanding experience in this way is acknowledgment that an occupation may be more than just an adult job. Dewey conveyed this using the example of an artist.

No one is just an artist and nothing else, and in so far as one approximates that condition, he [sic] is so much the less developed human being; he is a kind of monstrosity. He must, at some period of his life, be a member of a family; he must have friends and companions; he must either support himself or be supported by others, and thus he has a business career. He is a member of some organized political unit, and so on. We naturally name his vocation from that one of the callings which distinguishes him, rather than from those which he has in common with all others. But we should not allow ourselves to be so subject to words as to ignore and virtually deny his other callings when it comes to a consideration of the vocational phases of education. (Dewey, 1916, p. 359)

Our lives are constituted by many occupations, be it brother, parent, coworker, friend, car-driver, and so on and so on. As we grow, our repertoire of occupations expands as we engage with and learn new occupations, or continue to develop our current occupations such that they change—an ongoing circumstance—perhaps to the extent that they are significantly different to what they were previously (Quay, 2015). The nuance of occupations results in a level of complexity which marks the complexity of life (p. 16). In the context of this research, I understand the various types of partnership between classroom teachers and LEV educators around the implementation of school-based drug education to possibly result in subtly different forms of occupation, expressed in different ways of “being-a-classroom-teacher.”
Of central importance to this research is understanding that all occupations are comprised of three dimensions: “being, doing and knowing” (Quay, 2015, p. 20). These three ways (see Quay & Seaman, 2013, p. 86) are brought together in Dewey’s (1916) explanation of occupations. As a way of doing, an occupation is “a continuous activity having a purpose” (p. 361). As a way of knowing, this same occupation is also “an organizing principle for information and ideas; for knowledge and intellectual growth” (p. 362). Encapsulating both of these ideas of occupation is the notion that an occupation is a way of being. But how is this to be understood? More than just doing and knowing, an occupation circumscribes the situation in which one is living, in the present moment. Hence, an occupation is more than an identity in a sociological or psychological sense; it is the ontological character of occupations, comprehended phenomenologically, that expresses the meaning I have in mind here. Dewey conveyed this by referring to an occupation as “the existence of a whole” which “depends upon a concern or interest; it is qualitative, the completeness of appeal made by a situation” (p. 232).

Quay (2015) provided examples of occupations lived by young people in school, for example, being-a-maths-student, being-a-history-student, or being-a-band-member. Each school subject and each school activity offers a different occupation: a different way of being, way of doing, and way of knowing. Attending to what people are doing, their purposeful activity, cannot be separated from how they know the things they know in order to achieve these tasks. At the same time, this doing and knowing highlight a living way of being. It is these concepts that will support my understanding of the various partnerships between classroom teachers and LEV educators.

Accordingly, I aim to utilize Quay’s framework to investigate the experiences of generalist teachers as they partner together with specialist educators. The primary research question is: How do primary school teachers and LEV specialist educators partner together to facilitate school-based drug education programs?

Summary

In this chapter, I examined previous literature concerning the roles of generalist teachers and specialist health and drug educators, the nature of their partnerships, as well as the rationale, benefits, and challenges associated with outsourcing health education generally and drug education specifically.

Schools engage external providers for a range of motivations: to provide students with unique experiences and teacher PD opportunities, as well as to access resources and
specialists’ expertise, which may not be held by generalist teachers. Further, schools outsource health educational work in order to meet new outcomes that may add to an already overcrowded curriculum, demanding teacher responsibilities and time constraints.

In spite of the numerous reasons schools employ the services of external providers, schools are cautioned about the corollaries that accompany the outsourcing of health education in general and drug education in particular. Engaging external specialists in school-based educational programs poses diverse challenges including financial costs and narrow understanding of the learners and school context, as well as undermining teachers or overreliance on external specialists. This criticism has been directed specifically at LEV as an external provider of school-based drug education programs.

Consequently, guidelines have been proposed to stimulate meaningful collaboration, analogous of mutual partnership, between external specialists and classroom teachers. However, to date, there is no available research that has examined the nature of the partnerships among qualified teachers (specialist and generalist) in the unique setting whereby specialist educators are invited into the school setting, yet not into the actual classrooms.

The roles of the classroom teachers and specialist educators are not merely identities, as they also encompass both skills and knowledge that each brings to bear in conducting drug education. A methodological framework was required, which embraces all three of these aspects. Such a framework is available in the work of Quay (2013, 2015), who suggested the nested interrelation of ways-of-being, ways-of-doing, and ways-of-knowing.

Accordingly, I aimed to utilize Quay’s framework to investigate the experiences of generalist teachers working together with specialist educators in facilitating school-based drug education programs. The primary research question was: How do primary school teachers and external specialists partner together to facilitate school-based drug education programs?
CHAPTER 4: Investigating School-Based Drug Education Partnerships

In Chapters 2 and 3, I surveyed the approaches and goals of school-based drug education, the roles of generalist and specialist drug educators, as well as the nature of the partnerships between both to facilitate drug education in primary schools.

The purpose of this research was to (1) examine the nature of the partnerships between schools and LEV (i.e., the context of the partnership between generalist teachers and specialist educators) and (2) examine generalist classroom teachers’ experiences working together with specialist educators, particularly in the unique setting whereby specialist educators are invited into the school setting, yet not into the actual classrooms. The primary research question was: How do primary school teachers and external specialists partner together to facilitate school-based drug education programs?

In this chapter, I provide a justification of the methodological framework applied in this investigation, including an outline of the comparative case studies method. I describe the context of the three participating schools and the generalist teachers involved in the study. Furthermore, I explain the methods of data collection and data analysis employed to answer the research question.

Qualitative Case Studies

Qualitative research is an umbrella term applied to a diverse range of research designs and strategies. It is defined as “a research paradigm which emphasizes inductive, interpretive methods applied to the everyday world which is seen as subjective and socially created” (Anderson, 1987; cited in Hatch, 2002, p. 6). The purposes of qualitative research are to describe, interpret, verify, and/or evaluate phenomena in naturalistic settings (Creswell, 2013; Hittleman & Simon, 2006; Marshall & Rossman, 2011).

As inductive and interpretative, qualitative methods support educational research which aims to explicate complexities (Creswell, 2009; Freebody, 2003; Neuman, 2003), allowing researchers to “approach the subject, probe the setting, and describe it in a natural fashion and in great depth” (Drew, Hardman, & Hosp, 2008, p. 187). This is achieved by focusing more on process rather than outcomes, observing phenomena in naturalistic settings, and gathering verbal rather than numerical data. These data are multilayered and descriptive, incorporating
participants’ subjective perceptions, their voices, and the meanings they attribute to their experiences (Bogdan & Biklen, 2007; Denzin & Lincoln, 2005).

This research adopted a qualitative approach in order to examine generalist teachers’ experiences as they partnered with LEV specialist educators in teaching a drug education program in their primary schools. An important facet of these experiences is the contextual situation within which they are situated. The research investigated the experiences of teachers from three primary schools that engage with LEV, with each primary school in a different Victorian education region, although located in suburban Melbourne: South-Eastern Victoria (Southern Melbourne), North-Western Victoria (Hume Moreland), and North-Eastern Victoria (Inner Eastern Melbourne).

The three schools, in their different regions, were purposefully selected from the large number of schools which partner with LEV in Melbourne in order to provide a maximum variation sample (Neuman, 2003; Patton, 2002). According to Patton (2002, p. 235), maximum variation sampling provides “(1) high-quality, detailed descriptions of each case, which are useful for documenting uniqueness, and (2) important shared patterns that cut across cases and derive their significance from having emerged out of heterogeneity.” The three schools were the first to accept the invitation to participate in the research and had notable variation in (1) their geographical location, (2) their length of involvement with LEV, (3) the size of the school, and (4) the general socioeconomic status of the families that made up the school community. Variation among these school sites was considered important in order to increase the diversity of teacher experiences on which the research was drawing. (More detail is provided about schools and teachers in Chapter 4, in the section Schools and Teachers.)

Each of the three primary schools constitutes a research site with similarities and differences to the other sites. Thus, each school amounts to a particular case, suggesting strongly that a case study methodology be applied. According to Hatch (2002, p. 13), case studies are “a special kind of qualitative work that investigates a contextualised contemporary (as opposed to historical) phenomenon within specific boundaries.” Creswell (2013, p. 61) defines case study research as the “exploration of a ‘bounded system’ or a case (or multiple cases) over time through detailed, in-depth data collection involving multiple sources of information rich in context.” The case is therefore a unit of analysis; it can be “a thing, a single entity, a unit around which there are boundaries. . . . The case could be a person . . . a
program . . . a group” (Merriam, 1998, p. 27). In this study, each case is the particular primary school participating in the LEV program, resulting in a multisite or multicase study.

The strengths and limitations of case study research were succinctly articulated by Hodkinson and Hodkinson (2001). Case studies are challenging to analyse and are expensive to implement due to the magnitude of the data they generate, the complexities of the educational phenomenon they reveal, and the time required to collect and analyze. Regardless of the rigorous approach of the researchers, case studies cannot be entirely objective, since it is difficult to transparently communicate all the researchers’ judgements. Accordingly, case studies can easily be dismissed by critics who claim problems with the size of the sample, the uniqueness of the findings, or the bias of the researchers. Finally, case studies cannot ascertain generalizability since it is empirically problematic to demonstrate the extent to which the individual teachers or the three schools under study were similar or different from other teachers and/or schools throughout Victoria.

Contrastingly, Hodkinson and Hodkinson (2001) highlighted that case studies can illuminate complex interrelationships, such as the relationships examined in this research. By restricting the scope of the research, case studies afford a depth of understanding of the partnership between specialist drug education providers and classroom teachers. Case studies are grounded in “lived reality,” relating the phenomena under study to the experiences of the participating teachers and schools. Case studies provide rich conceptual and theoretical development due to the rich data they generate, clarifying themes pertinent to the notion of partnership between LEV and government schools in providing drug education programs. Multiple-case study research facilitates an understanding of the significance of the idiosyncratic, identifying features common to all teachers and/or the three schools as well as features which are different or exceptional.

The reason case study research was chosen for this study resides in its alignment to (1) the research question, (2) the investigator’s lack of control over the behaviours exhibited by LEV educators, teachers, and school community members, and (3) the contemporary as opposed to historic events investigated in this study. The case study was particularly suitable because the proposed study is exploratory in nature (Yin, 2009).

Multiple-case design was preferred in this research for the analytic benefits it provides. Yin (2009) strongly recommends the use of at least two cases in order to strengthen the findings, and to respond to criticism and “fears about the uniqueness or artifactual conditions” (p. 61) which may surround any particular case. Herriott and Firestone (1983;
cited in Yin, 2009, p. 53) affirm that evidence from multiple cases is considered more compelling, rendering the research more robust.

In my research, evidence from each of the three cases was brought together in a form of analysis wherein “two or more case studies are done and then compared and contrasted” (Bogdan & Biklen, 2007, p. 63). This comparison enriches and bolsters the analytic conclusions arising independently from each case. Stake (1981, cited in Merriam, 1998, pp. 31–32) suggests that one of the features of a multiple-case design is that it supports “extending generalization to reference populations.” In other words, there is increased capacity to develop principles which may help inform further cases beyond those involved in this particular research (Johnson & Christensen, 2008).

However, while a multiple-case design provides an opportunity for cautious generalization of the research findings, one must be aware of the limitations of this design. The purposefully selected sample of three government schools, which vary in substantial ways, may not yield findings representative of teachers’ experiences in every Victorian primary school. Care must be taken when attempting to apply the findings to other school contexts. Furthermore, findings may not be applicable to other external providers or drug education programs offered in Victorian primary schools. The context of the schools, as well as the support offered by external specialists, must determine the extent of similarity and hence the transferability of the findings to other settings.

Schools and Teachers

In Term 2, all schools engaged with the Life Education program in Victoria were sent a written invitation to participate in this research. I made follow-up telephone calls to further explain the study to interested schools. Three schools confirmed their participation, one from each of three diverse regions: South-Eastern Victoria (Southern Melbourne), North-Western Victoria (Hume Moreland), and North-Eastern Victoria (Inner Eastern Melbourne).

Prior to the commencement of the research, the participating schools and LEV educators were sent a plain language statement and the consent form. The plain language statement outlined the purpose, scope, and time commitment required in the study and informed participants of the potential implication of their involvement. The participating school principals, drug education coordinators (at the schools), classroom teachers, and LEV educators were requested to sign the consent form prior to commitment to the study. The consent form outlined the voluntarily nature of their participation and their right to withdraw
at any time during the research. A separate consent form was signed by the CEO of LEV to grant me permission to observe the MLC sessions at the three schools.

I used pseudonyms in order to protect the anonymity of participating schools, principals, drug education coordinators, classroom teachers, and LEV educators. Schools were given names of famous tapestries that resembled my understanding of the school’s characteristics. Consistent with the tapestry metaphor, the classroom teachers I observed in the MLC were allocated pseudonyms of diverse thread colors. While every teacher who participated in the MLC sessions responded to a questionnaire, I only observed four classroom teachers from each school.
Table 2. Similarities and Differences Between the Participating Schools

<table>
<thead>
<tr>
<th>School Pseudonym</th>
<th>Education Region</th>
<th>School Size [Students]</th>
<th>Socioeconomic Status</th>
<th>Involvement With LEV</th>
<th>Staff</th>
<th>Classroom Teachers</th>
<th>LEV Educator</th>
</tr>
</thead>
</table>
| Unicorn Primary School | Southern Metropolitan | 500 | Lower socioeconomic | Continuous over 15 years | 47 | Ms. Orange (Grades 3 & 4)  
Ms. Black & Ms. White (Grade Prep)  
Ms. Blue (Grade 2)  
Mr. Red (Grades 3 & 4) | Ms. Robin |
| Hestia Primary School | Northern Metropolitan | 300 | Lower socioeconomic | First year back after a decade of absence | 50 | Ms. Purple (Grades 5 & 6)  
Ms. Green (Grades 5 & 6)  
Ms. Pink (Grade Prep)  
Ms. Magenta (Grades 3 & 4) | Ms. Sandy |
| Tree Primary School | Eastern Metropolitan | 500 | Higher socioeconomic | Continuous over 20 years | 44 | Ms. Brown (Grades 4)  
Ms. Gray (Grades 1 & 2)  
Ms. Yellow (Grade 1)  
Mr. Indigo (Grade 6) | Ms. Mandy |
Unicorn Primary School

Unicorn is a name inspired by one of the most artistically recognized tapestries in Europe: a series of six tapestries called the “Lady and the Unicorn,” woven in Flanders, in wool and silk. Five of these tapestries are interpreted as depicting the five senses, while the sixth represents love or understanding. These tapestries combined under one name remind me of the amalgamation of both campuses that make up this school.

Unicorn Primary School (“Unicorn”) is comprised of two campuses located in the South-Eastern Region of Victoria (Southern Melbourne). The main campus is established on a large site with two ovals surrounded by well-maintained gardens, grassed play areas, and well-established trees. The buildings include a spacious school hall, library, computer room, art room, multipurpose room, and a canteen offering healthy lunches and snacks. Classrooms are open and bright, all featuring computer areas and space for work and play.

Across both campuses, the school had an enrolment at the time of approximately 500 students. According to the Index of Community Socio-Educational Advantage (ICSEA, https://www.myschool.edu.au), this school ranked in the lower half of schools at the time (ICSEA = 964, average ICSEA = 1,000), suggesting that many families were of comparatively lower socioeconomic status. The school had a highly multicultural cohort, predominantly compromised of families with Vietnamese or Cambodian ethnic origins, with many other ethnic backgrounds represented as well, including Serbian, Indian, and Arabic.

Unicorn employed 31 teaching staff and 16 nonteaching staff on various time fractions. The Victorian Essential Learning Standards (VELS) provided the curriculum framework at the time. Specific literacy and numeracy teaching sessions occurred daily at the school with focused teaching to small groups or individual students. The general pedagogical approach was based on inquiry learning aimed at developing higher order thinking and problem-solving skills. The school offered specialist programs including the arts, information and communication technologies (ICT), physical education, oral language, reading recovery, and pastoral care.

The school’s curriculum emphasis was on the essential knowledge, skills, and behaviors that students need to prepare for further education, work, and life, particularly around building social relationships, developing thinking, ICT, and communication skills. The social and emotional development of students was supported through a range of social and personal development offerings: the Social Skills program, You Can Do It, Life
Skills/Resilience, and Year 5—Prep Buddies. Unicorn enriched its programs through special guest speakers, incursions, and excursions including the Life Education program, community guest speakers, and visits to Scieneworks.

*The Life Education program at Unicorn Primary School*

Unicorn has had a long and continual association with LEV. While operating from two campuses, at the time of this study the school was in the process of merging all students onto one main campus. Before their amalgamation, one campus had been inviting LEV annually for over 15 years, while the other campus organized biannual visits for much of the same period.

Robin, the LEV educator, is a qualified primary school teacher who had two years of experience with the organization. She conducted a previsit communication with Unicorn’s drug education coordinator two months prior to the scheduled visit of the MLC. The school was emailed a coordinator’s pack, which included orientation and logistical documents in order to organize the visit. These documents included an information sheet to outline the 10 primary school modules, administration forms to facilitate towing, a timetable schedule, and a parental permission slip. Additionally, a needs analysis form was emailed to each participating classroom teacher. These forms provided the classroom teachers with an opportunity to nominate their preferred outcomes and propose a suitable focus for their selected LEV modules.

Upon teachers’ selections of the modules to be facilitated, Robin delivered student and teacher booklets to the school prior to the visit. A timetable was organized by the school and presented to the educator two weeks in advance. Furthermore, a parent information session was arranged at each campus; however, a teacher PD session was not requested.

A total of 21 classes participated in the MLC. Junior grades (Prep–2) were allocated 60-minute sessions, while the middle (3–4) and upper grades (5–6) were scheduled 90-minute sessions. The modules selected included:

- Grades 5–6: It’s Your Call (90-minute sessions)
- Grades 3/4: Harold’s Diary (90-minute sessions)
- Grades 1/2: Clued Up (60-minute sessions)
- Preps: Harold’s Surprise (60-minute sessions)
**Coordinator and teachers**

At Unicorn, I interviewed the drug education coordinator and observed teachers from four classes: (1) Ms. Orange, (2) Ms. Black and Ms. White, (3) Ms. Blue, and (4) Mr. Red.

Ms. Orange is one of two teachers who teach Grades 3–4 at Unicorn. She had 20 years of teaching experience, six of which included her participation in the Life Education program. Mr. Red teaches the other Grades 3–4 class. He is the most experienced teacher I observed at Unicorn. With 30 years of teaching experience under his belt, and a 10-year involvement in the LEV program, Mr. Red carried a confident disposition throughout my observation and communication with him. Ms. Black and Ms. White together team-teach a Prep class at Unicorn. For both Ms. Black and Ms. White, Unicorn is their first and only school employer. They had five years and three years of teaching experience, respectively. They had both been involved with the Life Education program for three years. Ms. Blue teaches Grade 2 and has been teaching for 12 years. Her teaching career commenced at Unicorn. She has engaged with LEV each year.

**Hestia Primary School**

*Hestia is a name inspired by the Hestia tapestry, a Byzantine tapestry designed in the sixth century in Egypt. It is labeled in Greek: Hestia Polyolbos, meaning “Hestia full of blessing.”*

Hestia Primary School (“Hestia”) is located in the North-Western Region of Victoria (Hume Moreland). Established in 1980, the core building houses excellent facilities including a library/ICT laboratory as well as art, well-being, and general-purpose rooms. There are also 17 air-conditioned, computer-enhanced classrooms and a performing arts room. Most classrooms have interactive whiteboards.

In 2011, the school had approximately 300 students of which a very high proportion was from lower socioeconomic households (school ICSEA = 957, average ICSEA = 1,000). In fact, 55% of students had language backgrounds other than English. The main ethnic backgrounds of students at Hestia included Arabic, Macedonian, Vietnamese, Turkish, and Albanian.

Hestia employed over 35 staff members including 15 school support officers on various time fractions. The school was organized into multi-age classes: Preps, Grades 1–2, Grades 3–4, and Grades 5–6. As for all government schools, the curriculum at Hestia was based upon the VELS. The school facilitated Integrated Studies units, thematic units that bring together concepts from a number of curriculum areas including the humanities (economics,
geography, history), science and technology, as well as other disciplines such as English and mathematics. Students work collaboratively to investigate topics in depth over an extended period of time, often a whole school term. Significant emphasis was placed on the literacy and numeracy development of the children.

The vision articulated at Hestia is to provide students with experiences, skills, and knowledge to become efficient communicators and lifelong learners. The school’s strategic plan documents goals, targets, and key improvement strategies in the areas of student learning, engagement, and well-being, as well as pathways and transition.

*The Life Education program at Hestia Primary School*

Hestia has had a long association with LEV. However, after a decade of absence, this year marks a return of the school’s participation in the LEV program. Sandy, the LEV educator running the program at Hestia, was in her first year of employment in the organization. She was employed at a primary school in regional Victoria for two years prior to joining LEV. Four weeks prior to the arrival of the MLC to the school, Sandy made contact with the student well-being coordinator. Hestia was emailed a coordinator’s pack, which included documentation to explain the various modules available for each year level and administration forms to facilitate towing, timetabling, and information for parents. Additionally, a needs analysis form for each module was emailed to the participating teachers. These forms provided classroom teachers with an opportunity to indicate their preferred focus and emphasis for the modules to be delivered in the MLC.

Upon teachers’ selections of the modules to be facilitated, Sandy delivered the required booklets for the participating students and teachers. A timetable for each one of the five days was organized by the school and presented to the educator a week in advance. Furthermore, a parent information session was arranged; however, a teacher PD session was not requested.

During the LEV five-day visit to the school, 12 classes participated in the MLC. Junior grades (Prep 2) were allocated 60-minute sessions, while the middle and upper grades were scheduled 90-minute sessions. The modules selected included:

- Grades 5–6: It’s Your Call (90-minute sessions)
- Grades 3–4: Mind Your Medicine (90-minute sessions)
- Grades 1–2: Mystery Tour (60-minute sessions)
- Preps: Clued Up (60-minute sessions)
Coordinator and teachers

During the LEV five-day visit to Hestia, I interviewed the drug education coordinator and attended four random sessions in the MLC. I observed four teachers: (1) Ms. Purple, (2) Ms. Green, (3) Ms. Pink, and (4) Ms. Magenta.

Ms. Purple teaches Grades 5–6. She had nine years of teaching experience, two of which involved with the Life Education program. Similarly, Ms. Green teaches Grades 5–6 and had six years of teaching experience but only one year of involvement in the Life Education program. Ms. Pink teaches Grade Prep and was in the middle of her second year of teaching. This was her first year of involvement with the Life Education program. Ms. Magenta teaches Grades 3–4. While she had 30 years of teaching experience, this was her first year of involvement with the Life Education program.

Tree Primary School

Tree is a name inspired by a popular tapestry designed by William Morris. In the traditional interpretation of the 19th century, the Tree of Life tapestry symbolizes the tree in the biblical Garden of Eden, which provides immortality or eternal life.

Tree Primary School (“Tree”) is located in the North-Eastern Victoria (Inner Eastern Melbourne) region. The school grounds have well-maintained gardens, shading, asphalt, synthetic grass, grassy play areas, and adventure play equipment. Excellent learning and teaching facilities are provided, including a large hall used for a variety of purposes such as assemblies, performing arts, and physical education. In addition, the school has an art room, a music room, and a library. Classrooms are well resourced, as are specialist teaching areas. The extensive ICT infrastructure at the school includes 60 laptop and 70 desktop computers, interactive whiteboards in every classroom, FLIP cameras, robotics, and iPods used as listening posts. In 2011, the school enrolled approximately 500 students composed mainly of affluent families with Anglo backgrounds (school ICSEA value is 1,156, average ICSEA = 1,000).

At the time, Tree employed 32 teaching staff and 12 nonteaching staff, on various time fractions. As with the other two government schools, the VELS provided the curriculum framework. The school aimed to create a dynamic learning environment encouraging students to become active learners committed to personal success in education, work, and life as responsible citizens of the global community. Students were urged to strive for high academic success, acquire and practice higher order thinking skills, utilize ICT skills, and
develop self-confidence, responsibility, and cooperative skills. A spirit of mutual respect and support was underpinned by a whole-school approach linking learning and student well-being.

**The Life Education program at Tree Primary School**

Tree has had a long and continual association with LEV. The school has invited LEV annually for over 20 years. Mandy, the LEV educator, is one of the most experienced members of the team, having worked with LEV for over 18 years. A previsit communication with the school’s coordinator was conducted by Mandy two months prior to the scheduled visit. The school coordinator was a part-time teacher who was responsible for organizing the LEV visit. However, she was not involved in the overall implementation of drug education in the school. Mandy emailed a coordinator’s pack to the school, which consisted of documentation to organize the visit. These documents included information sheets to outline the 10 primary school modules, administration forms to facilitate towing, a timetable schedule, and a parental permission slip. Additionally, needs analysis forms were emailed to participating teachers. These forms provided class teachers with an opportunity to nominate their preferred focus and the outcomes from the modules selected.

Upon teachers’ selections of the modules, Mandy delivered student and teacher booklets to the school prior to the visit. A timetable was organized by the school and presented to Mandy a week in advance, and was amended upon arrival to the school. Furthermore, a parent information session was arranged; however, a teacher PD session was not requested.

A total of 20 classes participated in the MLC. Junior grades (Prep–2) were allocated 60-minute sessions, while the middle (3–4) and upper (5–6) grades were scheduled 90-minute sessions. The modules selected included:

- Grades 5–6: Think Twice (90-minute sessions)
- Grades 3–4: Mind Your Medicine (90-minute sessions)
- Grades 1–2: Harold's Heroes (60-minute sessions)
- Preps: Harold's Mystery Tour (60-minute sessions)

**Coordinator and teachers**

During the five days of the LEV’s visit to the school, I interviewed the school’s principal who was the de facto drug education coordinator, and attended four random sessions in the
MLC. I observed four teachers: (1) Ms. Brown, (2) Ms. Gray, (3) Ms. Yellow, and (4) Mr. Indigo. Ms. Brown teaches Grade 4. She had 10 years of teaching experience, but only one year of involvement with the Life Education program. Ms. Brown took over this class only six weeks prior when the permanent classroom teacher went on maternity leave. She was responsible for teaching the class until the end of the year. Ms. Gray teaches a combined class of Grades 1–2. She had two years of teaching experience, during which she participated in the Life Education program. Ms. Yellow teaches a Grade 1 class. She had five years teaching experience and had been involved with the Life Education program for four of those years. Mr. Indigo teaches Grade 6 at Tree. He had 16 years of teaching experience during which he had participated in the Life Education program every year.

The participating schools predominantly differed in their geographical locations, their length of involvement with LEV, the size of the school, and the general socioeconomic status of the families that made up the school community (see Table 2). The three schools belonged to three different education regions in Victoria: South-Eastern, North-Western, and North-Eastern Victoria. Two of the three schools (Unicorn and Tree) had been involved with LEV for over 15 years and had also a similar school size (500 students). Yet, they represented two diverse socioeconomic statuses: Unicorn (lower than average socioeconomic households) and Tree (higher than average socioeconomic households). Both schools differed from Hestia in school size (300 students) and length of involvement with LEV (returning after a decade of absence).

**Data Collection**

Drug education coordinators, a principal, as well as all classroom teachers participating in the LEV program from each school voluntarily elected to be involved in the data collection. Pseudonyms were used during the coding and recording processes in order to protect the anonymity of participating schools, teachers, and LEV educators.

The qualitative approach taken in this study supported elicitation of principals’, drug education coordinators’, and teachers’ perceptions of their experiences with LEV. Descriptive data of their practices and beliefs, as well as their interpretations of the role of external providers in facilitating school-based drug education programs, were collected and analyzed. As Patton (2002, pp. 136–137) asserts, “there is a very practical side to qualitative methods that simply involves asking open-ended questions of people and observing matters
of interest in real-world settings in order to solve a problem, improve programs or develop policies.”

Creswell (2009) argues that qualitative data should be collected from a variety of sources, using different collection methods, and from different perspectives. This triangulation process (described in the next section) was utilized in this study. Data were collected through interviews, observations, and questionnaires (see Table 3).

Table 3. Data Collection Methods Employed in This Study

<table>
<thead>
<tr>
<th>Method</th>
<th>Purpose</th>
<th>Personnel</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interview</td>
<td>Describe and evaluate the school’s approach and practices to facilitating a school-based drug education program</td>
<td>Two primary school drug education coordinators and a school principal</td>
</tr>
<tr>
<td>Observation</td>
<td>Describe and evaluate classroom teachers’ interactions with LEV educators in the MLC</td>
<td>Random sample of classroom teachers participating in the MLC sessions</td>
</tr>
<tr>
<td>Questionnaire</td>
<td>Describe and evaluate the way teachers facilitate drug education in conjunction with external providers</td>
<td>88.6% of participating classroom teachers from the three schools returned the questionnaire (total = 47 of 53 classes: Unicorn = 19; Hestia = 12; Tree = 16)</td>
</tr>
</tbody>
</table>

**Interviews**

Yin (2009) emphasizes that interviews are one of the most important sources of case study information. The purpose of interviews is “to gather descriptive data in the subjects’ own words so that the researcher can develop insights on how subjects interpret some piece of the world” (Bogdan & Biklen, 2007, p. 95). The principals (or drug education coordinators) in each of the participating three schools were interviewed at the commencement of this investigation. These interviews sought to describe and evaluate the school’s approach and practices to facilitating a school-based drug education program. The interview questions aimed at investigating the school’s approach to drug education and the support it offers to classroom teachers. Further, the rationale for inviting LEV into the school was elicited in order to examine the role of LEV in supporting the school’s drug education program. The questions sought to detect areas of strength and weakness in the support provided by LEV, as well as future support required by the school.
These focused interviews involved the use of a broad topic to guide the questions that were developed within a flexible interview schedule without predetermined fixed wording or ordering of questions. The questions attempted to gather data concerning the following four areas: (1) the school’s approach to facilitating a school-based drug education program (the planning and facilitation of the program), (2) the school’s role in supporting teachers in facilitating school-based drug education, (3) the school’s perception and understanding of the role of external providers in facilitating school-based drug education (LEV), and (4) the support desired by the school from LEV. At Unicorn and Hestia, I interviewed the drug education coordinators. At Tree, I interviewed the school principal. Each interview took place over 45 minutes and was audiotaped, transcribed, and sent to the interviewees who confirmed their accuracy.

Table 4. Interview Questions to Principal and Drug Education Coordinators

<table>
<thead>
<tr>
<th>N#</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Could you please tell me how you educate students about health/drug education in your school?</td>
</tr>
<tr>
<td>2</td>
<td>What support does your school provide classroom teachers in order to facilitate effective health/drug education?</td>
</tr>
<tr>
<td>3</td>
<td>Why do you invite LEV into your school?</td>
</tr>
<tr>
<td>4</td>
<td>What are the areas of strength and weakness in the support provided by LEV?</td>
</tr>
<tr>
<td>5</td>
<td>How can LEV better support your teachers in the future?</td>
</tr>
</tbody>
</table>

**Observations**

Observations can serve as an important source of evidence in a case study (Lincoln, 2006). “All relevant phenomena” may be observed and recorded through the taking of “extensive field notes without specifying in advance exactly what is to be observed” (Johnson & Christensen, 2008, p. 212). In this study, nonparticipant observation was utilized to document teachers’ experiences working together with the LEV educators. Unlike participant observation, nonparticipant observation lacks the insight attainable from being a true insider in the situation; however, important contextual information can be collected which helps situate the data gleaned from other sources.
Nonparticipant observation involves nonreactive and unobtrusive research, affording me the opportunity to observe and document teachers’ experiences as they worked together with LEV educators. The researcher was acknowledged by participants but not directly involved in the activities under study. Flick (1998) argued that the nonparticipant “maintains distance from the observed events in order to avoid influencing them” (p. 138). It is, however, doubtful that such nonparticipant observation completely avoids influencing the observed or the research at large. In fact, this research has been shaped by my own biography as a secondary school teacher as well as an educational manager at LEV.

As a secondary school teacher, I had limited experience of working with external providers. Correspondingly, I was restricted in presupposing or predetermining teachers’ experiences in partnering with external providers. As an LEV educational manager, I had a passion to investigate as well as initiate innovative ways to work with primary schools. My employment for almost two years prior to the commencement of this research helped me gain a comprehensive understanding of the LEV program, having observed countless sessions in the MLC. I had also built harmonious relationships with the educators, which enabled me to observe their classes without causing unnecessary pressure or substantially influencing their presentations.

As the researcher, I spent three days with the LEV educator at each of the three schools, observing four random sessions in the MLC. These observations provided further discernment into the nature of the partnership between generalist teachers and LEV specialist educators. Through these observations, details were recorded concerning: descriptions of the verbal interactions between teachers and the LEV educator (the priority was on recording conversations dealing with teaching students in the MLC); descriptions of the activities that took place throughout the MLC sessions that involved teacher and LEV educator; feelings, thoughts, and interpretations (emotional content and meaning); detailed points of clarification, analysis, and questions (Denzin & Lincoln, 2005; Lichtman, 2006).

Questionnaires
In this study, 89% of all participating teachers (47 in total of 53 classes) from the three schools completed a brief questionnaire (Unicorn = 19; Hestia = 12; Tree = 16). The questionnaire sought to collect information on the way teachers facilitate drug education in conjunction with LEV (see Appendix iv). More specifically, the questionnaire intended to elicit teachers’ views in the following areas: (1) how the school-based drug education
program was planned and facilitated (Questions 1–3), (2) the support they received from the school (Questions 4–5), (3) the role of LEV (Questions 6–7), and (4) the support they desired from LEV (Question 8).

Table 5. Questions on the Questionnaire Submitted to Generalist Classroom Teachers

<table>
<thead>
<tr>
<th>N#</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>How many years have you participated in the Life Education program throughout your teaching career?</td>
</tr>
<tr>
<td>2</td>
<td>What program/s do you use to facilitate drug education? (Internal or external resources)</td>
</tr>
<tr>
<td>3</td>
<td>What do you do to ensure the facilitation of an effective drug education program in your classroom?</td>
</tr>
<tr>
<td>4</td>
<td>What support do classroom teachers need in order to facilitate an effective drug education program?</td>
</tr>
<tr>
<td>5</td>
<td>What support do you receive from your school or region to facilitate your drug education program?</td>
</tr>
<tr>
<td>6</td>
<td>How does Life Education support you in facilitating your drug education program?</td>
</tr>
<tr>
<td>7</td>
<td>How useful have the following Life Education resources been for you?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resource</th>
<th>How do you use it?</th>
<th>Why is it useful?</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>What other support do you believe Life Education can provide you as a classroom teacher?</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Any other comments you would like to make about Life Education?</td>
<td></td>
</tr>
</tbody>
</table>

The questionnaire was piloted with teachers from other schools who also participated in the LEV program, prior to the commencement of this study. The “think-aloud technique” suggested by Johnson and Christensen (2008) was employed to gain feedback on the clarity of the questionnaire. Five teachers were asked to verbalize their thoughts about the questionnaire and communicate their interpretation of each question as they filled it out. The time it took teachers to complete the questionnaire was also examined. This turned out to be around eight minutes.

The questionnaire was hand delivered to each teacher from the three schools. Consent forms were distributed to the teachers and collected by the school’s drug education coordinator prior to the LEV visit to the schools. Upon their arrival to the MLC
accompanying their students, teachers were handed the questionnaires. During the session (facilitated by the LEV educator), classroom teachers responded to the questionnaire and placed it in the assigned collection box at the rear of the MLC when completed. Questionnaires completed in the presence of the researcher were attached to the observation notes to support understanding teachers’ experiences working with LEV.

**Data Analysis**

Bogdan and Biklen (2007) define data analysis as the process of “systematically searching and arranging the interview transcripts, field notes, and other materials . . . to enable you to come up with findings” (p. 147). Data analysis involves the constant interaction between the researcher, the data, and the emerging themes (Creswell, 2009; Smith & Osborne, 2003).

The data collected in this study were analyzed qualitatively. Marshall and Rossman (2011) define qualitative analysis as “a search for general statements about relationships among categories of data” (p. 111). This inductive approach revolved around two stages: within-case and cross-case analysis. Each one of the three schools was treated as an individual case study, followed by cross-case analysis to build general explanations of primary school teachers’ experiences in partnering with LEV. This analysis was conducted simultaneously with data collection, as suggested by Merriam (1998).

After conducting interviews and observations at each school, a transcript was created on a word processor. Stewart and Shamdasani (1990) suggest that some editing during transcribing may “increase readability, but it is important that the character of the respondents’ comments be maintained” (p. 104). The responses from the questionnaires were collated from each participant and responses were grouped under each question.

Interview transcripts, observation notes, and questionnaire responses were read numerous times in order to begin the process of classifying the major topics and issues identified. Johnson and Christensen (2008) refer to this process as the “open coding” stage. It involved naming and labeling important words and phrases in the data. This was applied to the interviews, observations, and teachers’ responses in the questionnaires. The data were then coded to divide them into analytically meaningful and easily locatable segments guided by the important topics identified. Each topic was defined and elaborated through the use of real examples and quotes from the data.

The next phase in the analysis involved categorizing topics in different ways. I constructed categories by revisiting the topics and attempting to group those which seemed
compatible (Charmaz, 2006). The list of groupings was merged into one master list to constitute a primitive outline or classification system reflecting the recurring regularities or patterns in the study (Merriam, 1998). Linking these categories of themes and patterns provided a rich description of teachers’ experiences working together with an LEV educator to facilitate the school-based drug education program in their school.

The findings of this research are presented in the following two chapters. The schools’ partnerships with LEV are portrayed in Chapter 5. The findings from the 47 teacher questionnaires, as well as the interviews with the drug education coordinators/principal, provide the context for the partnerships between generalist teachers and specialist LEV educators. Chapter 6 describes teachers’ experiences of working together with LEV educators in three government primary schools. The findings from my observations of 12 sessions in the MLC sessions are categorized together to explain the types of partnership teachers forge with LEV educators to facilitate school-based drug education programs within their respective schools.

Summary

In this chapter, I described the woven technique used in this study. A rationale of the qualitative methodology and an outline of the comparative case studies method were presented and justified.

This study adopted a qualitative approach in order to examine generalist teachers’ experiences as they partnered with specialist LEV educators in facilitating school-based drug education. The study investigated the experiences of teachers from three primary schools who engage with LEV, with each primary school in a different education region: South-Eastern, North-Western, and North-Eastern Victoria.

The three participating schools differed in (1) their geographical location, (2) their length of involvement with LEV, (3) the size of the school, and (4) the general socioeconomic status of the families that made up the school community. Each school amounted to a particular case, suggesting strongly that a case study methodology be applied. In this study, evidence from each of the three cases was brought together in a form of analysis. This comparison enriches and strengthens the analytic conclusions arising independently from each case.

Drug education coordinators, a principal, as well as all classroom teachers participating in the LEV program from each school voluntarily elected to participate in the data collection.
Pseudonyms were used during the coding and recording processes in order to protect the anonymity of participating schools, teachers, and LEV educators.

The qualitative approach taken in this study supported elicitation of principals, drug education coordinators, and teachers’ perceptions of their experiences with LEV. Descriptive data of their practices and beliefs, as well as their interpretations of the role of external providers in facilitating school-based drug education programs, were collected and analyzed.

The data were collected through interviews, nonparticipant observations, and questionnaires. The principal (or drug education coordinators) in each of the participating three schools was interviewed at the commencement of this investigation. These interviews sought to describe and evaluate the school’s approach and practices to facilitating a school-based drug education program. Four random sessions in the MLC were observed. These nonparticipant observations provided further insight into the nature of the partnerships between teachers and LEV educators. Further, 88.6% of participating teachers (47 in total) from the three schools completed a brief questionnaire (Unicorn = 19; Hestia = 12; Tree = 16). The questionnaire sought to describe and evaluate the way teachers facilitate drug education in conjunction with LEV.

The data collected in this study were analyzed qualitatively in two stages: within-case and cross-case analysis. Each one of the three schools was treated as an individual case study, followed by cross-case analysis to build general explanations of primary school teachers’ experiences in partnering with LEV.
CHAPTER 5: Schools Partnering With Life Education

Victoria—Three Different Tapestries

This chapter presents three tapestries of schools’ partnerships with LEV to facilitate school-based drug education programs. Tapestry is a fabric consisting of two sets of interlaced threads: warp and weft. The warp refers to the threads running parallel to length, while weft refers to the threads that are parallel to the width. The weft thread is woven back and forth across the wrap to create design used for wall hangings. Tapestry is weft-faced weaving, in which all the warp threads are hidden in the completed work. In cloth weaving, however, both the warp and the weft threads may be visible.

Employing the tapestry metaphor, I depict three distinct types of partnership between LEV and the schools under study: weft-faced, warp-faced, and cloth weaving. When LEV is the prominent deliverer of the school-based drug education program, we have an LEV-faced tapestry (warp-faced weaving), with the school program hidden in the completed work. Alternatively, when the school is the prominent provider of drug education, we have a school-faced tapestry (weft-faced weaving), with the LEV program hidden in the completed work. Finally, when the school and the LEV cofacilitate the school-based drug education program, we have an LEV/school-faced tapestry (cloth weave), where both the school and the LEV programs are equally valuable and visible.

The stories of three government primary schools in Victoria represent these three divergent types of partnership, distinguished by (1) the schools’ provision of drug education, (2) the role of LEV, and (3) the support afforded generalist teachers. The findings from the 47 questionnaires as well as from the interviews with the Tree principal and the drug education coordinators at both Unicorn and Hestia are presented to illustrate the distinguishing features of each partnership. A comparison between the schools’ types of partnership with LEV is summarized in Table 6.
Table 6. A Comparison Between the Schools’ Types of Partnership with LEV

<table>
<thead>
<tr>
<th>Partnership</th>
<th>School</th>
<th>Program</th>
<th>LEV Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEV-faced</td>
<td>Tree</td>
<td>External provider</td>
<td>Primary role</td>
</tr>
<tr>
<td>School-faced</td>
<td>Unicorn</td>
<td>Internal school unit</td>
<td>Supplementary role</td>
</tr>
<tr>
<td>School/LEV-faced</td>
<td>Hestia</td>
<td>Integrated approach</td>
<td>Cofacilitative role</td>
</tr>
</tbody>
</table>

**Tree Primary School—A More LEV-Faced Partnership**

Tree exemplified a more LEV-faced tapestry, where the partnership was considered as unequal with an overreliance on LEV as the prominent deliverer of the school-based drug education program. The school’s contribution was either hidden or potentially nonexistent in the completed work. Such a partnership was characterized by: (1) an externally facilitated drug education program, (2) the primary role of LEV, and (3) the limited support afforded the generalist teachers.

**An externally facilitated school-based drug education program**

Tree offered a one-off, isolated, and externally facilitated school-based drug education program. The school depended solely on LEV to provide drug education to the students. One teacher summarized the school’s approach to health and drug education as follows:

> We have nurses come in to conduct sex education (three sessions) focusing on puberty and reproduction. Life Education is the only formal drug education [program provider] unless it becomes relevant in class. (Teacher 4, Tree Primary School, Survey Question 1)

Teachers at Tree did not plan formal health and drug education units in 2011 due to the demands of the crowded curriculum, the presumed irrelevance of drug education for their student cohort, as well as the ambiguous place of drug education in primary schools. The demands of the curriculum and the time invested in sports activities prevented teachers from formally addressing drug education-related issues within their units. On Day 2 of my observations at Tree, the class teacher informed me that the school did not have a unit on health or drug education anymore. As a result of dealing with the crowded curriculum, drug education was the first to be delegated to external providers. On Day 3 of my observations, another teacher articulated this quandary. While affirming the importance of drug education for her Grade 6 students, she admitted that there was limited time to address drug education
due to the extensive time invested in interschool sports and training for other school programs.

Tree assumed that its affluent students were well informed about health- and drug-related topics. Drug education in particular was considered irrelevant for this student cohort. This view was articulated by the school principal (who was the school’s de facto drug education coordinator) and acknowledged by the classroom teachers as the subtle underlying reason for eliminating drug education from their Integrated Studies units.

Look, the kids pretty much know not to smoke. I think the message comes pretty clearly from commercial advertising and there’s been some fantastic ads on alcohol use and those sort of things . . . especially schools like ours—they are pretty naïve and innocent children, you know. We’re pretty much a middle class sort of area, so they wouldn’t really know some of those things [laughs] . . . There’s a subtle message amongst teachers at the school that students here are not really in need of learning about drug education, as they come from pretty good families. (Principal, Tree Primary School, Question 5)

On Day 3 of my observations at Tree, a Grade 1 classroom teacher who had been involved with LEV for four years acknowledged this general supposition. She hoped that the school’s leadership would eventually incorporate a health and drug education focus in the curriculum. She articulated to me that the majority of the student cohort came from high socioeconomic status families. The classroom teacher confided that teachers within the school presumed that their students knew about drug education from their home education.

Furthermore, ambiguity surrounding age-appropriate and developmental content had prompted Tree to adopt this LEV-faced partnership and recruit external providers to facilitate health and drug education. Teachers equally acknowledged that the vagueness of drug education learning outcomes in the VELS restricted them from addressing these matters in the classroom. Consequently, the principal was confident of the necessity of allowing external providers to do the bulk of drug education.

Yeah, and I think it’s important that it does come [drug education message] sometimes from someone who is actually not the teacher, you know like, the children have a different relationship with the teacher. When it is coming from an expert in the field who actually knows how to do those things and talk about all those sort of things that is developmentally appropriate, it’s good for it not to be the teachers sometimes actually doing that. (Principal, Tree Primary School, Question 3)
I think you need to know as a school what you are good at and what your core purpose is and the things that you’re not an expert in. You do not have to be an expert in everything . . . I think we need to be strategic about what we can actually provide as a school, holistically and what outside agencies can do for us as well, so I classified Life Education in that kind of range. (Principal, Tree Primary School, Question 4)

Ultimately, the principal conceded that drug education was not a priority at Tree. In fact, the very place of drug education in primary schools was questioned by the principal.

Drug education is a really interesting one. I’m not actually sure what its place is in the primary school to be honest, other than just to be aware of the effects of alcohol and smoking . . . and all the rest of the illicit drugs. I’m not really sure where that is placed in a primary school?

Sometimes you are telling them too much, I think. (Principal, Tree Primary School, Question 5)

Teachers reported that they complemented the LEV program through brief classroom discussions, activities, and online learning. While formally the Integrated Studies units did not focus on health and drug education in 2011, teachers reported utilizing digital resources to facilitate aspects of health and drug education. Three teachers incorporated interactive whiteboard activities and websites “to look up effects on body, etc.” (Teacher 11, Tree Primary School, Survey Question 2). Additionally, teachers exposed their students to thinking strategies in order to make informed choices in life (Teacher 13, Tree Primary School, Survey Question 2). Furthermore, the majority of questionnaire responses indicated that teachers constantly encourage, praise, and promote water breaks, healthy lunches, safety, and physical activities.

Aspects of health and drug education were incidentally incorporated in classroom discussions during Integrated Studies units or during the literacy program. The principal explained this rationale.

Although it [drug/health education] is not a unit as such, you know, there are things that come out when we’re doing literacy, when we’re doing numeracy that people actually ask questions and we can look at answering those, and teachers pretty much answer them as they actually arise. Children are very curious about their bodies and how things work and all that sort of stuff and it prompts them to ask lots and lots of questions. (Principal, Tree Primary School, Question 1)

Other initiatives at Tree also encompassed incidental incorporation of drug education. These included establishing a well-being culture: a whole-school approach to health and safety. The
principal affirmed that well-being was a significant part of the school’s culture. The school
promoted physical education and participation in sport programs. Students were consistently
couraged to focus on healthy eating, and taking control and good care of their bodies.
Additionally, the school pioneered an internal program to explicitly teach students leadership,
social skills, and school values. This whole-school program was facilitated by Grade 6
students in the presence of a teacher. It covered topics such as responsibility, leadership,
initiative, and decision making. Fortnightly, students of different year levels participated
together in the program instead of attending school assembly.

The primary role of Life Education

Tree recruited LEV to be the primary provider of drug education. This role relieved teachers
from teaching seemingly “uncomfortable” content (drug or sex education), addressed the
compulsory requirement of drug education, and allowed teachers the opportunity to manage
the crowded curricula and focus on their areas of expertise. The principal and teachers at Tree
envisioned Life Education as a stand-alone program. The program facilitated the bulk of drug
education within the school.

I actually see it as supporting our actual program, so I think I’m very big about things being
integrated . . . but sometimes it’s important that there is a little bit of a stand-alone support part
of the curriculum as well. I think, the fact that it [Life Education program] is Prep to 6 I think
is really good and the kids are all getting the same message at the same time . . . you know that
little bit of expertise from people that know the best is good as well. (Principal, Tree Primary
School, Question 1)

Teachers at Tree depended on the LEV program to manage the introduction of drug
education, provide resources, stimulate classroom discussions, as well as prepare the children
for future challenges. One teacher commented that the LEV program was “a great one off
session, but at this stage it does not link in with my teaching. I would like it to be more
ongoing and to link with my teaching” (Teacher 5, Tree Primary School, Survey Question 5).

Strategically, teachers were permitted to focus on their areas of expertise while
partnering with external providers to complement the school’s offerings. An external
provider, such as LEV, was entrusted to provide a standardized curriculum, facilitate
developmentally appropriate content, and satisfy parental expectations. Teachers were saved
from the burden of teaching content they were not confident facilitating. Furthermore,
acknowledging the special student–teacher relationship, the school leadership believed it was
too challenging for classroom teachers to engage in teaching seemingly “awkward” content pertinent to drug or sex education.

On Day 5 of my observations of Tree, a Grade 6 classroom teacher with 16 years involvement with LEV told me that he believed that external providers were recruited to protect teachers from sharing controversial information that might disconcert the conservative parents in the school. The perceived lack of specific direction for drug education in the VELS made teachers feel vulnerable and reluctant to teach content that parents may disapprove of. External providers are protected through their optional parental permission slip to attend the program. He disclosed that parents give permission for their kids to attend (or not to attend) Life Education and sex education sessions; hence, teachers are not held accountable for the program content. He acknowledged that parents may have so many different views as to what should be taught or not taught concerning drug education. He preferred that classroom teachers be exempted from initiating discussions about these “contentious” issues in the classroom lest they get themselves in strife with their parents. The vagueness of direction for drug education in the VELS, in his view, renders teachers without firm foundations to teach such topics in the classroom.

While they facilitated informal health education lessons in their classrooms, teachers acknowledged that the LEV program replaced their focus on drug education. Consequently, the partnership between LEV and the school was skewed at Tree. This approach detached teachers from their role as the primary provider of school-based drug education.

The mobile learning center
The Tree principal and the classroom teachers agreed that the MLC sessions provided age-appropriate content, standardized curriculum, and an engaging learning experience for students. Participating in the sessions stimulated classroom discussions, inspired teachers with lesson ideas, and assisted them in evaluating students’ understanding.

At Tree, teachers valued the MLC sessions for presenting age-appropriate content. Facilitated by a “specialist,” the MLC sessions introduced students to relevant health- and drug-related information. Teachers believed that an LEV session “provides an insight into the language and information suitable for primary aged children” (Teacher 1, Tree Primary School, Survey Question 6).

Teachers valued the MLC sessions for stimulating classroom discussions. As an introduction in health and drug education, the MLC provided students with initial information
to be informally discussed in the classroom. Teachers indicated that the MLC sessions provided a “talking point” that stimulates further discussions and research in the classroom (Teachers 10 and 11, Tree Primary School, Survey Question 6).

Teachers at Tree believed that the MLC sessions offered students a unique learning environment and a fun experience (Teachers 5 and 8, Tree Primary School, Survey Question 6). The hands-on approach to the sessions facilitated an engaging and memorable experience for the participating students (Teachers 2 and 16, Tree Primary School, Survey Question 6).

Teachers articulated that observing activities in the MLC sessions allowed them the opportunity to evaluate their students’ understandings and misconceptions. Reviewing students’ knowledge in the MLC was critically important in a school where health and drug education matters were not addressed in the curriculum. One teacher expressed this point candidly:

To listen to students’ ideas and discussions to find misconceptions and questions. It’s hard to find the time to have these discussions if the school does not have a health scope and sequence, it is hard to know what is developmentally appropriate. (Teacher 12, Tree Primary School, Survey Question 6)

Furthermore, teachers indicated that the MLC sessions inspired them with ideas for follow-up activities in the classroom (Teachers 3 and 15, Tree Primary School, Survey Question 6).

**The Life Education student booklets**

Questionnaire responses indicated that the LEV student booklets supported teachers with follow-up sessions in the classroom. Teachers incorporated activities from the booklets to generate discussions, reinforce learning, and “calm the students!” However, informal conversations with teachers in the MLC clarified the inconsistent use of these resources in the classroom. While a few teachers used them in a class to stimulate informal discussions, the great majority of teachers did not utilize them at all because of time restrictions. Other teachers spontaneously resorted to these booklets when there was spare time.

Teachers communicated two areas for improvement with the LEV student booklets. The first related to better instructions concerning the appropriate use of the booklets, and the second referred to providing online resources in replacement of the hard copies. One teacher indicated her frustrations when she stated:

I was just given a pile of [LEV] booklets and that was all. As I had not planned for them and due to timing I had not used them. (Teacher 5, Tree Primary School, Survey Question 7)
The LEV booklets were adjudicated ineffective as compared to digital resources. A teacher asserted that the hard copies are “less effective than programs such as Mathletics [an online learning resource to help students enjoy mathematics] where kids can use it at home” (Teacher 9, Tree Primary School, Survey Question 7).

**Limited drug education support**

The school’s belief in the importance of drug education mirrored its organizational and practical support for generalist teachers. Tree refuted the importance of drug education for their affluent student cohort. As a result, it did not offer support for teachers to facilitate drug education. The school relinquished responsibility of teaching drug education, delegating this subject to the expertise of an external provider.

Teachers at Tree reported being offered *limited* support in order to facilitate health and drug education in the classroom. Questionnaire responses (92%) assert that LEV is the chief support provided to teachers by the school. Only a few responses outlined the minimum support offered by the school or region. This limited support included notifications of PD opportunities, provision of material to facilitate the school’s well-being program, as well as time allowance for team planning. This support, however, was not directly related to drug education since there were no specific units to plan in this domain.

The support offered to teachers was proportionate to the role teachers played in the health and drug education at Tree. Since external providers were the sole providers of health and drug education, teachers did not require substantial support to facilitate the program in their classrooms.

Tree depicts a type of school partnership that is LEV-faced, whereby drug education is provided through external providers, LEV is considered the primary provider of drug education, and minimum or no support is afforded the generalist teachers. There are two other diverse types of partnership portrayed by the two other schools under study.

**Unicorn Primary School—A More School-Faced Partnership**

Unicorn exemplified a more school-faced partnership, whereby the school program is the prominent provider of drug education with the LEV program hidden in the completed work. Such partnership is distinguished by (1) an internally facilitated drug education program, (2) the supplementary role of LEV, and (3) the general/practical support afforded the generalist teachers.
Internal drug education program

Unicorn facilitated an internal program that was directed predominantly by their Integrated Studies unit, yet was supplemented by the LEV resources. Teachers, together with their peers and students, coplanned Integrated Studies units in order to facilitate inquiry-based drug education programs aligned to the VELS outcomes.

In my interview with the drug education coordinator, he outlined Unicorn’s approach to planning drug education:

Teachers come together in grade level teams from both campuses. They plan Integrated Studies units following the VELS outcomes, which include health, personal learning etc. . . .

The health focus for the term is planned around the Life Education visit and program. (Drug Education Coordinator, Unicorn Primary School, Question 1)

At the commencement of the school year, teachers in the same grade levels designed the overall theme of their Integrated Studies units. To determine the units’ content, teachers involved students in planning the topics to be investigated in groups throughout the term. This approach ensured that teachers facilitated the learning process by guiding students through their research and assisting them with age-appropriate resources.

The Integrated Studies units’ themes differed between grade levels, facilitating age-appropriate content of health, drug, and emotional/social skills. For example, in 2011 the junior grades focused on safety, the middle years addressed safety and social skills, while the upper primary students studied a unit on the human body. These units were designed to combine a balanced approach to drug-related knowledge and skills.

Teachers incorporated external programs, such as Life Education, into their units of work as required. Health and drug education at Unicorn was provided through an internal program guided by the VELS learning outcomes and supplemented by LEV resources. While seeking to address students’ interests, teachers ensured that the units’ content, activities, and assessments were aligned to the VELS learning outcomes for each year level.

Unicorn facilitated inquiry-based learning in the classroom, engaging students in active and cooperative learning activities. Students were involved in brainstorming topics related to the theme of the Integrated Studies units. Upon selecting a preferred topic, students accessed age-appropriate websites to conduct their investigations and submitted creative projects that demonstrated their learning. These assessment tasks included designing a pamphlet, producing a video, or creating a board game. This inquiry-based approach was initiated by
the current principal, sustained through teachers’ collaboration, and monitored through an external mentor who met with teachers twice per term.

While I did not observe teaching practice in the classroom, teachers consistently and unanimously reported their use of interactive and collaborative teaching strategies. Classroom lessons featured hands-on activities, interactive games, group investigations, Internet/intranet searches, problem solving, and various projects to cater for different learning styles. In their questionnaires, teachers described the interactive strategies used in the classroom as “Hands-on activities . . . computer and Internet . . . group activities” (Teacher 7, Unicorn Primary School, Survey Question 2) and “Researching. Computers, posters and books . . . MasterChef healthy sandwich (Invention test)” (Teacher 15, Unicorn Primary School, Survey Question 2).

Furthermore, teachers underscored that health and drug education was also taught incidentally due to the demands of the crowded curricula. This took place through “Constant reminders to children about health and safety issues” (Teacher 4, Unicorn Primary School, Survey Question 2), and further, “a very crowded curriculum makes it difficult to formulate a program as such. In many cases, the type of program is taught incidentally as a part of a broader unit” (Teacher 18, Unicorn Primary School, Survey Question 3).

**The supplementary role of Life Education**

The three schools under study recruited LEV to fulfill a role aligned to their approach to drug education. Unicorn considered the role of LEV to be supplementary in nature to their internal drug education program. While perceived as experts in the field, LEV complemented rather than directed the Integrated Studies units offered by the school. Subsequently, the LEV resources were used selectively (and inconsistently) as they aligned to the units of study.

Unicorn perceived LEV as an incursion, providing an expert voice and a unique experience for their students. The drug education coordinator as well as the classroom teachers reported that LEV delivered unique experiences and resources that supported their facilitation of health and drug education units. They valued the LEV program as an external “expert voice.” The coordinator stated:

Life Education is part of our program in the school. We value the program; staff, students and parents value it. We like Life Education because it offers a different approach as it is an outside voice. We are in a low socioeconomic area and struggle to get money in, so it is great
to have Life Education come in and great to see about 90% of our students participate. (Drug Education Coordinator, Unicorn Primary School, Question 3)

**The mobile learning center**

At Unicorn, teachers unanimously agreed that the MLC sessions supported their units of work. The unique learning experience in the MLC engaged students in the topic, stimulated lesson ideas for teachers to implement in the classroom, and modeled best practice in health and drug education.

Furthermore, as they observed their students interact and respond to questions in the MLC, teachers were able to evaluate students’ understanding. Consequently, teachers were able to assess students’ comprehension of topics discussed in the classroom, or ascertain their prior knowledge for topics yet to be addressed.

**The Life Education student booklets**

Questionnaire responses indicated that the LEV student booklets supported teachers with lesson ideas, stimulated classroom discussions, facilitated literacy activities, and inspired further research. However, conversations with teachers clarified the inconsistent use of this LEV resource in their classrooms. Some teachers incorporated activities extensively in their classrooms, others selected only a few activities that suited their planned unit, while others did not integrate the student booklets in their Integrated Studies units. On Day 1 of my observations at Unicorn, a Grades 3 and 4 teacher who had been involved with LEV for six years confessed that she did not use the LEV booklets in the classroom. She sourced and utilized other resources because the LEV printed material did not contain activities on safety, which was the focus of their Integrated Studies unit.

Teachers who used the LEV printed resource believed that students treated the booklets as a “novelty.” However, teachers proposed that student booklets need to include more “thinking” activities that are complemented with digital resources as well as ensuring the booklets are easy and relevant for different grade levels (Teachers 7 and 12, Unicorn Primary School, Survey Question 7).

**The frequency of the Life Education program**

The drug education coordinator explained that Unicorn’s board decided to only invite LEV into the school every second year, commencing that year. While the coordinator claimed that
teachers, students, and parents highly valued the LEV program, they perceived it to be repetitive if facilitated annually.

I have heard several teachers saying that it is too much to do the Life Education program each year; some teachers believe it is better every second year. Otherwise it gets too much for the kids—repetitive it may be. (Drug Education Coordinator, Unicorn Primary School, Question 5)

**General pedagogical support**

Unicorn attached general health and drug education onto their Integrated Studies units. Consequently, the school resourced and supported teachers with inquiry-based and interactive pedagogy rather than specific drug education-related support.

At Unicorn, teachers were offered limited drug education-specific support by their school and/or region. Teachers reported their dissatisfaction with the inadequate accessibility to drug education resources and relevant drug education PD opportunities. Conversely, teachers conveyed their contentment with their access to external programs (e.g., LEV) as well as the collaborative team environment afforded them to plan their Integrated Studies units.

In their questionnaires, three teachers indicated that the support offered by the school was limited (Teacher 18, Unicorn Primary School, Survey Question 4) to nonexistent (Teachers 8 and 16, Unicorn Primary School, Survey Question 4). Two responses, however, alluded to an accessible resource pack to help teachers facilitate health and drug education units (Teachers 6 and 12, Unicorn Primary School, Survey Question 4). This resource pack may refer to government resources produced and distributed to primary schools by the Department of Education (Teacher 14, Unicorn Primary School, Survey Question 4).

In their questionnaires, only three teachers commented on the PD opportunities afforded them by the school and the Department of Education (Teachers 2, 10, and 14, Unicorn Primary School, Survey Question 4). The drug education coordinator also confirmed the support available to teachers through PD and external training. Nevertheless, teachers considered these PD sessions as repetitive and unhelpful.

Conversing with teachers in the MLC sessions provided a more elaborate and potentially negative perspective on the uptake of specific health and drug education training. Opportunities to participate in drug education-related PD sessions were primarily reserved for senior year level teachers. One teacher had participated in drug education training 10 years
prior and had not had any access to PD since because she had transitioned to teaching junior grade levels. On Day 3 of my observations at Unicorn, a Grade 1 and 2 teacher with 12 years involvement with LEV summarized this notion by using the example of Turning the Tide PD opportunities. She underlined that many teachers in the other campus had participated in PD sessions on Turning the Tide, addressing topics on alcohol, smoking, and peer pressure—particularly with Grades 5 and 6. She admitted that she had not participated in PD in the previous few years, and attributed this to the fact that she was now teaching a junior grade level.

Notably, the Turning the Tide drug education strategy was an initiative introduced to government and nongovernment schools in the mid-1990s (Harvey, 2005). Consequently, one may conclude that teachers at Unicorn had not participated in drug education-related training for some years. Alarmingly, teachers did not seek PD opportunities. Only 22% of the questionnaire responses requested support with drug-related PD. Through the postquestionnaire conversations, teachers explained their desire for PD on available resources, rather than PD on drug-related knowledge and/or best practice. On Day 2 of my observations at Unicorn, two Grade Prep teachers with three years of involvement with LEV affirmed that they would like to participate in PD sessions focused on knowledge rather than drug education-related teaching skills.

In contrast, teachers were satisfied with the support that Unicorn offered them by providing access to external providers/programs, such as LEV. Teachers considered the visit to the MLC as an incursion that afforded students a unique learning experience. Teachers consistently commented on the value of specialists’ expertise:

Good to have someone out of the school to talk to the kids. (Teacher 4, Unicorn Primary School, Survey Question 6)

Good to hear and work with experienced presenters. (Teacher 18, Unicorn Primary School, Survey Question 5)

Very useful, kids enjoy a new face, and new classroom—van, experience and of course they love Harold. (Teacher 18, Unicorn Primary School, Survey Question 6)

Furthermore, teachers acknowledged the significant support offered by Unicorn to facilitate a collaborative team environment whereby they could plan, search, and share resources for the health and drug education units of study. Both the teachers, as well as the drug education coordinator, considerably valued this provision.
Unicorn depicts a type of school partnership that is school-faced, whereby drug education is provided through an internal school program, LEV is considered the supplementary resource of drug education, and the generalist teachers are afforded general pedagogical support. There is one other type of partnership disclosed in this study.

**Hestia Primary School—A School- and LEV-Faced Partnership**

Hestia exemplified a school- and LEV-faced partnership whereby both the school and LEV cofacilitated the drug education program. Such a partnership was distinguished by (1) an integrated drug education program, (2) the cofacilitative role of LEV, and (3) the organizational/practical support afforded the generalist teachers.

**Integrated drug education program**

Hestia provided an integrated program that fostered collaboration between the classroom teachers and LEV. Teachers collaboratively planned Integrated Studies units in conjunction with the Life Education program to facilitate age-appropriate drug education programs aligned to the VELS and the school’s strategic plan.

The well-being coordinator underlined the significant partnership between Hestia and LEV in facilitating a school-based drug education program.

By having LEV come out, it becomes a guarantee that aspects of our drug education program are covered and we can check them off, *not that it is our drug program in its entirety*, but we needed it to become a reasonably significant part, specifically because of the crowded curriculum we need to make sure that we can fit stuff in and have teachers happy with that it does not take too much time. (Well-being Coordinator, Hestia Primary School, Question 8; emphasis added)

Teachers of the same grade level designed their drug education units at the commencement of the school year with the LEV program in mind. Additionally, the school allocated a planning day during each term to facilitate an opportunity for teachers to develop their units together. A classroom teacher summarized this collaborative approach: “We work as a team to develop the curriculum” (Teacher 8, Hestia Primary School, Survey Question 8).

Each year level planned a whole term’s Integrated Studies units to be taught throughout the term. The content of the units differed from one year level to the next, facilitating age-appropriate content of health, drug, and human relations. For example, in 2011 the junior years focused on nutrition, safety, and hygiene, while the middle and upper years studied a unit on “health,” “drugs,” and “social skills.” These units were intended to combine a
balanced approach between knowledge and skills. A Grades 3–4 teacher summarized that balance when she listed the topics students studied in the health and drug education unit. The topics included:

Healthy Bodies, Healthy Minds, looking after our bodies, nutrition, exercise, community services that promote health. Safety. Social skills, peer pressure and conflict resolution are ongoing areas. Medicine is covered in health units. (Teacher 7, Hestia Primary School, Survey Question 5)

Teachers at Hestia integrated their health and drug education units into their literacy program. A Grades 5–6 teacher articulated this approach:

[Our] Integrated Unit on health and drug education covers a variety of topics . . . we run a unit of health and drug education where we spend a lot of time covering all major issues—we integrate it into our reading and writing activities. (Teacher 3, Hestia Primary School, Survey Questions 5 and 6)

Teachers were guided by the VELS learning outcomes as they planned their units. In fact, as one of the teachers shared a document with me regarding her Preps unit on “Healthy Me,” I recognized reference to each of the VELS learning outcomes. Moreover, teachers were guided by the school’s strategic plan to address various aspects of health and drug education in the context of student engagement and well-being. A Grades 3–4 teacher highlighted that “our student engagement health and wellbeing group drive areas we need to address” (Teacher 8, Hestia Primary School, Survey Question 5).

The well-being coordinator at Hestia acknowledged that the crowded curriculum restricts teachers from implementing health and drug education as comprehensively as they desire. He stated that teachers integrate drug education in their curriculum; however, “there is difficulty with that in terms of the crowded curriculum, in making that as comprehensive as we would like” (Well-being Coordinator, Hestia Primary School, Question 2).

Teachers reported utilizing interactive teaching strategies in facilitating their Integrated Studies units in the classrooms. They incorporated hands-on activities, group discussions, and interactive games in order to engage students in the learning process. This practice was particularly eminent in the junior classes. Questionnaire responses from the Prep teachers affirmed their interactive teaching strategies used in the classroom:
Hands on activities. Visits from community helpers (police, firefighters). Interactive Whiteboard activities—online games, videos etc. (Teacher 6, Hestia Primary School, Survey Question 6)

We have many activities, plastic fruit and vegetables, interactive whiteboard games/clips, books, DVDs, role plays. We have lessons where students try a variety of fruit and vegetables in class and take home a list of their favorites. The Sesame Street website is great. (Teacher 5, Hestia Primary School, Survey Question 6)

The cofacilitative role of Life Education

Hestia employed the services of LEV to partner with generalist teachers in cofacilitating a school-based drug education program. While the school acknowledged the importance of LEV expertise, it was expected that teachers would extend the program through classroom activities prior to and post the MLC visit. The students’ well-being coordinator and teachers perceived the role of LEV as complementing teachers’ expertise, co-covering the material, and inspiring teachers with knowledge, resources, and skills. Teachers reported that the MLC sessions, as well as student booklets, “tied really well with the classroom lessons.”

The well-being coordinator underlined the significant role that LEV played in providing expertise that cannot be demanded from generalist classroom teachers. It allowed Hestia to cover a significant part of the drug education curriculum as well as inspire teachers to expand on the program in their classrooms.

The role that LEV plays is basically one based on expertise. It’s nice to have people who are experts in this field who understand this field perfectly well and from my perspective it benefits in two ways: (1) the [drug education] program is delivered and (2) by the teachers being involved, it enables them to be able to adapt and further inspire them to expand on the actual drug education program at school and it becomes a facilitator of elaboration, if you like. (Well-being Coordinator, Hestia Primary School, Question 9)

Importantly, the coordinator asserted that LEV provided an external voice and an interesting experience for the students. The LEV program removed the potential “stale” nature of drug education if it was only facilitated by classroom teachers. He stated:

Well, the strength is quite obviously providing the children with an external experience. Sometimes it can be stale coming from within [the school], especially in the upper [levels] where ‘we are going to do this now’ and involves the same teacher delivering the same thing,
whereas this is just a new experience for the children and that’s a definite strength. (Well-being Coordinator, Hestia Primary School, Question 11)

Teachers’ questionnaire responses acknowledged the support offered by LEV as an external provider. The MLC was singled out as the preeminent channel of support.

The mobile learning center

Throughout the questionnaires and observations, teachers commented on the MLC as the preeminent support offered by LEV. Not all teachers were aware of the diverse means of support supplied by LEV. On Day 3 of my observations at Hestia, a Grade Prep teacher with one year of involvement with LEV asked me, while answering the questionnaire, if LEV provided PD opportunities. Another teacher explained that she could not participate in the questionnaire because she was not aware of the services LEV provided.

Evidently, teachers were pleased with the modules facilitated in the MLC. They indicated that the sessions were interactive, engaging, and informative for their students. Sandy, the LEV educator, was considered engaging, knowledgeable, as well as effective in managing students’ behaviors (Teacher 6, Hestia Primary School, Survey Question 9).

Teachers unanimously agreed that the MLC instructions supported their Integrated Studies units. The sessions provided an opportunity for discussion starters, elaboration of ideas, or a revision of content addressed in their classrooms. Teachers articulated their ideas in the following ways:

The program compliments [sic] what we run. It has been an engaging way to get students thinking about our next unit of study. (Teacher 4, Hestia Primary School, Survey Question 9)

Supports our units of work. Good revision. (Teacher 5, Hestia Primary School, Survey Question 10)

Acts as a springboard for discussion. (Teacher 1, Hestia Primary School, Survey Question 9)

Introduction to specific drugs . . . Great conversation starter. Engages the students. (Teacher 3, Hestia Primary School, Survey Question 10)

Teachers reported the benefit of observing the interactive learning environment in the MLC. The sessions exposed teachers to effective strategies, resources, and activities that would assist their facilitation of health and drug education in the classroom. Furthermore, a classroom teacher communicated that the MLC sessions were the most effective PD on drug
education, commenting that the MLC sessions had “shown me a variety of ways of how to teach children about health and drug” (Teacher 9, Hestia Primary School, Survey Question 5).

The Life Education student booklets
Throughout the questionnaires and my observations, I noticed that teachers briefly remarked on the student booklets. Teachers acknowledged that student booklets supported students’ learning, furthered classroom discussions, and facilitated revision of the MLC session. Teachers indicated that they selected individual activities from the LEV student booklets, which they utilized to “tie in with units of work” (Teacher 6, Hestia Primary School, Survey Question 5).

The language used by the teachers in their questionnaires to describe the role of LEV unmistakably implied that drug education was cofacilitated by the school and LEV.

Organizational drug education support
In contrast to Unicorn and Tree, Hestia provided substantial organizational support to their teachers, evident in their formulation of a drug education strategic plan and the appointment of a “Students’ Engagement & Well-being” team to support their teachers.

Hestia stipulated the importance of drug education in its strategic plan. The school had a drug education plan established in consultation with an external expert in 2008. Complementarily, the school established the Students’ Engagement & Well-being team to coordinate and support teachers in their implementation of drug education. In fact, the school also provided planning days for teachers to organize their Integrated Studies units collaboratively with colleagues. The school also adopted the You Can Do It external program for each year level within the school. Evidently, the school offered significant organizational support to its teachers.

The students’ well-being coordinator accentuated the role that his team played in coordinating and supporting teachers in their implementation of drug education:

We meet on a regular basis, two or three times a term, then we discuss aspects of the drug action plan that has to be put in place every three to four years . . . that teachers can refer to and then it drives their program in the classroom, and from there we can support them with various professional learning, access to resources etc. (Well-being Coordinator, Hestia Primary School, Question 4)
Remarkably, despite the significant organizational support offered by the school, teachers were critical of the lack of practical support (PD opportunities and resources) afforded them in implementing drug education in their classrooms. One classroom teacher described the support received from the school as “Nothing! There may be resources in our school library” (Teacher 1, Hestia Primary School, Survey Question 8; emphasis added).

Teachers appeared more preoccupied with the practical rather than the organizational support provided by Hestia. Significantly, teachers were most critical of the lack of PD opportunities and resources offered to assist them in implementing drug education in their classrooms. One teacher portrayed this clearly in the questionnaire:

[An external expert] has come to help us write the drug education plan but we do not have supporting materials or relevant information to use—we have to make it up ourselves, which isn’t a problem . . . but always wondering are we on track? (Teacher 7, Hestia Primary School, Survey Question 8)

Consequently, two teachers (Teachers 6 and 7, Hestia Primary School, Survey Question 7) indicated that they preferred support with understanding the health and drug education curriculum. This involved providing clear outcomes and specific content that was also progressive and developmental over the primary school years. Teachers were looking for an easy-to-follow program as well as time set aside to teach health and drug education.

Hestia offered “staff room” discussions about what needs to be taught in drug education. However, PD opportunities were predominantly reserved for newly appointed staff members, or when teachers specifically requested an external PD for a specific drug education program. Alarmingly, teachers had not been afforded a PD opportunity to enhance their knowledge and skills in drug education. The students’ well-being coordinator explained that PD on drug education had not been a priority at the school due to the demands of the crowded curricula. He stated:

We often get new teachers in the school who need to have some professional learning on the program, on that You Can Do It program, so we send them off to have some professional learning sessions which are available for that, and we organize for them to go off and do it and if there are teachers interested in various drug education programs, we can provide for that as well. However, as I mentioned before with [because of] the crowded curriculum it’s not always a priority; it can’t always fit in as a priority. (Well-being Coordinator, Hestia Primary School, Question 7)
Hestia depicts a type of school partnership that is school/LEV-faced, whereby drug education is coprovided through an integrated program, LEV plays an equal collaborative role in cofacilitating drug education, and the generalist teachers are afforded organizational and, to a lesser extent, practical support.

A Partnership Categorized as Cooperation

The partnerships framework developed by Weiland and Akerson (2013) (introduced in chapter 2) was employed to analyse the nature of the partnerships between LEV and the three schools under study. This framework is composed of eight dimensions, offering a means to interpret the relationships between partners based on pre-established definitions of these dimensions. The eight partnership dimensions are: communication, duration, formality, objectives, power and influence, resources, roles, and structure.

Employing these dimensions, all interactions pertaining to an educational partnership are analysed, enabling categorization into one of three types of partnership (see pages 23–25 for more detailed descriptions of these three types of partnership): cooperation (low level of partnership between organizations), coordination (middle level of partnership between organizations) or collaboration (high level of partnership between organizations). For example, in terms of the dimension of duration, a partnership is categorized as cooperation when it is established for a short term only. If a partnership extends to an intermediate or long term period, it is categorized as coordination or collaboration, respectively. The overall classification of the nature of a partnership is determined quantitatively by the highest number of dimensions that fall into a particular category. Hence, a partnership is classified as coordination, if more dimensions are ascribed to this category than to cooperation or collaboration. Similarly, using open coding (Merriam, 1998), the nature of the partnership between LEV and each of the three schools (via observations, questionnaires and interviews) were categorized as one of three types of partnerships with regard to each dimension of the framework, as described in Table 7.

Communication between LEV and the three schools did not differ in any significant way. In a standardized procedure, each of the LEV educators contacted the well-being coordinator at each of the three schools two months prior to the scheduled visit. A school coordinator’s pack was emailed, which consisted of documentation to organize the planning of the MLC visit to each school. Therefore, communication between the three schools and LEV is classified as cooperation since it was brief and primarily occurred for the purposes of
logistical planning of the MLC visit and the selection of the LEV modules. Communication between LEV and the schools only occurred for the duration of the MLC visit, which lasted for one or two weeks per annum.

LEV had a long-term partnership with each of the three schools under study. Tree and Unicorn had 20 and 15 years of partnership with LEV, respectively. Similarly, Hestia had engaged with LEV for over 10 years, albeit with some years of absence before their resumption of the partnership that year. Typically, in all three cases, the MLC visited the school annually and the LEV program was delivered sequentially year on year. The long-term nature of the association classified the partnerships between the three schools and LEV as collaboration with respect to duration. The only other dimension classified as collaboration was the formality of the partnership. LEV and the three schools established formalized and sustained partnerships through an annual service agreement.

Table 7. Classifying the Dimensions of the Partnerships Between LEV and Schools

<table>
<thead>
<tr>
<th>Dimension</th>
<th>Classification</th>
<th>Justification</th>
<th>Differences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>Cooperation</td>
<td>Occurred only for the purpose of task at hand</td>
<td>No difference</td>
</tr>
<tr>
<td>Duration</td>
<td>Collaboration</td>
<td>Long term</td>
<td>No difference</td>
</tr>
<tr>
<td>Formality of partnership</td>
<td>Collaboration</td>
<td>Formalized</td>
<td>No difference</td>
</tr>
<tr>
<td>Objectives</td>
<td>Cooperation and Coordination</td>
<td>Objective overlap?</td>
<td>Schools differ</td>
</tr>
<tr>
<td>Power and influence</td>
<td>Cooperation</td>
<td>Locus of control rested with individual organizations; disagreements about turf were not an issue</td>
<td>No difference</td>
</tr>
<tr>
<td>Resources</td>
<td>Cooperation</td>
<td>The LEV program was supported with discretionary funds controlled by the individual organizations</td>
<td>No difference</td>
</tr>
<tr>
<td>Roles</td>
<td>Cooperation</td>
<td>Roles did not overlap between both organizations</td>
<td>No difference</td>
</tr>
<tr>
<td>Structure</td>
<td>Cooperation and Coordination</td>
<td>Program can be done alone?</td>
<td>Schools differ</td>
</tr>
</tbody>
</table>
While the LEV objectives remained consistent (to jointly facilitate drug education), the three schools were differentiated on account of their *objectives*. Tree and Unicorn were classified as cooperation partnerships, while Hestia was classified as a coordination partnership with respect to objectives. These classifications were developed and explained above (see LEV-faced and school-faced partnerships). Tree and Unicorn’s objectives may or may not have overlapped with LEV’s objectives. In contrast, Hestia partnered with LEV to address a “complex single task, involving common goals, even though there was [sic] no shared rewards” (Weiland & Akerson, 2013, p. 1338).

The *power and influence* dimension in the partnerships between LEV and the schools was classified as cooperation, where “the locus of control rested with individual organizations and disagreements about turf were not an issue” (Weiland & Akerson, 2013, p. 1338). Moreover, while the generalist teachers selected one of 10 LEV modules for their respective classes, the LEV educator followed a well-rehearsed script to facilitate specific content and activities in the MLC sessions. The standardized age-appropriate modules rarely varied among the same aged groups or the three schools.

The dimension of *resources* was classified as a cooperation partnership between LEV and the participating schools. The LEV program was supported with discretionary funds controlled by the individual organizations. Each school contributed a fee-for-service on behalf of each student, while LEV sought sponsorship funds from other sources to cover all costs. Moreover, organizational “resources were kept separate” (Weiland & Akerson, 2013, p. 1338) as LEV provided schools with unique experiences and learning materials not readily available to them.

The dimension of interorganizational *roles* was classified as cooperation. Consistent in the three schools, the roles of the organizations did not overlap in the partnership; each had a specialized expertise that their partner either did not or could not offer. LEV provided content expertise and specialized resources, including the MLC experience which generalist teachers felt they could not offer their students.

On account of the *structure* dimension, the three schools were differentiated in their partnerships with LEV. The Tree partnership with LEV was classified as cooperation since the facilitation of their school-based drug education program could be done alone. The principal underlined the strategic overreliance on LEV to be the primary provider of drug education in the school. In contrast, Unicorn and Hestia’s partnerships with LEV were
classified as coordination because facilitating drug education in their environments could not be done alone by either organization. This dimension may have differentiated the three types of partnership explained above: LEV-faced, school-faced and school/LEV-faced partnerships.

Based on the Weiland and Akerson (2013) framework, the nature of the partnerships between LEV and the three schools under study can be classified as cooperation because “quantitatively, more dimensions fell into this category,” (p. 1347) than coordination or collaboration. A partnership of cooperation involves “a short term relationship focused on the completion of a single task,” (p. 1336) that can be completed separately or together. Unlike coordination and collaboration, cooperation is considered to espouse the least level of commitment, risk, negotiation, and involvement in a partnership.

Quantitatively, more dimensions of the Weiland and Akerson (2013) framework (between four and six dimensions in each school) fell into the cooperation category (see Table 7). Only two dimensions, duration and formality of partnership, were classified under the category of collaboration. Unexpectedly, there were no substantial differences between the classifications of the eight dimensions among the three schools’ partnerships with LEV, suggesting that it would be implausible to differentiate the three partnerships, based on this framework.

**Summary**

In this chapter, I depicted three divergent types of partnership between LEV and the schools under study, each able to be designated as cooperation using the framework of Weiland and Akerson (2013). Each partnership was distinguished by the school’s provision of drug education, the role LEV played, and the support afforded the generalist teachers.

Tree exemplified an LEV-faced partnership, whereby there was an unequal and overreliance on LEV to be the prominent deliverer of the school-based drug education program. The school’s program was either hidden or potentially nonexistent in the completed work. Such a partnership was distinguished by an externally facilitated drug education program, LEV played the primary role of delivering drug education, and generalist teachers were afforded limited support from their school or region.

Unicorn exemplified a school-faced partnership, whereby the school program was the prominent provider of drug education with the LEV program hidden in the completed work. Such a partnership was distinguished by an internally facilitated drug education program, the
supplementary role LEV played at the school, and the general/practical support afforded the generalist teachers.

Hestia exemplified a school/LEV-faced partnership, whereby both the school and LEV cofacilitated the drug education program. Such a partnership was differentiated by an integrated drug education program, the cofacilitative role LEV played at the school, and the organizational/practical support afforded the generalist teachers.

Based on the Weiland and Akerson (2013) framework, the nature of the partnerships between LEV and the three schools under study was classified as cooperation. Unlike coordination and collaboration, cooperation is considered the least level of commitment, risk, negotiation, and involvement in a partnership. Quantitatively, more dimensions (between four and six in each school) fell into this category than in that of coordination or collaboration.

These three types of school partnership with LEV provide the context for generalist teachers’ experiences working together with LEV specialist educators to facilitate a school-based drug education program. This is the subject of Chapter 6.
CHAPTER 6: Teachers’ Experiences Partnering With Life Education Victoria—Five Colorful Threads

In Chapter 5, I presented three divergent types of partnership, designated as cooperation (Weiland & Akerson, 2013), between LEV and the three schools under study, namely: LEV-faced, school-faced, and both school- and LEV-faced tapestries. Each partnership was differentiated by the school’s provision of drug education, the role LEV played, and the support afforded the generalist classroom teachers.

These schools’ partnerships provided the context for teachers’ experiences in teaching with LEV to facilitate a school-based drug education program. Such stories are described in this chapter based on my findings from the questionnaires, observations, and my informal conversations with 12 teachers at the schools examined. Over a period of 12 days, I observed 12 random LEV sessions in the MLC. My focus was on the classroom teachers’ interactions with the LEV educator and the participating students. I observed four divergent, yet repeated teachers’ experiences as they worked with LEV.

Generalist teachers’ attitudes, interactions, and behaviors ranged from disengagement, to partial engagement, to full engagement to over engagement in partnership with the LEV program. These teachers’ ways-of-being are categorized in order of engagement: (1) being-a-disengaged-teacher, (2) being-an-observing-teacher, (3) being-a-takeover-teacher, (4) being-a-learning-teacher, and finally (5) being-a-collaborative-teacher. Each of these ways-of-being is described in this chapter based on Quay’s (2015) framework of the interrelation of ways-of-being, ways-of-doing, and ways-of-knowing as occupation.
### Table 8. Summary of Teacher Occupation, Schools, and Partnership Type

<table>
<thead>
<tr>
<th>Teacher Occupation</th>
<th>Teacher</th>
<th>School</th>
<th>Partnership Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being-a-disengaged-teacher</td>
<td>Mr. Indigo</td>
<td>Tree</td>
<td>LEV-faced</td>
</tr>
<tr>
<td></td>
<td>Ms. Brown</td>
<td>Tree</td>
<td>LEV-faced</td>
</tr>
<tr>
<td></td>
<td>Ms. Grey</td>
<td>Tree</td>
<td>LEV-faced</td>
</tr>
<tr>
<td>Being-an-observing-teacher</td>
<td>Ms. Blue</td>
<td>Unicorn</td>
<td>School-faced</td>
</tr>
<tr>
<td></td>
<td>Mr. Red</td>
<td>Unicorn</td>
<td>School-faced</td>
</tr>
<tr>
<td></td>
<td>Ms. Pink</td>
<td>Hestia</td>
<td>School- and LEV-faced</td>
</tr>
<tr>
<td>Being-a-takeover-teacher</td>
<td>Ms. Purple</td>
<td>Hestia</td>
<td>School- and LEV-faced</td>
</tr>
<tr>
<td>Being-a-learning-teacher</td>
<td>Ms. Black and Ms. White</td>
<td>Unicorn</td>
<td>School-faced</td>
</tr>
<tr>
<td></td>
<td>Ms. Green</td>
<td>Hestia</td>
<td>School- and LEV-faced</td>
</tr>
<tr>
<td>Being-a-collaborative-teacher</td>
<td>Ms. Yellow</td>
<td>Tree</td>
<td>LEV-faced</td>
</tr>
<tr>
<td></td>
<td>Ms. Orange</td>
<td>Unicorn</td>
<td>School-faced</td>
</tr>
<tr>
<td></td>
<td>Ms. Magenta</td>
<td>Hestia</td>
<td>School- and LEV-faced</td>
</tr>
</tbody>
</table>

**Being-a-Disengaged Teacher**

Being-a-disengaged-teacher is a category that describes generalist teachers’ very low level of partnership with the LEV program within and outside the MLC. Being-a-disengaged-teacher portrays teachers’ least level of valuing of drug education in general and/or the LEV program within and outside the MLC.

All but one observed teacher at Tree (Ms. Yellow) did not engage in the MLC sessions (i.e., three out of four teachers were disengaged). Mr. Indigo, Ms. Brown, and Ms. Grey confided that they had no intention of facilitating a formal unit of study on health and drug education. Drug education was perceived as an irrelevant component of their teaching responsibilities; its provision was delegated to external providers. Consequently, generalist
teachers could not comprehend how the MLC session content or the LEV resources be incorporated into their Integrated Studies units.

Mr. Indigo had 16 years of teaching experience participating in the LEV program. Yet, he acknowledged his sole reliance on external providers to present drug education. Accordingly, Mr. Indigo did not intend to teach drug education to his students for two main reasons: (1) potential parental disapproval and (2) irrelevance of drug education for his students. In his informal communication with me during my observations, Mr. Indigo articulated his reservations to teach drug education. He warned that parents may have divergent views as to what should be taught about drug education in the classroom. It is judicious, he confirmed, that teachers should not initiate discussions about these issues in the classroom lest they generate contention with the parents.

Mr. Indigo also believed that his school’s affluent student cohort did not need drug education. In fact, in his conversation with me in the MLC, he indicated that Tree may be different from other schools, given that drug education is irrelevant to their student cohort. Mr. Indigo’s beliefs were reflective of Tree’s dismissive attitude toward school-based drug education. This was further evident through my observations of his colleagues: Ms. Brown and Ms. Grey.

Ms. Brown and Ms. Grey had no intention of facilitating a unit of studies on health and drug education. Ms. Grey, who had two years of teaching experience during which she participated in the LEV program, alluded to health/drug education having no real place in the Integrated Studies unit. At Tree, the focus of the Integrated Studies unit in 2011 was on design creativity and science (toy design), mini beasts, and packaging and recycling. Hence, Ms. Grey argued that health and drug education could not be incorporated in her program because it lacked alignment with her Integrated Studies unit. She articulated this dilemma:

I think it [LEV program] is a great one-off session, but at this stage it does not link in with my teaching. I would like it to be more ongoing and to link with my teaching. (Teacher 5, Tree Primary School, Survey Question 5)

Disengaged teachers devalued drug education or the LEV program for three reasons: (1) it seemed irrelevant for their students, (2) it did not link to their ascribed Integrated Studies units, or (3) it appeared as a potentially contentious matter that could provoke parents’ disapprobation.
Ways-of-doing as a disengaged teacher – inside the MLC

Three teachers from Tree (Mr. Indigo, Ms. Brown, and Ms. Grey) did not facilitate formal drug education program in their classrooms, did not engage with students’ learning activities in the MLC, and did not collaborate with the LEV educator.

Mr. Indigo, Ms. Brown, and Ms. Grey did not engage in the MLC sessions. The MLC sessions appeared to be the only formal channel through which the school facilitated health and drug education. Ms. Grey (teacher of Grades 1 and 2) approached the MLC as a one-off session, providing her students with a program that she “may not offer” (Teacher 5, Tree Primary School, Survey Question 6). Consequently, her actions and interactions in the MLC reflected her disengagement in the program.

Grades 1 and 2 with Ms. Grey and the Heroes module

Ms. Grey’s class participated in the LEV module Heroes, facilitated by the LEV educator during a 60-minute session in the MLC. The module centered around a fictional scenario where Harold the Giraffe (the LEV mascot) formed a team of superheroes and he recruited the class to assist the superheroes with their mission of making the world a safer and healthier place.

The superheroes characters—Extinguisher, Mediminder, Emergiman, and Littergator—were recruited for rescue missions, assisting the class to solve environmental health issues. With the aid of interactive animations, students explored the topics of passive smoking, syringe safety, as well as safe use and storage of medicines. Finally, through a role-play students learned about and rehearsed emergency procedures.

The MLC session commenced with establishing rules of interactions, followed by a whole-class brainstorming activity. LEV set up the superheroes narrative by inviting the class to join Harold on a rescue mission. Grades 1 and 2 students excitedly agreed to join Harold and his superheroes. As Harold strode “down stairs” to prepare for the rescue mission, he slipped on a banana peel and hurt his head. The ensuing loud bang shook the MLC and ushered cheers and hysterical laughter by the captivated students.

While awaiting Harold’s appearance on the video screens in order to commence the superheroes’ adventure, the LEV educator engaged the class in a brainstorming activity. In pairs, students were asked to discuss how they could work together as a team who were about to engage in a rescue mission. As selected students reported to the rest of the class, the LEV
educator scribed their ideas on the interactive whiteboard. These included: share, speak clearly, collaborate, and make sure everyone is included.

Students were assembled into small groups by the LEV educator and reminded to work well together as a team for their activity. The activity required students to categorize plastic food items under two headings: “good choice” and “sometime food.” Upon the completion of the activity, students presented their findings to the rest of the class.

Promptly, a short animation screening featuring Harold and his superheroes introduced the class to diverse unsafe situations. After each segment screened, the LEV educator facilitated a whole-group discussion inquiring: “Why was Harold concerned about safety in this situation?” Students’ responses were always followed by an elaborate explanation from the LEV educator and a dress-up role-play involving a selected student.

Throughout the MLC session, Ms. Grey sat at the back of the MLC observing the session without participating in any of the students' learning activities.

**Grade 4 with Ms. Brown and the Mind Your Medicine module**

Similarly, Ms. Brown, who taught Grade 4 at Tree, was disengaged in the MLC session. Her class participated in the LEV module Mind Your Medicine. Through a game show narrative, students explored two main topics: medicine and communication. Students were involved in assorted interactive activities in the session: think–pair–share, small-group investigations, screening and analyzing short DVDs, as well as participating in role-plays.

From the commencement of the session, the LEV educator engaged students with short segments from a DVD. The first video screened displayed recorded interviews with similar-aged students addressing various types of medicines and their functions (e.g., diabetics, heart condition, analgesics, insulin, asthma, Ventolin, antibiotics). Upon the conclusion of the screening, students discussed two questions in pairs. These included: “What are the medicines screened?” and “Why are these medicines used?” Two pairs were then invited to share their ideas with the rest of the class.

Following the debriefing of students’ presentations, the LEV educator divided the class into small groups. Each group, composed of four students, gathered under a laminated A4 label of a specific medicine. Students were tasked with investigating the function of the medicine: “What is it?” and “Why do people need it?” Following their discussions, each group presented its findings to the rest of the class.
Students promptly screened another video clip of how medicines enter the body. In application to their learning, students received a handout of a sketch of the human body and were encouraged to mark and explain, “How does medicine enter the body and travel into the blood stream?” The subsequent students’ presentations were interrupted by the LEV educator’s demonstration of the nervous system on TAM.

Following the screening of another infomercial about reading labels, the LEV educator asked students to examine their apportioned medicine package and list three instructions on an A3 laminated picture of a medicine bottle. In the presentations of their findings, students were asked to share only one warning per group. Moreover, the LEV educator restricted students from sharing personal stories during their presentations.

The composition of the small groups was changed in order to shift the session’s focus toward communication. The LEV educator introduced the segment and directed students’ attention to the video screen. The DVD depicted different scenarios in the playground surrounding the issue of inclusion and exclusion. Students were requested to work in their small groups to re-imagine and enact another ending to the scenario screened. She asked students to think of “what needs to be done to get people to join in and end successfully?” Upon the conclusion of their planning, groups were provided the opportunity to volunteer to perform their role-play. After each presentation, the LEV educator debriefed the role-play.

There were ample opportunities for Ms. Brown to engage with her students during the many small-group activities in the MLC. However, throughout the –90-minute session, Ms. Brown did not engage with her students in any of the learning activities. She sat in her allocated teacher seat in the back of the MLC, passively observing the session.

Unlike Ms. Grey, Ms. Brown was actually interested in the communication segment of the LEV module presented, and particularly the short video clip addressing inclusion in the playground. Upon the conclusion of the screening of the video and during the whole-class discussion that followed, Ms. Brown remarked to me that she would pursue this topic further in the classroom. She had informed me that “inclusion” was a real issue among girls in the playground. She had tackled this matter with her class recently and decided to continue the discussion after the MLC session. While she was disengaged in the session, Ms. Brown was interested in a brief (and the only relevant) aspect of the LEV program, rather than adopt a holistic approach to facilitating drug education in her classroom.
**Grade 6 with Mr. Indigo and the Think Twice module**

Mr. Indigo, who taught Grade 6 at Tree, was predictably disengaged in the MLC. A dismissive attitude toward drug education was evident in his interactions with students and the LEV educator in the MLC. His class participated in the LEV module Think Twice. This – 90-minute session revolved around addressing the topic of alcohol. Students were expected to learn that alcohol is a legal drug, which can affect all body systems resulting in short- and long-term consequences. They were encouraged to identify services that advise, educate, and inform people of the facts about drinking alcohol. Students were supported with resources to examine the harmful effects that alcohol can have on our community as well as describe the laws governing the advertising, sale, and use of alcohol products. Finally, students were equipped to identify, develop, and practice personal strategies to reduce alcohol-related harm.

The MLC session commenced with discussions in small groups. The LEV educator asked the class to brainstorm: “What is important to cover in this session?” Upon reporting their groups’ ideas, the LEV educator immediately introduced the first video and subsequent small-group activity. In their syndicate groups, students were allocated one of six stations each with a different task.

The first small group investigated how alcohol enters the body. They were to present their findings through a large drawing on laminated A3 paper. The second group discussed the short-term effects of alcohol, while the third group focused on the long-term effects as outlined in a colorful and scientific leaflet. The fourth group calculated the number of “standard drinks” associated with different alcoholic beverages. Students were to present their findings by classifying in an ascending order, as well as affixing on the Velcro MLC walls, the diverse alcoholic drinks allotted to them, each represented through a photograph/print. The fifth group undertook risk analysis of diverse written “drinking” scenarios. Their assessment was based on the “environment,” the “person” involved, and the “type of beverage” consumed. The last syndicate group was allotted statements to read, discuss, and judge whether they were “true” or “false.”

Following each group’s presentation, the LEV educator used colorful A4 sheets to outline refusal strategies. These strategies were expected to empower students to say “no” in the event that they were socially pressured to participate in an unsafe or an illegal endeavor. Finally, by watching a DVD scenario on the screen, students were invited to work in small groups to practice refusal strategies in order to maneuverer a different ending to an unsafe
scenario. Students took their creative task seriously and presented their refusal strategies through thought-provoking role-plays.

Even though the MLC session was composed of highly interactive and collaborative group activities, it did not inspire the classroom teacher’s active engagement. Throughout the session, Mr. Indigo sat in his seat, observed the various learning activities, and interacted predominantly with me, the researcher.

Furthermore, Mr. Indigo indicated that drug education was facilitated only incidentally in his classroom. Through my informal discussion with him, Mr. Indigo asserted that there was no need to incorporate the LEV booklets in classroom discussions. Contrary to his questionnaire responses, drug-related issues were addressed in the classroom only when students brought them up after the MLC visit. There was no formal facilitation of drug education in Mr. Indigo’s classroom.

Being-a-disengaged-teacher was patently a reflection of the generalist teachers’ (and their school’s) attitude toward drug education.

**Ways-of-doing as a disengaged teacher – outside the MLC**

Being-a-disengaged-teacher describes teachers’ least level of collaboration with colleagues outside the MLC. Teachers who disengaged with the LEV educator or their students within the MLC also had limited collaborative partnerships with other teachers outside the MLC.

The three teachers from Tree did not articulate any collaborative engagement with their teacher colleagues outside the MLC. Their ways-of-doing with others outside the MLC was reflected within it.

**Ways-of-knowing as a disengaged teacher**

Being-a-disengaged-teacher describes teachers’ least level of perceived competence to teach drug education in general, or the LEV program, within and outside the MLC.

The three teachers from Tree articulated their perceived lack of competence with propositional and/or pedagogical drug education knowledge. Ms. Brown, for example, confessed her lack of clarity on the drug education program in general (propositional knowledge). Consequently, she requested further support to provide content clarity of the drug education program. She remarked in her questionnaire that generalist teachers need “a clear outline of what information we can/should teach and at what levels” (Teacher 1, Tree Primary School, Survey Question 3).
Mr. Indigo similarly articulated his lack of clarity regarding the drug education curriculum in general. The seeming lack of specific direction for drug education in the VELS made him vulnerable and reluctant to teach content that parents may refute. Mr. Indigo transparently and informally shared his insights with me on this predicament. He lamented that there were not many specific directions for drug education in the VELS; hence, teachers do not really have a solid footing on which to guide their instructions surrounding these topics.

Additionally, Ms. Grey articulated her perceived lack of competence with drug education-related pedagogical knowledge. Consequently, she asserted that teachers in her school should be trained more/receive PD in order to deliver an effective health program. Additionally, Ms. Grey requested further support with the implementation of the various LEV resources. She reported being given the LEV booklets without being informed of how to incorporate them in her classroom.

Being-a-disengaged-teacher describes generalist teachers’ least level of partnership with the LEV program within and outside the MLC. For diverse reasons, these three teachers from Tree did not facilitate formal drug education in their classroom, did not support their students’ learning in the MLC, nor did they collaborate with the LEV educator. They considered drug education as irrelevant to their students or their Integrated Studies units, as well as reported the least level of collaboration with colleagues in the school (ways-of-doing). Additionally, they perceived themselves as incompetent facilitators of drug education-related propositional and/or pedagogical knowledge (ways-of-knowing).

Being-an-Observing-Teacher

Being-an-observing-teacher is a category that describes generalist teachers’ low level of partnership with the LEV program inside and outside the MLC. Ms. Blue and Mr. Red from Unicorn did not engage with students’ learning activities in the MLC, yet facilitated formal drug education programs in their classrooms. Interestingly, Ms. Pink from Hestia also worked in this way.

Being-an-observing-teacher describes teachers who valued drug education in general yet did not value a partnership with the LEV program within and outside the MLC.

Teachers from Unicorn (Ms. Blue and Mr. Red) considered their internal school program as the prominent provider of drug education, with the LEV program playing a supplementary role. Ms. Blue utilized the services of external specialists as a resource that
supplemented her Integrated Studies unit. External providers were invited into the classroom to support with specific topics; for example, a speaker from the Royal Automobile Club of Victoria addressed the importance of seatbelts with students. Another expert was scheduled to address the class on the topic of car education. The term concluded with an emphasis on healthy eating and cooking.

Ms. Blue considered the LEV program as a supplementary resource used as needed for her unit of study. This was particularly evident in her use of the LEV student booklet. Ms. Blue selected activities that were advantageous for her Integrated Studies unit. She described her rationale for using the booklet:

I picked up pages from the Life Education booklets, I didn’t go through the whole book I picked what fits with our unit. For example for our safety segment I picked scenes from the booklet, which showed dangerous situations at school and park. We started with the pictures and talked about safety. (Teacher 3, Unicorn Primary School, Observations Day 3)

Equally, as a teacher at Unicorn, Mr. Red employed the LEV program as a supplementary resource for his Integrated Studies unit. While Mr. Red valued drug education in general, he did not articulate the same appreciation for the partnership with LEV. From his questionnaire responses, it was evident that Mr. Red perceived himself as a creative and self-sufficient facilitator of health and drug education. When asked what program/s he used to facilitate health and drug education, Mr. Red wrote that he had made up his own program (Teacher 17, Unicorn Primary School, Survey Question 2).

The LEV resources and program did not feature significantly in Mr. Red’s Integrated Studies unit. Since safety was the focus of his Integrated Studies unit, Mr. Red preferred to utilize safety books from the library, rather than LEV booklets, in order to develop students’ knowledge and vocabulary. Following their reading, students were asked to complete a project, which incorporated procedural writing, spelling, and vocabulary. He informed me that he intended to evaluate students’ learning creatively by asking them to create a safety game, one similar to Snakes and Ladders.

Contrary to Mr. Red and Ms. Blue from Unicorn, Ms. Pink (Hestia) valued partnership with the LEV program. Even though this was her first year of involvement with the LEV program, Ms. Pink articulated the alignment of the LEV program to the units studied in the classroom. In her questionnaire responses, Ms. Pink stated that the MLC session “ties in
really well with our [classroom] lessons. It supports what we are doing at school about being safe” (Teacher 6, Hestia Primary School, Survey Question 5).

Collaboratively with another Prep teacher, Ms. Pink planned Integrated Studies units to facilitate health and drug education. The units focused on “Healthy Me” and “I’m Special” types of topic. She explained that other external programs were utilized to introduce simple aspects of safety with medicine. All lessons were prepared by the teachers and designed to meet the VELS learning outcomes. Her explanations of the Integrated Studies units confirmed that Ms. Pink and her colleague covered many of the topics and activities in the LEV program. Ms. Pink’s attitude reflects one of partnership with LEV to facilitate a school-based drug education program.

Ms. Blue and Mr. Red’s lack of partnership with the LEV program within and outside the MLC paralleled Unicorn’s attitude. As a school-faced partnership, Unicorn utilized LEV as a supplementary resource to their internally planned and facilitated school-based drug education program. Being-an-observing-teacher reflected their school value of drug education, yet moderate valuing of the partnership with LEV.

Contrastingly, Ms. Pink’s ways-of-being in the MLC (being-an-observing-teacher) did not reflect her school’s attitude. Unlike Unicorn, Hestia exemplified a school/LEV-faced partnership whereby both the school and LEV cofacilitated the drug education program. Hence, being-an-observing-teacher did not, in Ms. Pink’s case, fully reflect the school’s attitude toward drug education or LEV partnership.

**Ways-of-doing as an observing teacher – inside the MLC**

**Grades 1 and 2 with Ms. Blue and the Harold’s Diary module**

Ms. Blue, a Grades 1 and 2 teacher, had been involved with LEV for 12 years. She considered the LEV program as a “low cost incursion” (Teacher 3, Unicorn Primary School, Survey Question 4) that only supported the unit of study taught in the classroom. The classroom was perceived as the main program and driver for students’ learning. Accordingly, Ms. Blue’s participation in the MLC session reflected an observing disposition with a preoccupation with her own classroom program.

On Day 3 of my observations at Unicorn, Ms. Blue entered the MLC with her class and sat comfortably in the allocated teacher seat at the back of the MLC. The Harold’s Diary module is often facilitated with the Grades 3 and 4 classes in a 90-minute session. However, for her Grades 1 and 2 classes, Ms. Blue requested only a 60-minute version of the module,
which revolved around Harold’s multimedia diary entries. Students explore friendship issues relevant to middle year students, food choices, and the way these choices can affect their health. The module concludes with a segment on physical activity, fitness, and well-being.

As they enthusiastically entered the MLC Robin, the LEV educator, asked the Grades 1 and 2 students if they wanted to see Harold the Giraffe. Students yelled loudly, “YEAH!” The atmosphere was rather electric from the commencement of the session. As Harold was introduced, students immediately noticed his sadness, which related to friendship matters. When Robin asked Harold to elaborate on his concerns, he motioned to his diary, affixed to the MLC Velcro wall. By gaining his permission, the LEV educator elected to read the diary aloud to the class.

Upon reading the first entry in the diary, Robin asked the class: “What sort of day did Harold have on Monday?” A whole-group discussion guided students toward depicting specific factors that assisted Harold to stay healthy (e.g., food, exercise). The diary was further employed to transition the discussion toward Tran’s feelings (Harold’s friend). Robin requested students to discuss the following questions: “Do you think you can tell the way a person is feeling by observing/looking at them?” and “What things may you look for?”

Following this brainstorming activity, students viewed a vox pop DVD segment exploring the topic of emotions. In this video, Harold interviewed young people about contrasting emotions and why they were feeling this way. In the conclusion to this segment, Robin encouraged the class to ponder how students feel on their first day at school. Students raised their hands and articulated words such as sad, shy, and nervous. Upon hearing their insightful responses, Ms. Blue remarked aloud to me, “It’s good to see how much they grasp from the classroom.”

Prior to this incident, Ms. Blue had just informed me that her students had been involved in discussing the topic of emotions/feelings in the past two weeks. She was impressed by her students’ learning and retention of information from her classroom discussions.

Ms. Blue only participated in the MLC session when the LEV educator called upon her to select students for an activity. Throughout the session, however, she did not support the LEV educator or her students in any of their small-group activities. Importantly, Ms. Blue was not distracted by any other tasks; rather, she appeared to authentically consider her role as a nonparticipant observer. In fact, later in the MLC session, as the LEV educator
facilitated a whole-class questions and answers (Q&A) segment about the food wheel, the students responded enthusiastically and confidently. Ms. Blue looked at me proudly and commented, “I think they *know* much more than I thought.”

By observing her students’ responses to the questions posed by the LEV educator, Ms. Blue was able to assess her students’ learning from their unit of study. The role of an observer restricted Ms. Blue from collaborating with the LEV educator, yet reaffirmed her position as the “assessor” of her students’ learning.

**Grades 3 and 4 with Mr. Red and the Harold’s Diary module**

On Day 4 of my observations at Unicorn, Mr. Red entered the MLC accompanied by his student teacher and Grades 3 and 4 classes. The session commenced with a revision of the learning that students remembered from the previous year. The class surprised me by their recollection of information gained in the MLC the previous year. Following the revision exercise, Harold the Giraffe was introduced to the class and permitted them to access his diary.

Upon reading the first dairy entry, Robin asked students to reflect on the following questions: “How would Tran [Harold’s friend] feel on her first day at school?” “How do you welcome new students at your school?” and “What could we do to make new people feel welcomed?”

In a smooth transition from the previous activity, Robin asked the class to assemble in small groups of four students and come up with helpful tips to share with Harold on how he can meet new friends at his school. As the students eagerly discussed their tips in small groups, Mr. Red turned to his student teacher and remarked that the LEV educator was modeling good teaching practice.

Within the MLC, Mr. Red carried a confident disposition: adopting the role of an assessor, passively observing the session, and only interacting with his student teacher and commentating on the LEV educator’s pedagogy. Throughout his questionnaire responses, my observations, and informal discussion, he appeared to assume a role of mentor. His survey responses included phrases most notable on a student-teacher report. When asked how LEV supported the facilitation of effective health and drug education, Mr. Red embarked on an assessment of the educator’s teaching practice:
Wonderful modeling of teaching . . . clear, use of voice, builds on knowledge . . . uses names, computer, children working in groups . . . picking different kids to respond. (Teacher 17, Unicorn Primary School, Survey Question 6)

In fact, throughout the MLC session, Mr. Red sat cross-legged, observing the session and communicating with his student teacher. As I attempted to listen in on their conversations, it became apparent that Mr. Red was engaged in an ongoing commentary of the LEV educator’s pedagogy. For example, during a small-group activity, Mr. Red turned to his student teacher and remarked that the LEV educator was modeling good teaching practice. I heard him share the following:

She’s not dominating the session, she is allowing kids to share their ideas and feelings . . . She allows them to work in small groups and walked around to see how they are doing. She also gives very clear instructions; this is a great modeling for us teachers. (Teacher 17, Unicorn Primary School, Observations Day 4)

Again, as Robin was walking around the room observing and helping the various small groups with their tasks, she stopped and instructed the class about their time limits. Mr. Red addressed his student teacher again and said:

Look how she uses her clear voice . . . She looks around the room but she keeps her head up. It’s coming from within without being squeaky. She obviously has had lots of practice at this. (Teacher 17, Unicorn Primary School, Observations Day 4)

Further, while the LEV educator was explaining the food wheel to the class, one of the students yelled out his answer without gaining permission. Instead of drawing attention to the misbehavior, Robin said, “Thanks to those people who are listening.” Mr. Red looked at the student teacher next to me and remarked, “Look how she politely ignores his comments and only acknowledges the ones who talked in turn.”

Mr. Red’s assessment of the LEV educator’s teaching practice was further outlined in the final question on the questionnaire. Mr. Red commented:

This was an excellent lesson that modeled perfect teaching. Student teachers could use it, to pinpoint the positive things done. Maybe it could be used in college as a model and promote life ed. (Teacher 17, Unicorn Primary School, Survey Question 9)

While appearing involved in the MLC session, Mr. Red as well as Ms. Blue and Ms. Pink were nonparticipating observers who did not collaborate with the LEV educator or engage with their students’ learning activities within the MLC.
**Grade Prep with Ms. Pink and the Clued Up module**

Similarly, Ms. Pink from Hestia was also an inactive participant in the MLC, despite facilitating a drug education unit in her classroom. Ms. Pink was in the middle of her second year of teaching and her first year of involvement with the LEV program. She taught a small Prep class consisting of a highly multicultural cohort. Collaboratively with another Prep teacher, Ms. Pink planned her Integrated Studies units to facilitate health and drug education throughout the year.

Ms. Pink’s class participated in the LEV module, Clued Up. In this module, students were engaged with a narrative involving Harold opening a detective agency center. Harold enlisted their help to find Possum’s missing friend, Cocky. In their search for Cocky, the student detectives encountered and solved many problems including safe/unsafe living, syringe safety, friends and people we can turn to for help, as well as cooperation and working together.

During the 60-minute session in the MLC, Ms. Pink observed the session eagerly without participating in the students’ activities. Only when requested by the LEV educator, Ms. Pink proposed the names of students to contribute to an activity. Her lack of participation was not an indication of dissatisfaction with the presentation. In fact, Ms. Pink indicated her enjoyment and appreciation of the LEV educator’s pedagogy and her behavior management strategies. She felt that the LEV educator’s teaching practices were well aligned to her practices in the classroom.

Ms. Pink’s emphasis on pedagogy reflected her own interest and focus on interactive pedagogy. In her response to the final question in the survey, Ms. Pink remarked:

> Loved the combination of activities and resources—hands on, video, visual displays, songs, discussions . . . Kept the children engaged and enthralled!! Was great. Sandy was excellent with the children—reminding them to put hands up and sit on their bottoms—very much in line with our classroom rights and responsibilities. Thank you!! (Teacher 6, Hestia Primary School, Survey Question 9)

Ms. Pink affiliated with the LEV educator’s pedagogy yet did not actively participate with the students’ activities within the MLC session. Mr. Red from Unicorn similarly enjoyed the LEV educator’s pedagogy yet remained a nonparticipating observer in the MLC session.
Ways-of-doing as an observing teacher – outside the MLC

Being-an-observing-teacher describes teachers’ low level of collaboration with colleagues outside the MLC. Teachers who observed the LEV educator or their students within the MLC were likely to be engaged in limited collaborative partnerships with other teachers outside the MLC.

A lack of collaboration with the LEV educator resembled Ms. Blue’s current interactions with colleagues outside the MLC. In my informal conversation with her, Ms. Blue explained her solitary teaching experience that year. She informed me that most teachers in her grade team-teach, except her. For five years, Ms. Blue had taught Preps in a team-teaching environment. She felt that teaching was easier and more desirable when there was another teacher in the classroom. She offered a simple example to portray the advantages associated with team teaching, even during a food segment session in the classroom whereby one teacher cooks and the other leads the literacy session. Ms. Blue argued that teaching by herself had been a harder experience for her that year.

Mr. Red similarly did not engage in significant collaborative efforts outside the MLC. While he reported visiting other classes to observe teachers’ practices, Mr. Red’s language appeared more of an assessor of teachers’ abilities than a collaborator with colleagues. Assuming a role of a mentor to the student teacher outside the MLC was consistent with Mr. Red’s interactions within the MLC. In fact, he used the teaching practice of the LEV educator to “model” good practice to his student teacher. He adopted a disposition of an assessor, a mentor, and a teacher of teachers. His partnership with others outside the MLC was a top-down approach consistent with his role as a mentor of his student teacher.

When Robin was concluding the MLC session, conversing with Harold, and answering students’ questions, Mr. Red sensed his students’ excitement. He leaned over to the student teacher and instructed him to change the upcoming classroom’s activity:

Let’s change tomorrow’s task. Let’s get them to revise what they’ve learnt today . . . Get the kids to do that task as we agreed, but before then, let them write a letter to Harold. (Teacher 17, Unicorn Primary School, Observations Day 4)

In contrast to Ms. Blue and Mr. Red, Ms. Pink engaged in collaborative partnerships outside the MLC. In fact, Ms. Pink emphasized collaboration with other colleagues when she reported on her planning or facilitation of a health and drug education program. Collaboratively with another Prep teacher, Ms. Pink planned Integrated Studies units. She
also reported that in collaboration with her colleagues, she sought to establish a learning environment that catered for different learning styles. Evidently, Ms. Pink’s language implied her ongoing collaborative interactions with colleagues outside the MLC, yet she remained a passive observer in the MLC session.

For diverse reasons, Ms. Blue, Mr. Red, and Ms. Pink did not collaborate with the LEV educator or engage with students’ activities in the MLC session. The three teachers valued drug education in their schools, yet Ms. Blue and Mr. Red (Unicorn) considered the LEV as a supplementary resource for their Integrated Studies unit. Ms. Pink (Hestia) in contrast valued both drug education and partnership with LEV. Additionally, Ms. Pink, unlike Ms. Blue and Mr. Red, engaged in collaborative partnerships outside the MLC. Yet, the three teachers exhibited the same level of passive interaction within the MLC session.

**Ways-of-knowing as an observing teacher**

Being-an-observing-teacher describes teachers’ high (and moderate) level of perceived competence to teach drug education in general. While Ms. Blue and Mr. Red perceived themselves as confident facilitators, Ms. Pink acknowledged her partial incompetence with teaching health and drug education.

With 30 years of teaching experience, Mr. Red from Unicorn carried a confident disposition regarding his facilitation of his Integrated Studies unit incorporating health and drug education. Mr. Red applied an interactive and inquiry-based approach to learning:

The students are instructed to find safety posters for Homework. They come back to school and share words and signs to make safety posters and bumper stickers... Students are expected to explore an idea on fire safety, write a good report and produce a flipbook about fire safety. (Teacher 17, Unicorn Primary School, Observations Day 4)

Mr. Red distinguished himself from other teachers by the way he consulted resources and learned from others. He exclaimed to me that he visited other colleagues’ classes to grasp what other teachers were doing. Mr. Red lamented that there were many teachers who did not want to learn or observe their colleagues but rather sought the lazy way out of photocopying worksheets to hand to their students.

Ms. Blue, like Mr. Red, perceived herself as a competent facilitator of health and drug education. She particularly emphasized her capacity to engage students in active and cooperative learning. She described her teaching philosophy to me during the MLC session:
I like hands-on experience in inquiry-based approach . . . it really works. I’ve gained this experience over the years . . . I’ve done a lot of PDs, which have helped me with this teaching methodology. Watching other teachers teach help develop my teaching repertoire. Kids learn by doing it, you can’t talk at them . . . otherwise, they switch off and you lose them. (Teacher 3, Unicorn Primary School, Observations Day 3)

While she had participated in diverse PD opportunities, Ms. Blue had not been involved in health and drug education-specific training for three to four years. Nevertheless, she felt confident with facilitating health and drug education on her own without the need for any further training. The only support Ms. Blue desired from LEV was related to the provision of resources:

Resources are our biggest issue . . . Importantly a KIT from Life Education with resources and have the different props and we could buy this. Maybe one kit per two classes and we could do more ourselves because resources are at biggest issue. (Teacher 3, Unicorn Primary School, Observations Day 3)

Ms. Blue and Mr. Red perceived themselves as capable facilitators of health and drug education. This perception may have further prompted them to embrace their partnership with the LEV program. On the contrary, Ms. Pink from Hestia did not exude the same confidence, but rather articulated her incompetence toward drug education and/or the LEV resources.

Ms. Pink’s (Hestia) recent learning experience, as a young graduate and her PD participation, had helped her establish an interactive pedagogy that is highly effective in drug education. Ms. Pink reported that her units were facilitated through highly interactive strategies. She and her colleagues sought to establish a learning environment that catered for different learning styles. Lessons consisted of many hands-on activities, interactive whiteboard exercises, online games, and role-plays. External presenters such as police and firefighters were also incorporated in the units. In her informal discussions with me, Ms. Pink articulated the approach she adopted in order to facilitate effective health and drug education units:

We are always encouraged to make our lessons interactive. We’ve been exposed to different PDs on different thinking tools. You know, multiple-intelligence requires us to cater for different senses, movements to try to engage students with different learning styles. (Teacher 6, Hestia Primary School, Observations Day 3)
However, Ms. Pink’s knowledge of the specific nuances of drug education appeared limited. In her questionnaire responses, Ms. Pink desired better support with information on the age-appropriate content for the health units. She stated the need for “a clear statement on what content needs to be taught at particular stages of a child’s development” (Teacher 6, Hestia Primary School, Survey Question 4). This is not a surprising request from a relatively inexperienced teacher who is juggling the various demands of the curriculum.

Teachers’ perceived competence did not directly correlate with their level of participation in the partnership. While two out of the three teachers perceived themselves as highly competent facilitators, one perceived herself as partially incompetent facilitator of health and drug education.

**Being-a-Takeover-Teacher**

Being-a-takeover-teacher is a category that describes generalist teachers’ exaggerated level of partnership with the LEV program within and outside the MLC, where the teacher is not so concerned with partnering with the LEV educator, but rather with maintaining control and dominance as the primary educator.

Being-a-takeover-teacher describes teachers’ high level of valuing of drug education in general and the LEV program within and outside the MLC. In her questionnaire responses, Ms. Purple implied that she took full advantage of the LEV resources to facilitate effective drug education in her classroom. This involved facilitating previsit classroom discussions, participating in the MLC sessions, and utilizing the LEV student booklets during postvisit classroom discussions.

Furthermore, Ms. Purple explained that the MLC “acts as a springboard for discussion and associated activities for my class” (Teacher 1, Hestia Primary School, Survey Question 6). Accordingly, she perceived the MLC sessions as an extension of the classroom activities prior to and post the LEV visit.

**Ways-of-doing as a takeover teacher – inside the MLC**

Ms. Purple (Hestia) worked with LEV to facilitate a collaborative drug education program in the classroom, yet continually interrupted the LEV educator and took over the facilitation of the MLC session. Ms. Purple taught Grades 5 and 6 at Hestia. She had nine years of teaching experience, two of which involved with the LEV program.
Grades 5 and 6 with Ms. Purple and the It’s Your Call module

On Day 1 of my observations of Hestia, I encountered Ms. Purple as she guided her Grades 5 and 6 classes into the MLC. From the moment they entered the MLC, students demonstrated enthusiasm more often associated with junior classes. They quietly sat down on the ground facing Sandy, the LEV educator. On the screen, at the front of the MLC, the title of the module was displayed: It’s Your Call. Several posters on smoking were also affixed around the Velcro walls of the MLC. To commence the session, Sandy asked the class: “What are we talking about today?”

From the first whole-class activity, it was apparent that the students had engaged in previsit activities. This was particularly evident during Sandy’s whole-group Q&A session on smoking. At the commencement of this segment, Ms. Purple leaned over to me and explained that in the classroom her students had been involved in a lot of discussions on smoking.

During the whole-class discussion on smoking, Ms. Purple actively participated in the session. In fact, whenever Sandy asked students a question, Ms. Purple would promptly look around the room to elicit her students’ responses: “What did I tell you in the classroom about that?” or “Who remembers that from our classroom discussions?”

Throughout the MLC session, Ms. Purple volunteered questions, directed the discussions, and gave answers to her own questions. In fact, when students directed their questions to Sandy, Ms. Purple took a license to answer them. “Why can’t the government sue the cigarette companies?” a student asked Sandy. Ms. Purple immediately jumped in with the answer, without waiting for Sandy to respond. She commented, “That’s a great question. The government is making money out of cigarette companies . . . taxes.”

This apparent interference was evident throughout the MLC session as Ms. Purple enthusiastically fired another question at the class. At one stage, she asked, “Okay, there’s been something in the media about plain packaging. Why aren’t those companies happy about plain packaging? Why do those companies care about that?”

Some students raised their hands to share their opinions. Yet, Ms. Purple continued her dominance of the session: “A few years ago when I was a smoker, there was none of those photos that show the impact of smoking.”

Another student asked, “Why do people keep on smoking if cigarettes are so harmful to our bodies?” Ms. Purple, again unprompted, volunteered her answer before anyone else had a
chance to communicate. Sandy remained silent, yet appeared astounded as Ms. Purple assumed control of the MLC session.

Ways-of-doing as a takeover teacher – outside the MLC

Being-a-takeover-teacher describes teachers’ least level of collaboration with school colleagues outside the MLC (this is different to the way in which a teacher may value the LEV program). Ms. Purple did not report any level of collaboration with colleagues outside the MLC. While being a teacher at Hestia, Ms. Purple did not comment on collaborating with other colleagues on planning days. Such omission did not necessarily reflect on the actual collaborative planning undertaken, but rather the value that Ms. Purple may have placed on collaborative interactions with colleagues.

Surprisingly, Ms. Purple argued that Hestia offered very insignificant support for teachers in facilitating effective drug education. She summarized the support offered by the school as “Nothing! [Except] there may be resources in our school library.” (Teacher 1, Hestia Primary School, Survey Question 5). Evidently, staff planning days offered by Hestia did not register as noteworthy support offered to Ms. Purple.

For diverse reasons Ms. Purple worked to dominate the partnership with the LEV educator, continually interrupting and taking over the facilitation of the MLC session. Yet, she did not report engaging collaboratively with colleagues outside the MLC.

Ways-of-knowing as a takeover teacher

Being-a-takeover-teacher describes teachers’ exaggerated level of perceived competence to teach drug education in general or the LEV program within and outside the MLC. She had an inflated perception of her competence in facilitating health and drug education. Ms. Purple’s eagerness to “preach” against smoking did not necessarily match her comprehension of drug education best practice. Teacher-centered, fear tactics, and contradiction to normative education were all evident in Ms. Purple’s communication in the MLC:

Cigarettes are horrible—addictive you can’t stop—you can’t stop like when you start on a tasty packet of chips, do you stop after eating just one? No you can’t stop, just like you can’t stop playing your DS after your first game. That’s what addiction is all about. (Teacher 1, Hestia Primary School, Observations Day 1)

Ms. Purple’s perceived competence prompted her to engage with students throughout the session. After viewing a short DVD, Sandy asked students to prepare a role-play to practice
refusal strategies. She asked students to think about the last scenario screened on the DVD and to design a “preferred ending.” Students were asked to practically demonstrate how they could refuse the offer of a cigarette.

As students assembled to discuss their strategies and plan their role-plays, Ms. Purple volunteered to join a small group and decided to be part of their role-play. As I observed her interactions with the students, I noticed that she actually assumed full control of her group’s preparation and directing the roles of the various students involved. Without any prior planning or consultation with the students, she began to act out a scenario and then motioned to the student next to her to offer a cigarette to another group member. When the student refused the offer of the cigarette, Ms. Purple interrupted, “Why not? Everyone is smoking—go on, have one.” This comment was contrary to normative education principles emphasized in drug education best practice. Research asserts that it is necessary to use examples in role-plays that are realistic, representative of the stats, and explain that not all young people smoke (Botvin, 2000; MacKinnon et al., 1991; Stead & Angus, 2002).

While Ms. Purple was busily directing her small group, Sandy went around the other groups assisting students with their planning of the role-plays. After approximately six minutes of preparation, Sandy asked Ms. Purple to select two groups to present their role-plays to the rest of the class. Most groups excitedly raised their hands to be nominated to perform. Surprisingly, Ms. Purple promoted her own group to present.

Ms. Purple’s participation in the MLC session demonstrated her immense interest in the topic; however, it was noticeable that she did not have the up-to-date strategies to facilitate effective drug education in her classroom. Ms. Purple’s teacher-centered approach outside the MLC was apparent in her eliciting students’ responses:

What did I tell you in the classroom about that?

Who remembers that from our classroom discussions? (Teacher 1, Hestia Primary School, Observations Day 1)

The phrasing of her questions implied that Ms. Purple provided information to students instead of facilitating inquiry-based, active, and cooperative learning environments. Ms. Purple’s emphasis on “recall” and “regurgitation” of information, evident in her questions, may have prompted her teaching practice in the MLC, taking over the role of the LEV educator, providing lengthy answers and assuming full control of her students’ role-play.
Remarkably, Ms. Purple was not aware of the negative implication of her “preaching” style of teaching in the MLC. This was most apparent in her “ex-user” storytelling: “A few years ago when I was a smoker, there was none of those photos that show the impact of smoking” (Teacher 1, Hestia Primary School, Observations Day 1).

As an ex-addict, Ms. Purple positioned herself as an “expert” in drug education. Consequently, throughout the MLC session, she repeatedly referred students back to her story and experience. Clearly, it was her communication tool to deter students from smoking, ill informed of the latest drug education research warning against this strategy’s pitfall.

Taking over the MLC session was not an indication of Ms. Purple’s dissatisfaction with the knowledge or pedagogy of the LEV educator. In fact, in her survey responses, Ms. Purple stated:

Fantastic session—fantastic and knowledgeable presenter. Great with kids. Great posters, diagrams [e.g., circulatory system] and fantastic conversations—real life examples that the children could relate to. The SEARCH model—great to generate discussions. (Teacher 1, Hestia Primary School, Survey Question 9)

Taking over the MLC session was a reflection of Ms. Purple’s exaggerated yet misinformed perception of her competence as a facilitator of health and drug education.

**Being-a-Learning-Teacher**

Being-a-learning-teacher is a category that describes generalist teachers’ moderate level of partnership with the LEV program within and outside the MLC. Being-a-learning-teacher describes teachers who valued drug education in general, as well as partially valued partnership with the LEV program within and outside the MLC. Two teachers from Unicorn (Ms. Black and Ms. White) and a teacher from Hestia (Ms. Green) facilitated a formal drug education program in their classrooms and adopted a learning disposition in the MLC.

Ms. Black and Ms. White from Unicorn embraced the innovative play-based curriculum, where “topics [are] run by kids’ interests” (Teacher 2B, Unicorn Primary School, Survey Question 2). They utilized interactive pedagogy to facilitate health and drug education through hands-on activities, the use of the Internet, and through small-group interactions. They believed that the LEV program supported their study unit in the classroom. I noticed their emphasis on the word “support.”
The Integrated Studies units directed Ms. Black and Ms. White’s teaching, supplemented by the LEV resources. They reported that the LEV student booklets were selectively “incorporated into students’ learning; used as a focus for literacy groups” (Teacher 2A, Unicorn Primary School, Survey Question 7). Ms. Black highlighted that using the booklets “depends on how easy and relevant the booklet is. At this stage, can’t use it!” (Teacher 2B, Unicorn Primary School, Survey Question 7). Clearly, the LEV booklets did not fully align with their Integrated Studies unit.

Consistent with their school’s approach, Ms. Black and Ms. White employed the LEV program as a supplementary resource for their Integrated Studies unit. As a school-faced partnership, Unicorn utilized LEV as a supplementary resource to their internally planned and facilitated school-based drug education program.

Contrastingly, Ms. Green from Hestia’s ways-of-being in the MLC (being-a-learning-teacher) partially reflects her school’s attitude toward LEV. Unlike Unicorn, Hestia exemplified a school/LEV-faced partnership whereby both the school and LEV cofacilitated the drug education program. In her questionnaire responses, Ms. Green indicated that she facilitated health and drug education through an internal unit delivered in Term 3. The focus of the unit was on drug, health, and human relations. By being-a-learning-teacher in the MLC, Ms. Green sought to glean ideas from the LEV educator in order to complement her classroom facilitation of health and drug education.

Ways-of-doing as a learning teacher – inside the MLC

Ms. Black, Ms. White, and Ms. Green attentively engaged with the LEV session’s content, discussed strategies modeled by the LEV educator, and adopted ideas presented in the MLC in order to implement them in their classrooms.

Grade Prep with Ms. Black and Ms. White and the Harold Surprise module

Ms. Black and Ms. White team-taught a Prep class at Unicorn. They had five years and three years of teaching experience, respectively. They had both been involved with the LEV program for three years. Ms. Black and Ms. White believed that the MLC provided a “good introduction to safety, body and healthy eating” (Teacher 2A, Unicorn Primary School, Survey Question 7). They reported that the LEV session stimulated discussions and prompted follow-up activities in the classroom, such as investigations and literacy.

On Day 2 of my observations of Unicorn, I observed Ms. Black and Ms. White’s interactions with students, Robin the LEV educator, and each other. Both teachers entered the
MLC with a positive vibe; I could gauge it through their smiles and energetic communication with their students. They directed the class to adhere to the LEV educator’s direction as they sat down at the back of the MLC in their allocated teacher spots.

In the Harold Surprise module, Harold’s friend Possum invites the class to a party in a park. Along the way to the party, a selection of issues are raised and explored including health and well-being, physical activity and the body’s response to it, safety awareness including syringe safety, as well as expressing feelings, needs, and wants in an appropriate manner. At the conclusion of the MLC session, Possum thanks all her friends with a special surprise, contained in a big wrapped box.

The excited Prep students could not wait to enter the MLC—Harold’s home. As he was introduced to the students, Harold invited the class to accompany him to Possum’s party. Upon reading the invitation, Robin facilitated a Q&A session asking students, “Why might Possum want healthy food at the party?” “What foods are healthy?” and “What makes foods healthy?”

Robin presented each small group of students with a bag of plastic food items. She requested them to discuss which food items would be placed on the healthy food circle fixed onto the wall and hence, taken to Possum’s party. Groups’ findings were reported to the rest of the class, who were also permitted to judge their peers’ choices and propose any required adjustments.

Following their presentations, Robin engaged the students in a game of “pass the parcel.” The items incorporated in the parcel included a plastic heart, stomach, lungs, and brain. Using the DVD player, Robin played music as students passed the parcel around a circle. As the music stopped, a student pulled out a body part and showed it to the class. Robin asked students, “Who would like to take a guess at what this part is?” and “Where does this part go on the body?”

After every round, Robin used TAM to highlight the functions of the body part pulled out from the “parcel.” While Robin was demonstrating the various body parts to the class, Ms. Black leaned back and shared an idea with her colleague, Ms. White. She suggested that they should focus their next classroom investigation session on “body parts.” When I asked them, they explained the activity to me:

The investigation session will begin with a station for the body. Our class has a model with removable body parts that students will assemble. The class also has body aprons that kids
could utilize. During the tuning in time, one of us will ask students what they learned in the MLC—a revision time. Hopefully this activity will lead children towards their area of interest and spark something that we could build on for the rest of their class time. (Teachers 2A and 2B, Unicorn Primary School, Observations Day 2)

While the LEV session was only scheduled for 60 minutes, both teachers reflected a keen desire to glean ideas from the session. They observed the LEV educator’s practice and regularly communicated ideas with each other. Notably, Ms. Black and Ms. White did not actively participate in the MLC session. Admittedly, the session was principally educator-centered, given the age of the students. However, throughout the session I observed them watch and discuss ideas with each other. Consistent with their practice outside the MLC, both teachers demonstrated a willingness to adopt concepts gained from the LEV educator to improve their teaching practice in the classroom.

On the surface, the classroom teachers did not collaborate with LEV in facilitating drug education. They assumed the back seat in the MLC and rarely engaged in the discussions or the learning activities. Yet, their willingness to align their classroom activity to the topic addressed in the MLC suggests that they intended to complement their students’ learning following the MLC session.

**Grades 5 and 6 with Ms. Green and the It’s Your Call module**

Ms. Green taught Grades 5 and 6 class at Hestia. She had six years of teaching experience, but only one year of involvement in the LEV program. Her class was involved in the LEV module, It’s Your Call. Ms. Green and a teacher aide accompanied this multicultural class in the MLC. Although Ms. Green sat in her allocated chair at the back of the MLC, she was keenly engaged with and gleaned ideas from all the activities facilitated by Sandy, the LEV educator.

At the commencement of the MLC session, students were required to come up with a definition for a drug in their small groups. Each group was provided with a plastic pouch containing a puzzle with laminated sentences, which they needed to construct in the right order to reveal the definition. Students appeared engaged in the learning process, sharing ideas and arranging the puzzle on the Velcro wall. As soon as the activity was underway, Ms. Green turned toward her teacher aide seated next to me and remarked, “I’d like to get sentences like that for the kids to come up with definitions. It’s a good exercise for the classroom.” The teacher aide responded, “I was thinking the exact thing.”
This learning disposition was maintained throughout the MLC session. In another small-group activity, students were presented with 10 laminated names of drugs that they were tasked to sort into various categories. One group was to classify their drugs into harmful vs. helpful, another group was to sort them into safe vs. unsafe, and another into legal vs. illegal, and yet another into life-saving vs. life-ending.

Immediately, as students embarked on discussing and sorting out their laminated drugs under the appropriate categories, Ms. Green picked up a pen and a notepad and walked around the room copying the different headings, classifications, and categories affixed on A4 laminates on the MLC walls.

The session concluded with screening a short DVD on the front screen. The scenario on the DVD captured a quandary experienced by a young teenager. Her older sister was instructed by her mum to drive her younger sibling home from a party by 10:30 p.m. However, the younger sister was heard sharing her concerns with a couple of friends about her older sister’s alcohol consumption. The young sister appeared uncomfortable to be driven home by her seemingly intoxicated older sibling. The short clip concluded with a question raised by the distressed younger sister: “What should I do?”

Sandy asked students to assemble into their syndicate groups again and go through the SEARCH model to discover the best plan of action for the little sister. The SEARCH model was explained to the students through the aid of A3 posters affixed to the MLC walls. The model refers to Situation, Emotion, Action, Result, Choice, and How did it go. Beneath each heading, there was a question to help students think through the model. This model aimed to assist students to consider various alternative solutions to any given scenario, prompting them to think through the potential ramifications before making a decision. As soon as Ms. Green observed this activity, she leaned forward and picked up her notepad and pen again to scribe the questions beneath each letter of the SEARCH model.

**Ways-of-doing as a learning teacher – outside the MLC**

Being-a-learning-teacher describes teachers’ engagement with (or desire for) a high level of collaboration with colleagues outside the MLC.

Ms. Black and Ms. White exhibited a very high level of collaboration with colleagues outside the MLC. They team-taught their Prep class, positioned themselves as collaborative learners, and reported their ongoing support of one another.
While Ms. Green did not engage in a high level of collaboration outside the MLC, she persistently alluded to her desire to collaboratively facilitate health and drug education with other staff members. In order to facilitate effective health and drug education, Ms. Green believed that teachers need to “team-teach with support from experienced staff in this subject area” (Teacher 4, Hestia Primary School, Survey Question 3). Furthermore, Ms. Green articulated that involving male and female teachers in separate discussions with students could be advantageous.

**Ways-of-knowing as a learning teacher**

Being-a-learning-teacher describes teachers’ moderate level of perceived competence to teach drug education in general or the LEV program within and outside the MLC.

Being relevantly new teachers, Ms. Black and Ms. White embraced learning and innovation, as evident in their adoption of the play-based curriculum. They reported being enthusiastic about inquiry-based and collaborative pedagogy. Play-based curriculum was introduced to staff through the school principal, who provided staff with PD opportunities through training and the regular support offered by an external mentor. Ms. Black and Ms. White were excited about their school’s teaching philosophy and described it with excitement, saying:

The school’s philosophy revolves around a collaborative approach, investigations and inquiry-based learning . . . The inquiry-based approach opens the door to collaborative learning. However, the investigations in the play-based curriculum is mostly individualized [for the students]. Collaborative approach to students’ learning is what is being promoted in the school from the leadership team. Whether this approach is actually embraced in the classroom [by other teachers] is yet to be proven. (Teachers 2A and 2B, Unicorn Primary School, Observations Day 2)

While adopting a learning disposition, both teachers were moderately confident of their ability to teach health and drug education. When asked of their desired support beyond the MLC session, Ms. Black and Ms. White requested access to resources rather than PD opportunities. They hoped that LEV could support their school by supplying interactive whiteboard lessons, simple books for Prep level students, as well as ideas for a play-based curriculum. Furthermore, LEV could “provide body parts for the children to touch . . . sensory experiences, food with Velcro so children can go shopping for healthy food” (Teacher 2B, Unicorn Primary School, Survey Question 8).
Their experiences within the MLC mirrored their view of themselves and their competence outside of the MLC. Both teachers positioned themselves as learners who participated in PD for play-based learning, experimented with new pedagogy, and engaged with an external mentor regularly.

Similarly, as a relatively inexperienced teacher with six years of classroom practice, Ms. Green adopted a learning disposition outside of the MLC. In her questionnaire responses, she articulated that effective teaching of health and drug education required “team-teach[ing] with support from experienced staff in this subject area” (Teacher 4, Hestia Primary School, Survey Question 3). This request for partnership with more experienced staff reflected Ms. Green’s perception of her own level of competence with drug education. Correspondingly, in her response to support desired from LEV, Ms. Green requested “follow up activities, lesson ideas, PD session for staff showing activities specific for different ages” (Teacher 4, Hestia Primary School, Survey Question 8). A learning disposition is evident throughout Ms. Green’s questionnaire responses and informal communication in the MLC.

Similar to Ms. Black and Ms. White, Ms. Green desired support with resources: student appropriate texts, teacher reference books, videos, and child-friendly websites. However, at the conclusion of the MLC session, Ms. Green asked if LEV provided PD opportunities for teachers. Two types of PD were desired: sessions to learn about, and actual practice activities to be utilized in the classroom as well as sessions on available resources. Her desire to develop her teaching practice through PD opportunities discrepated Ms. Green from other teachers in her school who only desired resources or PD opportunities to inform them of available resources.

Ms. Black, Ms. White, and Ms. Green all seemed to perceive themselves as moderately competent in facilitating health and drug education. While confident in their skills, they were also enthusiastic about engaging with training opportunities to improve their capabilities.

For diverse reasons, Ms. Black, Ms. White, and Ms. Green partially partnered with the LEV program within and outside the MLC. They facilitated a formal drug education program in their classrooms, and adopted a learning disposition in the MLC. They attentively engaged with the LEV session’s content, discussed strategies modeled by the educator, and adopted ideas presented in the MLC in order to implement them in the classroom.

While the three teachers valued drug education in their schools, Ms. Black and Ms. White considered the LEV as a supplementary resource for their Integrated Studies unit. Ms.
Green in contrast valued both drug education and partnership with LEV. The three teachers perceived themselves as moderately competent facilitators of health and drug education. Additionally, Ms. Black, Ms. White, and Ms. Green engaged or desired collaborative partnerships outside the MLC. Yet, despite their minor difference, the three teachers exhibited the same level of partial partnership with the LEV educator in the MLC sessions.

**Being-a-Collaborative-Teacher**

Being-a-collaborative-teacher is a category that describes generalist teachers’ highest level of partnership with the LEV program within and outside the MLC.

Three teachers from the three different schools under study (Ms. Orange, Ms. Magenta, and Ms. Yellow) facilitated a formal drug education program in their classrooms, collaborated with the LEV educator, as well as supported their students’ learning in the MLC sessions.

**Ways-of-doing as a collaborative teacher – inside the MLC**

Being-a-collaborative-teacher describes teachers’ high (or at least moderate) level of valuing drug education in general and the LEV program within and outside the MLC. Generalist teachers who collaborated with the LEV educator came from all three contrasting and opposing types of school partnership: school-faced, LEV-faced, and LEV/school-faced partnerships.

Surprisingly, Ms. Yellow (Tree) collaborated with the LEV educator in the MLC session. In her questionnaire responses, Ms. Yellow implied that she utilized several programs to facilitate health and drug education. When I asked her to elaborate on these programs, she explained that the school had no formal unit on health and drug education. In fact, she acknowledged that health and drug education was not considered a priority at Tree since many students belonged to very affluent households.

Contrary to her school’s attitude toward drug education, Ms. Yellow planned to utilize the MLC session for further discussions in the classroom. Being-a-collaborative-teacher in the MLC mirrored the value Ms. Yellow placed on drug education and her desire to continue facilitating postvisit activities in the classroom. While she did not plan or facilitate a formal drug education program in her classroom prior to the MLC visit, Ms. Yellow exhibited a desire for a more collaborative partnership with LEV.
Contrastingly, at Hestia, health and drug education was covered under the Integrated Studies units in collaboration with the LEV program. In her questionnaire responses, Ms. Magenta indicated that the health and drug education units focused on Healthy Bodies, Healthy Minds: looking after our bodies, nutrition, exercise and community services that promote health. Safety. Social skills, peer pressure and conflict resolution are ongoing areas. Medicine is covered in health units. (Teacher 7, Hestia Primary School, Survey Question 2)

Ms. Magenta was impressed with the LEV program for its structured approach, clarity of content and consequently, the support that it offered her in planning drug education. In her questionnaire responses, Ms. Magenta commented:

The [LEV] program is excellent at this level. I like how it is explained . . . It demonstrates what we [should] do and don’t do . . . [regarding the MLC session] Will use this information to plan some other explicit teaching. The role modeling and role-play was excellent—will do more of this and also the strategies for what if? (Teacher 7, Hestia Primary School, Observations Day 4)

Ms. Magenta’s collaboration with the LEV educator mirrored Hestia’s attitude to partner with the LEV program to facilitate a school-based drug education program.

Ms. Orange from Unicorn, on the other hand, employed the LEV program to support her Integrated Studies unit. The LEV program did not determine the overall focus of her unit; rather, it complemented it. In her questionnaire, Ms. Orange explained that the MLC was useful for “class discussion and sharing what children have learnt” (Teacher 1, Unicorn Primary School, Survey Question 7). Ms. Orange told me that the MLC session supported, advanced, and followed up students’ learning in their classroom. The LEV student booklets were used inconsistently because they did not fully cater for activities related to the focus of her unit, that being safety.

Ms. Orange’s approach mirrored Unicorn’s attitude toward drug education in general and the LEV program specifically. Despite the moderate level of partnership with the LEV program outside the MLC, Ms. Orange displayed the highest level of collaboration within the MLC session.

Grades 3 and 4 class with Ms. Orange and the Harold’s Diary module

Ms. Orange is one of two teachers who taught Grades 3 and 4 classes at Unicorn. She had 20 years of teaching experience, six of which participating in the LEV program. At the
commencement of the academic year, Ms. Orange, together with her colleague, planned the health and drug unit, focusing on safety. The LEV program did not determine the overall focus of her Integrated Studies unit; rather, it supplemented it. In her questionnaire, Ms. Orange explained that the MLC is useful for “class discussion and sharing what children have learnt” (Teacher 1, Unicorn Primary School, Survey Question 7). Ms. Orange told me that the MLC session supported, advanced, and followed up students’ learning in their classroom.

In the Harold’s Diary module, Harold the Giraffe shared his multimedia diary entries with the class. Throughout the MLC session, students explored age-appropriate friendship issues, food choices, and the way these choices can affect their health. Moreover, students discussed the impact of physical activity on their fitness and well-being, and identified services and products that promote health and safety.

As students lined up outside the MLC, Robin, the LEV educator, introduced herself and invited them to enter in an orderly manner. As the students came into the MLC, Ms. Orange proceeded to the back of the MLC and sat in her allocated spot.

Throughout the MLC session, I observed Ms. Orange collaborate with Robin. While she was not deliberately invited to participate in a significant way, Ms. Orange volunteered her assistance. She was engaged throughout the session, aware of her students’ involvement in the learning activities, and volunteered to assist them on at least two occasions.

In one of the MLC activities, Robin asked students to select a plastic food item from the Velcro wall and place it in the correct section of the wooden-shaped food wheel. There were 16 food items; some were made of plastic and others were packaged like familiar brand products. The food items included corn, watermelon, carrots, chicken drumsticks, apples, celery, cereal, milk, cheese, egg, chocolates, and a can of soft drink. Robin invited Ms. Orange to select students to participate in this activity.

As the nominated students placed their food items on the relevant sections on the wall, Robin asked the class to remain alert and identify any items that do not belong to a food section. At that stage, Ms. Orange volunteered to help one of the students to reconsider placing eggs in the dairy section. She interrupted the activity and addressed the whole class: “Alex is not sure where the eggs come from—what does everyone else think?” (Teacher 1, Unicorn Primary School, Observations Day 1). Ms. Orange engaged students in this activity and facilitated the discussion while Robin observed silently.
This collaborative disposition was further reinforced by Ms. Orange’s willingness to support her students throughout the MLC session. During a small-group activity, Robin walked around the MLC to assist the various small groups with the task at hand. Similarly, Ms. Orange volunteered to assist the small group of students seated next to her at the back of the MLC. Almost as though they had prearranged their collaboration, both Robin and Ms. Orange used similar clarifying questions to assist students with their comprehension of the activity. Questions like, “What have you got here?” “What does it do?” “What is safe here?” and “How could that be dangerous?” were probed.

To an observer, both the LEV educator and the classroom teacher engaged in an unplanned coteaching partnership of the students in the MLC session. Ms. Orange appeared comfortable to sit back when Robin presented information or facilitated discussions; yet, she was also eager to step up uninvited and contribute to students’ learning in the MLC. This collaboration was neither planned nor required, as would be expected in a team-teaching context.

Similar to Ms. Orange, Ms. Magenta collaborated with the LEV educator in the MLC session. While she did not overtly engage in teaching aloud as Ms. Orange did, Ms. Magenta supported her students in a significant way behind the scenes.

**Grades 3 and 4 class with Ms. Magenta and the Mind Your Medicine module**

Ms. Magenta taught Grades 3 and 4 classes at Hestia. She had 30 years of teaching experience, yet only one year of involvement with the LEV program. Her class participated in the Mind Your Medicine module. Through a game show, students explored two main topics: medicine and communication. The medicine segment helped students to define drugs, categorize helpful and harmful drugs, as well as examine the function of various medicines: antibiotics, analgesics, and insulin.

The MLC session commenced with Harold the Giraffe informing the class of his desire to work as a pharmacist. As a whole class, students brainstormed the prerequisite knowledge and skills that would thrust Harold into his dream vocation. Upon the completion of this introductory activity, students were assembled into syndicate groups of four students. Each group was positioned beneath a sign indicating a specific type of medicine. Affixed on the Velcro wall next to the sign was an empty package of the medicine as well as a sketch of a body map. Students were immediately invited to watch a DVD that provided information on the diverse types of medicine displayed across the MLC.
By reflecting on their learning from the video screened, students were asked to focus on the medicine package apportioned to them and answer two questions in their small groups. The questions were repeated several times by Sandy, the LEV educator: “What is the name of the medicine?” and “How does this medicine help the person taking it?” As students collaborated in their small groups, documenting their responses on a laminated paper, Ms. Magenta sat among them to support their learning.

In fact, Ms. Magenta supported her students subtly and practically throughout the MLC session. As students worked in their small groups, she sat on the floor among them, asking probing questions, sharing ideas, and responding to their enquiries. She actually moved among the small groups, spending just a couple of minutes with each group of students. Sandy also travelled to the various small groups, supporting students with their activities. Throughout the MLC session, Ms. Magenta engaged with her students and did not return to her allocated teacher seat at the back of the MLC.

**Grade 1 with Ms. Yellow and the Heroes module**

Similarly, Ms. Yellow collaborated with the LEV educator in the MLC session. She taught a Grade 1 class at Tree. Ms. Yellow had five years’ teaching experience and had been involved with the LEV program for four of those years. Ms. Yellow explained to me that the school had no formal unit on health and drug education. In fact, she acknowledged that health and drug education units were not considered a priority at Tree. Although the school did not encourage the facilitation of health and drug education units, Ms. Yellow had planned to utilize the LEV session for further discussions in the classroom.

Ms. Yellow’s class participated in the Heroes module, revolving around a narrative of superheroes. Harold formed a team of superheroes and he recruited the class to join the team and assist in their mission to make the world a safer and healthier place. With the assistance of the superheroes (Extinguisher, Mediminder, Emergiman, and Littergator), the class solved environmental health issues such as passive smoking and syringe safety. Moreover, students were encouraged to form ideas for safe use and storage of medicines, make healthy food choices, and rehearse emergency procedures.

Mandy, the LEV educator, facilitated an interactive session, incorporating students in a whole-class brainstorming activity, think–pair–share, DVD screening, and role-plays. Following the introduction of the narrative, students were assembled in syndicate groups to categorize food items in their activity bags. Mandy asked each group to affix the healthy
items on one section of the MLC wall with a label “good choice” and to categorize the “sometime food” on a separate section on the wall.

From the commencement of the activity, Ms. Yellow interacted with the group of students closest to her. She immediately asked them to rephrase the task assigned to them. Then she guided the group with clarifying questions in order to help them sort through their food items. Gradually, she moved away from the first group and reached another small group to help them with their categorization. Mandy was also moving among the groups supporting their learning.

At the conclusion of their “food activity,” the class screened a short video that introduced students to diverse unsafe situations encountered by Harold and his team of superheroes. The first video illustrated the danger of smoking indoors without adequate ventilation. After the screening of the short video, Mandy facilitated a whole-class discussion around the question: “Why is Harold concerned about safety in this situation?”

Following the whole-group discussion, Mandy asked Ms. Yellow to select a student to play the role of the Extinguisher superhero. The student was given a superhero costume and “powers” to fly through the MLC and save the environment. Ms. Yellow “dressed up” the superhero in character and encouraged him to fly through the crowd.

The final DVD segment of the MLC session was followed by a lengthy role-play where a student phoned the emergency line, triple zero. Only one student was selected to join Mandy in demonstrating what happened when a call is made. Mandy sat at one end of the MLC holding a mobile phone and communicated with the student standing next to Ms. Yellow on the other end of the MLC. Ms. Yellow assisted her student in his conversation with Mandy (the emergency operator).

Being-a-collaborative-teacher was reflected in Ms. Yellow’s willingness to support various groups of students and individuals during the MLC session. She unobtrusively helped her students to grasp the activity, put their superhero costume on, as well as helped a student communicate with the emergency service operator.

**Ways-of-doing as a collaborative teacher – outside the MLC**

Being-a-collaborative-teacher reflects teachers’ level of collaboration with colleagues outside the MLC. Teachers who collaborated with the LEV educator or their students within the MLC were likely to have collaborative partnerships with colleagues outside the MLC.
Ms. Yellow’s collaborative behavior in the MLC reflected her coteaching context in the classroom. She was engaged in daily collaboration with another teacher who was responsible for other Grades 1 and 2 classes. Both classes were located in the same open classroom, often referred to as the “pod.”

While both teachers worked in the same classroom, they adopted different roles at various times. They worked in stations, teaching different small groups of students throughout the day. The “stations” around the large room engaged students in diverse learning activities: reading with a teacher, independent reading and comprehension, ICT, spelling, and an online program Reading Eggs to improve their reading aptitude.

It is evident that Ms. Yellow’s collaboration in the MLC was consistent with her significant daily collaboration with another colleague in the classroom. This level of formal collaboration was not experienced by either Ms. Orange or Ms. Magenta, who only engaged in collaboration with colleagues for planning purposes.

Ms. Orange, together with her colleague, planned the health and drug unit at the commencement of the academic year. In my informal discussion with her in the MLC, Ms. Orange elaborated on the collaborative process of planning that she employed with her coworkers within both campuses. She articulated that there was another colleague who alongside her was responsible for Grades 3 and 4 on their campus. Both teachers elected to plan their unit together at the start of the term. They apportioned part of their planning day to gather resources for their Integrated Studies unit, focusing on safety. Ms. Orange explained that while their unit is similar, but not identical to their counterpart’s unit on the other campus, they often passed on their resources to their colleagues. Not surprisingly, in her survey, Ms. Orange indicated that effective facilitation of health and drug education units required teachers’ collaboration and sharing of resources (Teacher 1, Unicorn Primary School, Survey Question 3).

Regardless that Ms. Orange was not engaged in a formal collaborative structure in her school, she functioned as a collaborative teacher within and outside the MLC environment.

Ways-of-knowing as a collaborative teacher

Being a collaborative teacher describes teachers’ high level of perceived competence to teach drug education in general or the LEV program within and outside the MLC.

Ms. Orange (Unicorn) had 20 years of teaching experience, six of which included her participation in the LEV program. She perceived herself to have a high level of competence
of teaching health and drug education in the areas of interactive pedagogy and resourcefulness.

In her survey, Ms. Orange reported facilitating highly interactive classroom sessions. In her informal discussion with me, she informed me that her students accessed websites to play interactive games that exposed them to problem-solving activities. Students were confronted with scenarios where they were required to identify dangerous situations and design fire-escape plans. These activities were further discussed in the classroom. Hands-on and fun interactive activities were complemented with the reading of narratives, and whole-class Q&A sessions.

Ms. Orange also demonstrated her resourcefulness in facilitating health and drug education. Together with her colleague, Ms. Orange accessed diverse websites with outstanding digital resources, interactive games, and activity sheets. Further, they posted links to helpful and child-friendly websites on the school’s Grades 3 and 4 intranet page. The websites included the Royal Children’s Hospital and other global websites addressing the topic of “safety.”

As a highly experienced teacher, Ms. Orange perceived competence in interactive pedagogy and resourcefulness, and extended her role into supporting other colleagues by passing on her resources to team members in the other Unicorn campus.

Similarly, Ms. Magenta was a very experienced teacher at Hestia. She had 30 years of teaching experience, yet only one year of involvement with the LEV program. Ms. Magenta’s competence was unpredictably reflected in her frustration with the lack of comprehensive, progressive, and whole-school approach to drug and health education.

In our informal discussions, Ms. Magenta shared that the teachers were aggravated with the drug education curriculum in the school. This exasperation was associated with the seemingly ambiguous VELS outcomes articulated for drug education. Ms. Magenta expressed her concerns that while the government demanded 10 hours of teaching drug education, there was no clarity as to where it fit in the curriculum and what exactly needed to be taught.

Given her extensive teaching experience, Ms. Magenta desired a comprehensive and well-articulated whole-school approach to the health and drug education program. In her questionnaire response, Ms. Magenta stated:
[An external expert] has come to help us write the drug education plan, but we do not have supporting materials or relevant information to use—we have to make it up ourselves which isn’t a problem but we are always wondering: Are we on track? (Teacher 7, Hestia Primary School, Survey Question 8)

Ms. Magenta’s quest for clarity on the curriculum could imply her incompetence. However, she affirmed her capacity to overcome such confusion by stating, “We have to make it up ourselves which isn’t a problem” (Teacher 7, Hestia Primary School, Survey Question 8). Evidently, since Ms. Magenta’s request extended beyond her own teaching position and directed toward a whole-school approach and coherence, it communicates her perceived high level of competence. In fact, no other teacher observed or informally interviewed articulated such a high level of concern and vision for a whole-school health and drug education curriculum consistent with the literature (Meyer, 2004). Ms. Magenta’s concern for the whole school was repeatedly expressed to me during our informal discussion in the MLC. She underscored the need for an outline of more specific drug education content to cover each year level in the school. Ms. Magenta claimed that teachers need concrete drug education content for each year level that builds on students’ knowledge and understanding progressively throughout their P–6 years.

Ms. Magenta’s vision for a whole-school approach to health and drug education illustrated her high level of competence and teaching experience. On the opposite side of the scale, Ms. Yellow, a relatively inexperienced teacher (five years), perceived herself to be a competent facilitator of health and drug education. This is evident in her only request for support with better resources instead of training opportunities. Ms. Yellow proposed that LEV should support teachers with digital resources instead of the hardcopy booklets. She specified examples of helpful resources:

- I-pod—stories on CD comprehension.
- I-pad applications—to connect to IWB.
- ICT programs e.g., ABC Reading Eggs. Hands on activities to support program. (Teacher 9, Tree Primary School, Survey Question 8)

Even though Ms. Yellow did not facilitate a formal unit, she perceived herself to be competent in facilitating health and drug education, a perception that may have prompted her collaboration with the LEV educator in the MLC session.

For diverse reasons, Ms. Orange, Ms. Yellow, and Ms. Magenta significantly collaborated with the LEV educator and engaged with their students’ activities in the MLC.
sessions. The three teachers valued drug education in their schools. Consistent with Unicorn’s attitude, Ms. Orange considered the LEV as a supplementary resource for their Integrated Studies unit. Ms. Magenta’s approach was also consistent with Hestia’s attitude toward drug education and partnership with LEV. Ms. Yellow, however, valued drug education despite the fact that her school did not facilitate formal health and drug education units.

Additionally, Ms. Orange, Ms. Yellow, and Ms. Magenta engaged in different levels of collaborative partnerships outside the MLC. Ms. Yellow engaged in a formal daily collaboration with a colleague, while Ms. Orange and Ms. Magenta’s collaboration was limited to team-planning opportunities and sharing resources with their colleagues. Yet, the three teachers exhibited the same level of collaborative interactions within the MLC sessions.

In diversified manner and proportions, all three teachers perceived themselves as competent facilitators of health and drug education. As a highly experienced teacher, Ms. Orange perceived competence in interactive pedagogy and resourcefulness, and extended her role into supporting other colleagues with her resources. Ms. Magenta’s competence was evident in her vision and concern for a whole-school comprehensive approach to health and drug education. Ms. Yellow seemingly perceived herself as a competent facilitator of health and drug education, as evident in her only request for support with better resources instead of training opportunities.

Summary

In this chapter, I presented four divergent yet repeated teachers’ experiences as they worked with LEV. These experiences were depicted through my observation of 12 random LEV sessions complemented by teachers’ questionnaires and informal discussions in the MLC.

Generalist teachers’ attitudes, interactions, and behaviors ranged from disengagement, to partial engagement, to full engagement to over engagement in partnership with the LEV program. These teachers’ ways-of-being were categorized in order of engagement: (1) being-a-disengaged-teacher, (2) being-an-observing-teacher, (3) being-a-takeover-teacher, (4) being-a-learning-teacher, and finally (5) being-a-collaborative-teacher. Each of these ways-of-being was described in this chapter through Quay’s (2015) framework: ways-of-doing (inside the MLC), ways-of-doing (outside the MLC), and ways-of-knowing.

Being-a-disengaged-teacher is a category that describes generalist teachers’ very low level of partnership with the LEV program within and outside the MLC. For diverse reasons,
Mr. Indigo, Ms. Brown, and Ms. Grey from Tree did not facilitate formal drug education in their classroom, did not support their students’ learning in the MLC, nor did they collaborate with the LEV educator. They considered drug education irrelevant to their students or their Integrated Studies units, perceived themselves as incompetent facilitators of drug education-related propositional and/or pedagogical knowledge (ways-of-knowing), as well as reported the least level of collaboration with colleagues in the school (ways-of-doing outside the MLC).

Being-an-observing-teacher is a category that describes generalist teachers’ low level of partnership with the LEV program within and outside the MLC. Ms. Blue and Mr. Red from Unicorn, as well as Ms. Pink from Hestia, did not engage with students’ learning activities in the MLC, yet facilitated a formal drug education program in their classrooms.

The three teachers valued drug education in their schools, yet Ms. Blue and Mr. Red (Unicorn) considered the LEV as a supplementary resource for their Integrated Studies unit. Ms. Pink (Hestia) in contrast valued both drug education and partnership with LEV. While Ms. Blue and Mr. Red perceived themselves as confident facilitators, Ms. Pink acknowledged her moderate competence with teaching health and drug education (ways-of-knowing). Additionally, Ms. Pink, unlike Ms. Blue and Mr. Red, engaged in collaborative partnerships outside the MLC (ways-of-doing outside the MLC). Yet, the three teachers exhibited the same level of passive interactions within the MLC sessions.

Being-a-takeover-teacher is a category that describes generalist teachers’ exaggerated level of partnership with the LEV program within and outside the MLC. For diverse reasons, Ms. Purple exhibited an exaggerated level of collaboration with the LEV program, continually interrupting the LEV educator and taking over the facilitation of the MLC session.

Ms. Purple appeared to value both drug education and partnership with LEV. She extensively utilized the LEV program to facilitate effective drug education in her classroom. This involved facilitating previsit classroom discussions, participating in the MLC session, and utilizing the LEV student booklets during postvisit classroom discussions. She had an inflated perception of her competence in facilitating health and drug education (ways-of-knowing). Additionally, Ms. Purple did not report engaging in meaningful collaborative partnerships outside the MLC (ways-of-doing outside the MLC).
Being-a-learning-teacher is a category that describes generalist teachers’ moderate level of partnership with the LEV program within and outside the MLC. For diverse reasons, Ms. Black, Ms. White, and Ms. Green moderately partnered with the LEV program within and outside the MLC.

Ms. Black and Ms. White from Unicorn and Ms. Green from Hestia facilitated a formal drug education program in their classrooms and adopted a learning disposition in the MLC. They attentively engaged with the LEV session’s content, discussed strategies modeled by the educator, and adopted ideas presented in the MLC in order to implement them in the classroom.

While the three teachers valued drug education in their schools, Ms. Black and Ms. White considered the LEV as a supplementary resource for their Integrated Studies unit. Ms. Green in contrast valued both drug education and partnership with LEV. The three teachers perceived themselves as moderately competent facilitators of health and drug education (ways-of-knowing). Additionally, Ms. Black, Ms. White, and Ms. Green engaged in or desired collaborative partnerships outside the MLC (ways-of-doing outside the MLC). Yet, despite their minor differences, the three teachers exhibited the same level of partial partnership with the LEV educator in the MLC sessions.

Being-a-collaborative-teacher is a category that describes generalist teachers’ highest level of partnership with the LEV program within and outside the MLC. For diverse reasons, Ms. Orange, Ms. Yellow, and Ms. Magenta significantly collaborated with the LEV educator and engaged with their students’ activities in the MLC session.

The three teachers valued drug education in their schools. Consistent with Unicorn’s attitude, Ms. Orange considered the LEV as a supplementary resource for their Integrated Studies unit. Ms. Magenta’s approach was also consistent with Hestia’s attitude toward drug education and partnership with LEV. Ms. Yellow, however, valued drug education despite the fact that her school did not facilitate formal health and drug education units.

In diverse manner and proportions, all three teachers perceived themselves as competent facilitators of health and drug education (ways-of-knowing). Additionally, Ms. Orange, Ms. Yellow, and Ms. Magenta engaged in different levels of collaborative partnerships outside the MLC (ways-of-doing outside the MLC). Yet, the three teachers exhibited the same level of collaborative interactions within the MLC session.
CHAPTER 7: Three-Dimensional Tapestry and Four Colorful Threads

In this thesis, I examined the nature of the partnership between LEV and primary school teachers in facilitating school-based drug education programs. In tapestry terms, this partnership is analogous to the weaving of two primary threads: the role of the external specialists (warp) and the role of generalist classroom teachers (weft) in school-based drug education. In this chapter, I present a discussion of the research findings as well as potential implications for policy, LEV’s operations, and teacher professional development.

Generalist teachers are considered the best providers of drug education in the primary school context (Meyer, 2004). Presumably, they are better informed of their learners and the school context than many external providers; hence, they develop a strong connection to learners, form a caring learning environment, and facilitate programs that better meet the needs of their students (Alton-Lee, 2003; Faucette & Patterson, 1990; Petrie et al., 2007).

However the capacity of the classroom teachers to deliver effective school-based health education programs has also been questioned. Informed by a review of the literature in this area, Whipp et al. (2011, p. 68) asserted that the delivery strategies employed by generalist classroom teachers “present substantial barriers to quality student learning outcomes.” The classroom teachers’ lack of time, knowledge, energy, training, confidence, and experience results in a reduced capability to design and facilitate effective lessons (Faucette & Patterson, 1989; Morgan, 2008; Morgan & Bourke, 2008). Consequently, schools have sought to establish partnerships with external providers to facilitate school-based health education.

Bevan and Dillon (2010) called for a deeper understanding of how informal and formal educators and institutions work together to support teachers’ and students’ interests and capacities for engaging in science, including an examination of how varied settings can provide different opportunities for their partnership. Weiland and Akerson (2013) indicated that there was no research found that examined the nature of the partnership between classroom teachers and specialist educators when they were invited into the classroom.

Accordingly, I intended to investigate the nature of the partnerships between LEV and primary school teachers in facilitating school-based drug education programs. The primary research question was: How do primary school teachers and external specialists partner together to facilitate school-based drug education programs?
Therefore, the purpose of this research was to contribute to our understanding through (1) an examination of the nature of the partnerships between schools and LEV (i.e., the *context* of the partnerships between generalist teachers and specialist educators) and (2) an examination of the generalist teachers’ experiences working together with specialist educators, particularly in the unique setting whereby specialist educators are invited into the school setting, yet not into the actual classroom. A framework to examine the nature of the partnerships between LEV and schools was adopted from Weiland and Akerson (2013).

**Three Types of Partnership**

Based on Weiland and Akerson’s (2013) framework, the nature of the partnerships between LEV and the three schools under study was classified as cooperation. Unlike coordination and collaboration, cooperation is considered to espouse the least level of commitment, risk, negotiation, and involvement in a partnership. Quantitatively, more dimensions of the partnerships between LEV and the three schools (four to six dimensions) fell into this category than in that of coordination or collaboration.

Given that six out of the eight dimensions in the framework were consistent among the three schools, the classification of their partnerships with LEV could not be fully differentiated from each other. Consequently, according to the Weiland and Akerson (2013) framework, the discrepancies (in two dimensions) evident among the three partnerships could not be categorized uniquely. Therefore, an expanded classification of the cooperation partnership type was required to describe the diversity observed among the three schools.

Within this cooperation classification, I depicted three divergent types of partnership between LEV and the schools under study. Each partnership was distinguished by the school’s provision of drug education, the role LEV played, and the support afforded the generalist teachers.

Table 9. A Comparison Between the Schools’ Types of Partnership With LEV

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<tr>
<th>Partnership</th>
<th>School</th>
<th>Program</th>
<th>LEV Role</th>
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<tr>
<td>LEV-faced</td>
<td>Tree</td>
<td>External provider</td>
<td>Primary role</td>
</tr>
<tr>
<td>School-faced</td>
<td>Unicorn</td>
<td>Internal school unit</td>
<td>Supplementary role</td>
</tr>
<tr>
<td>School/LEV-faced</td>
<td>Hestia</td>
<td>Integrated approach</td>
<td>Cofacilitative role</td>
</tr>
</tbody>
</table>
**LEV-faced partnership**

Tree exemplified an LEV-faced partnership, whereby there was an unequal and overreliance on LEV to be the prominent deliverer of the school-based drug education program. The school’s program was either hidden or potentially nonexistent in the completed work. Such a partnership was distinguished by an externally facilitated program, LEV played the primary role of delivering drug education, and generalist teachers were afforded limited support from their school or region. An external provider, LEV was entrusted to provide a standardized curriculum, facilitate developmentally appropriate content, and satisfy parental expectations. LEV’s role relieved teachers from teaching “uncomfortable” content, addressed the compulsory requirement of drug education, and allowed teachers the opportunity to manage the crowded curricula and focus on their areas of expertise.

**School-faced partnership**

Unicorn exemplified a school-faced partnership, whereby the school program was the prominent provider of drug education with the LEV program hidden in the completed work. Such a partnership was differentiated by an internally facilitated drug education program, the supplementary role LEV played at school, and the general/practical support afforded generalist teachers. The LEV program was perceived as an incursion, providing an expert voice and a unique experience for the students. While perceived as experts in the field, LEV complemented rather than directed the Integrated Studies units offered by the school. The LEV resources were used selectively (and inconsistently) as they aligned to the units of study.

**School/LEV-faced partnership**

Hestia exemplified a school/LEV-faced partnership, whereby both the school and LEV cofacilitated the drug education program. Such a partnership was distinguished by an integrated drug education program, the collaborative role LEV played at the school, and the organizational/practical support afforded generalist teachers. While the school acknowledged the importance of the LEV expertise, it was expected that the program would set the platform for continued teacher-led classroom activities pre and post the MLC visit. The students’ well-being coordinator and teachers perceived the role of LEV as complementing teachers’ expertise, co-covering the material, and inspiring teachers with knowledge, resources, and skills. The language used by teachers to describe the role of LEV evidently implied that drug education was cofacilitated by LEV and the classroom teachers.
While LEV perceived its program as being cofacilitated with the generalist classroom teacher, such partnership was inconsistent across the three schools. Astbury (2011) reported that the LEV program is “designed to be delivered in part by the Life Education educator with the support of the class teacher, and in part, by the class teacher who is provided with resources to support the delivery of an additional 20 hours of follow up, complementary learning” (p. 18). These three types of school partnership with LEV elucidated the context for generalist teachers’ experiences of working together with LEV to facilitate a school-based drug education program.

**Teachers’ Experiences of Partnership with Life Education**

Within the context of these three types of partnership between LEV and the participating schools, I found five divergent yet repeated forms of teacher experience as they worked with specialist educators. These were depicted through my observation of 12 random LEV sessions complemented by teachers’ questionnaires and informal discussions in the MLC. A framework to examine generalist teachers’ *experiences* of working together with specialist educators was available in the work of Quay (2013, 2015) who suggested the nested interrelation of ways-of-being, ways-of-doing, and ways-of-knowing.
Table 10. Teacher Occupation at Each of the Three Participating Schools

<table>
<thead>
<tr>
<th>School</th>
<th>Partnership Type</th>
<th>Teacher</th>
<th>Teacher Occupation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tree</td>
<td>LEV-faced</td>
<td>Mr. Indigo</td>
<td>Being-a-disengaged-teacher</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Brown</td>
<td>Being-a-disengaged-teacher</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Grey</td>
<td>Being-a-disengaged-teacher</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Yellow</td>
<td>Being-a-collaborative-teacher</td>
</tr>
<tr>
<td>Unicorn</td>
<td>School-faced</td>
<td>Ms. Blue</td>
<td>Being-an-observing-teacher</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mr. Red</td>
<td>Being-an-observing-teacher</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Black and Ms. White</td>
<td>Being-a-learning-teacher</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Orange</td>
<td>Being-a-collaborative-teacher</td>
</tr>
<tr>
<td>Hestia</td>
<td>School- and LEV-faced</td>
<td>Ms. Pink</td>
<td>Being-an-observing-teacher</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Purple</td>
<td>Being-a-takeover-teacher</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Green</td>
<td>Being-a-learning-teacher</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Magenta</td>
<td>Being-a-collaborative-teacher</td>
</tr>
</tbody>
</table>

Generalist teachers’ attitudes, interactions, and behaviors ranged from disengagement to over engagement to partial engagement to full engagement in partnership with the LEV program. These teachers’ ways-of-being were categorized in order of ascending levels of engagement: (1) being-a-disengaged-teacher, (2) being-an-observing-teacher, (3) being-a-takeover-teacher, (4) being-a-learning-teacher, and finally (5) being-a-collaborative-teacher.

**Being-a-disengaged-teacher**

Being-a-disengaged-teacher was a category that described generalist teachers’ very low level of partnership with the LEV program within and outside the MLC. For diverse reasons, Mr. Indigo, Ms. Brown, and Ms. Grey from Tree did not facilitate formal drug education in their classroom, did not support their students’ learning in the MLC, nor did they collaborate with the LEV educator. They considered drug education as irrelevant to their students or their Integrated Studies units, perceived themselves as incompetent facilitators of drug education-
related propositional and/or pedagogical knowledge (ways-of-knowing), as well as reported the least level of collaboration with colleagues in the school (ways-of-doing).

**Being-an-observing-teacher**

Being-an-observing-teacher was a category that described generalist teachers’ low level of partnership with the LEV program within and outside the MLC. Ms. Blue and Mr. Red from Unicorn as well as Ms. Pink from Hestia did not engage with students’ learning activities in the MLC, yet facilitated a formal drug education program in their classrooms. The three teachers valued drug education in their schools, yet Ms. Blue and Mr. Red considered the LEV as a supplementary resource for their Integrated Studies unit. Ms. Pink in contrast valued both drug education and partnership with LEV. While Ms. Blue and Mr. Red perceived themselves as confident facilitators, Ms. Pink acknowledged her partial incompetence with teaching health and drug education (ways-of-knowing). Additionally, Ms. Pink, unlike Ms. Blue and Mr. Red, engaged in collaborative partnerships outside the MLC (ways-of-doing). Yet, the three teachers exhibited the same level of passive interaction within the MLC session.

**Being-a-takeover-teacher**

Being-a-takeover-teacher was a category that described generalist teachers’ overengagement level of partnership with the LEV program within and outside the MLC. For diverse reasons, Ms. Purple exhibited an exaggerated level of collaboration with the LEV program, continually interrupting the LEV educator and taking over the facilitation of the MLC session.

Ms. Purple valued both drug education and partnership with LEV. She extensively utilized the LEV resources to facilitate drug education lessons in her classroom. This involved facilitating previsit classroom discussions, participating in the MLC session, and utilizing the LEV student booklets during postvisit classroom discussions. Ms. Purple had an inflated perception of her competence in facilitating health and drug education (ways-of-knowing). Additionally, she did not report engaging in meaningful collaborative partnerships outside the MLC (ways-of-doing).

**Being-a-learning-teacher**

Being-a-learning-teacher was a category that described generalist teachers’ moderate level of partnership with the LEV program within and outside the MLC. For diverse reasons Ms. Black, Ms. White, and Ms. Green moderately partnered with the LEV program within and
outside the MLC. Ms. Black and Ms. White from Unicorn and Ms. Green from Hestia facilitated a formal drug education program in their classrooms, and adopted a learning disposition in the MLC. They attentively engaged with the LEV session’s content, discussed strategies modeled by the educator, and adopted ideas presented in the MLC in order to implement them in the classroom.

While the three teachers valued drug education in their schools, Ms. Black and Ms. White considered the LEV as a supplementary resource for their Integrated Studies units. Ms. Green in contrast valued both drug education and partnership with LEV. The three teachers perceived themselves as moderately competent facilitators of health and drug education (ways-of-knowing). Additionally, Ms. Black, Ms. White, and Ms. Green engaged in or desired collaborative partnerships outside the MLC (ways-of-doing). Yet, despite their minor difference, the three teachers exhibited the same level of partial partnership with the LEV educator in the MLC session.

Being-a-collaborative-teacher

Being-a-collaborative-teacher was a category that described generalist teachers’ highest level of partnership with the LEV program within and outside the MLC. For diverse reasons, Ms. Orange, Ms. Yellow, and Ms. Magenta meaningfully collaborated with the LEV educator and engaged with their students’ activities in the MLC session. The three teachers valued drug education in their schools. Consistent with Unicorn’s attitude, Ms. Orange considered the LEV as a supplementary resource for her Integrated Studies unit. Ms. Magenta’s approach was also consistent with Hestia’s attitude toward drug education and partnership with LEV. Ms. Yellow, however, valued drug education despite the fact that her school did not facilitate formal health and drug education units.

In diverse manner and proportions, all three teachers perceived themselves as competent facilitators of health and drug education (ways-of-knowing). Additionally, Ms. Orange, Ms. Yellow, and Ms. Magenta engaged in different levels of collaborative partnerships outside the MLC (ways-of-doing). Yet, the three teachers exhibited the same level of collaborative interaction within the MLC session.

Teachers’ Ways-of-Being at Tree Primary School

Teachers’ ways-of-being in the MLC predominantly mirrored their school’s environment at Tree. The school’s dismissive attitude toward drug education shaped teachers’ lack of collaboration with the LEV educator and students’ activities in the MLC. Three (Mr. Indigo,
Ms. Brown, and Ms. Grey) of the four teachers observed were categorized as being-a-disengaged-teacher.

Table 11. Teachers’ Ways-of-Being, Ways-of-Doing, and Ways-of-Knowing at Tree Primary School

<table>
<thead>
<tr>
<th>School</th>
<th>Partnership Type</th>
<th>Teacher</th>
<th>Teacher Way of Being in the MLC</th>
<th>Teacher Way of Doing Outside the MLC</th>
<th>Teacher Way of Knowing Outside the MLC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tree</td>
<td>LEV-faced</td>
<td>Mr. Indigo</td>
<td>Being-a-disengaged-teacher</td>
<td>No collaboration</td>
<td>Incompetence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Brown</td>
<td>Being-a-disengaged-teacher</td>
<td>No collaboration</td>
<td>Incompetence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Grey</td>
<td>Being-a-disengaged-teacher</td>
<td>No collaboration</td>
<td>Incompetence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Yellow</td>
<td>Being-a-collaborative-teacher</td>
<td>Collaboration</td>
<td>Competence</td>
</tr>
</tbody>
</table>

In contrast to the above-mentioned three teachers, Ms. Yellow was observed as being-a-collaborative-teacher in the MLC. This was reflected in her willingness to support various groups of students and individuals during the session. She unobtrusively helped her students to grasp the small-group activity, put a superhero costume on, as well as helped a student communicate with the emergency services operator. Therefore, the school environment alone did not predict teachers’ ways-of-being in the MLC.

Their ways-of-being in the MLC mirrored teachers’ perceptions of their competence as drug education teachers (ways-of-knowing), as well as their interactions with other colleagues (ways-of-doing) outside the MLC. Contrary to the other three teachers observed, Ms. Yellow perceived herself as a competent drug education teacher (ways-of-knowing) as well as engaged in a collaborative relationship with a colleague (ways-of-doing) outside the MLC. Therefore, the teachers’ ways-of-being in the MLC contrasted significantly (being-a-disengaged-teacher and being-a-collaborative-teacher, respectively).

**Teachers’ Ways-of-Being at Unicorn Primary School**

At Unicorn, teachers’ ways-of-being in the MLC reflected predominantly the nature of their relationships with colleagues outside the MLC (ways-of-doing outside the MLC).
Collaboration with other teachers outside the MLC predicted their collaboration with the LEV educator within the MLC. Being-a-collaborative-teacher and being-a-learning-teacher were aligned, respectively, to the teachers’ collaborative interactions with their colleagues (e.g., Ms. Orange) or their team-teaching approach in the classroom (e.g., Ms. Black and Ms. White).

Table 12. Teachers’ Ways-of-Being, Ways-of-Doing, and Ways-of-Knowing at Unicorn Primary School

<table>
<thead>
<tr>
<th>School</th>
<th>Partnership Type</th>
<th>Teacher</th>
<th>Teacher Way of Being in the MLC</th>
<th>Teacher Way of Doing Outside the MLC</th>
<th>Teacher Way of Knowing Outside the MLC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unicorn</td>
<td>School-faced</td>
<td>Ms. Blue</td>
<td>Being-an-observing-teacher</td>
<td>No collaboration</td>
<td>Competence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mr. Red</td>
<td>Being-an-observing-teacher</td>
<td>No collaboration</td>
<td>Competence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Black and Ms. White</td>
<td>Being-a-learning-teacher</td>
<td>Collaboration</td>
<td>Competence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Orange</td>
<td>Being-a-collaborative-teacher</td>
<td>Collaboration</td>
<td>Competence</td>
</tr>
</tbody>
</table>

Conversely, the lack of collaboration outside the MLC was mirrored in teachers’ ways-of-being within it. For example, Ms. Blue and Mr. Red did not collaborate with others within or outside the MLC (being-an-observing-teacher). Ms. Blue, who taught her classroom alone for the first time in five years, did not collaborate with the LEV educator in the MLC. Being-an-observing-teacher, she assessed students’ responses without engaging in the learning activities or supporting the educator within the MLC session. Similarly, Mr. Red, who engaged in mentoring relationships outside the MLC, functioned as an observer within it. Throughout the session, he assessed, albeit positively, the educator’s pedagogy. Mr. Red did not engage with students’ learning activities or collaborate with the LEV educator. Teachers’ ways-of-doing outside the MLC seemed to reflect their ways-of-being within it.
Furthermore, at Unicorn, teachers’ views of their competence with drug education (ways-of-knowing) did not seem to mirror their ways-of-being within it. For example, while all four teachers observed indicated a level of competence as drug education facilitators, they differed significantly in their ways-of-being in the MLC (being-an-observing-teacher, being-a-learning-teacher, as well as being-a-collaborative-teacher). It is noteworthy that Ms. Black and Ms. White, who positioned themselves as learners outside the MLC, participated in PD for play-based learning, experimented with new pedagogy in their classroom, and engaged with an external mentor regularly throughout the year. Their ways-of-knowing outside the MLC mirrored their ways-of-being (being-a-learning-teacher) within it. In contrast, viewing himself as an experienced, competent, and mentoring teacher outside the MLC mirrored Mr. Red’s ways-of-being in the MLC (being-an-observing-teacher).

At Unicorn, teachers’ ways-of-doing outside the MLC were a more influential conjecturer of their ways-of-being within it.

**Teachers’ Ways-of-Being at Hestia Primary School**

Unlike Unicorn, teachers’ interactions with colleagues at Hestia (ways-of-doing outside the MLC) did not seem to forecast their ways-of-being within the MLC.

Table 13. Teachers’ Ways-of-Being, Ways-of-Doing, and Ways-of-Knowing at Hestia Primary School

<table>
<thead>
<tr>
<th>School</th>
<th>Partnership Type</th>
<th>Teacher</th>
<th>Teacher Way of Being in the MLC</th>
<th>Teacher Way of Doing Outside the MLC</th>
<th>Teacher Way of Knowing Outside the MLC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hestia</td>
<td>School- and LEV-faced</td>
<td>Ms. Pink</td>
<td>Being-an-observing-teacher</td>
<td>Collaboration</td>
<td>Incompetence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Green</td>
<td>Being-a-learning-teacher</td>
<td>Collaboration</td>
<td>Competence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Magenta</td>
<td>Being-a-collaborative-teacher</td>
<td>Collaboration</td>
<td>Competence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Purple</td>
<td>Being-a-takeover-teacher</td>
<td>No collaboration</td>
<td>Competence</td>
</tr>
</tbody>
</table>

For example, while three teachers engaged in similar collaborative interactions with colleagues (ways-of-doing) outside the MLC, their ways-of-being differed significantly.
within it. Being-an-observing-teacher portrayed a lack of collaboration with the LEV educator despite the classroom teacher’s collaborative efforts with colleagues outside of the MLC (e.g., Ms. Pink). In contrast, being-a-learning-teacher as well as being-a-collaborative-teacher described a more collaborative approach in the MLC that reflected their collaboration (ways-of-doing) outside of it (e.g., Ms. Green and Ms. Magenta).

While these three classroom teachers worked in the same school environment and shared the same relational interactions with other colleagues (ways-of-doing) outside the MLC, these teachers varied in their ways-of-being in it. Therefore, another factor may have contributed to teachers’ ways-of-being in the MLC.

Teachers’ ways-of-being in the MLC emulated the way teachers viewed their competence as drug education facilitators (ways-of-knowing) at Hestia.

Teachers’ perceptions of their own capacity as drug education teachers echoed their collaborations with the LEV educator within the MLC. Being-a-collaborative-teacher (e.g., Ms. Magenta) and being-an-observing-teacher (e.g., Ms. Pink) were two opposites on the spectrum of collaboration in the MLC and reflected two contrasting ways-of-knowing outside the MLC. On the one hand, perceiving self as an effective drug education teacher (ways-of-knowing) dictated the way Ms. Magenta cofacilitated the MLC session with the LEV educator. In contrast, being-an-observing-teacher mirrored Ms. Pink’s perception of her incompetency as a drug education teacher (ways-of-knowing). Consistent with her view of self as an inexperienced teacher who desired clarity on drug education, Ms. Pink passively observed the LEV educator in action.

Similarly, being-a-learning-teacher mirrored Ms. Green’s perception of herself as a drug education teacher. While being a moderately experienced teacher (five to 10 years’ experience), she articulated her need for drug education knowledge (textbook) and skills (teaching practice). Ms. Pink’s ways-of-knowing (partial incompetency) may have influenced her learning disposition within the MLC.

**Three-Dimensional Tapestry**

Teachers’ experiences working with an external provider varied significantly based on their school (environment), their relationship with colleagues (ways-of-doing outside the MLC), and their own perceptions of their competence as drug education teachers (ways-of-knowing).
Table 14. A Summary of Teachers’ Ways-of-Being, Ways-of-Doing, and Ways-of-Knowing Across the Three Schools

<table>
<thead>
<tr>
<th>School</th>
<th>Type</th>
<th>Teacher</th>
<th>Teacher Way of Being in the MLC</th>
<th>Teacher Way of Doing Outside the MLC</th>
<th>Teacher Way of Knowing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tree</td>
<td>LEV-faced</td>
<td>Mr. Indigo</td>
<td>Being-a-disengaged-teacher</td>
<td>No collaboration</td>
<td>Incompetence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Brown</td>
<td>Being-a-disengaged-teacher</td>
<td>No collaboration</td>
<td>Incompetence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Grey</td>
<td>Being-a-disengaged-teacher</td>
<td>No collaboration</td>
<td>Incompetence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Yellow</td>
<td>Being-a-collaborative-teacher</td>
<td>Collaboration</td>
<td>Competence</td>
</tr>
<tr>
<td>Unicorn</td>
<td>School-faced</td>
<td>Ms. Blue</td>
<td>Being-an-observing-teacher</td>
<td>No collaboration</td>
<td>Competence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mr. Red</td>
<td>Being-an-observing-teacher</td>
<td>No collaboration</td>
<td>Competence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Black</td>
<td>Being-a-learning-teacher</td>
<td>Collaboration</td>
<td>Competence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and Ms. White</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Orange</td>
<td>Being-a-collaborative-teacher</td>
<td>Collaboration</td>
<td>Competence</td>
</tr>
<tr>
<td>Hestia</td>
<td>School- and LEV-faced</td>
<td>Ms. Pink</td>
<td>Being-an-observing-teacher</td>
<td>Collaboration</td>
<td>Incompetence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Green</td>
<td>Being-a-learning-teacher</td>
<td>Collaboration</td>
<td>Competence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Magenta</td>
<td>Being-a-collaborative-teacher</td>
<td>Collaboration</td>
<td>Competence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ms. Purple</td>
<td>Being-a-takeover-teacher</td>
<td>No collaboration</td>
<td>Competence</td>
</tr>
</tbody>
</table>

The school environment and teachers’ ways-of-being in the MLC

The schools’ levels of engagement with drug education seemed to predict teachers’ levels of collaboration with external providers inside and outside the MLC. Unsurprisingly, at least half of the teachers at Hestia and Unicorn (e.g., being-a-learning-teacher and being-a-
collaborative-teacher) as compared to only one out of three of the teachers at Tree, collaborated with the LEV educator in the MLC (e.g., being-a-collaborative-teacher).

The schools’ levels of support for drug education precisely mirrored these levels of collaboration. Hestia highly valued drug education and planned to facilitate an integrated program consistent with its strategic plan. Hence, it is understandable that at least 50% of the teachers observed actively collaborated with the LEV educator. If the being-a-takeover-teacher is interpreted as an exaggerated level of collaboration or as overengagement, then three out of four generalist classroom teachers at Hestia desired or engaged in collaborative endeavors with the LEV educator.

Unicorn provided an internal drug education program, using the LEV program as a supplementary resource. Therefore, it is reasonable that at least 50% of the teachers observed actively collaborated with the LEV educator. Tree, on the other hand, refuted the value of drug education to their students’ cohort and hence, their teachers predominantly disengaged with the LEV educator in the MLC.

Teachers’ lack of collaboration in the MLC was consistent with their school’s lack of support for drug education. Three of the four teachers observed at Tree did not collaborate with the LEV educator. Ms. Brown, Ms. Grey, and Mr. Indigo were disengaged in the MLC session.

Conversely, while Ms. Yellow also taught at Tree, her ways-of-being in the MLC were unexpectedly collaborative. The unsupportive school environment should have dictated her lack of collaboration in the MLC. This insinuates that Ms. Yellow’s ways-of-being were not implicated by her school environment alone, but also by her relationships with other colleagues outside the MLC (ways-of-doing). Unlike the other three teachers observed at Tree, Ms. Yellow engaged in collaborative relationships with colleagues outside the MLC.

Teachers’ ways-of-being in the MLC were predicated on their school’s environment as well as their relationships with colleagues (ways-of-doing) outside the MLC.

Ways-of-doing outside the MLC and teachers’ ways-of-being in the MLC
Teachers who engaged in collaborative interactions outside the MLC collaborated with the LEV educator within it. Three teachers at Tree who did not report engaging in collaborative relationships with colleagues (Ms. Brown, Ms. Gray, and Mr. Indigo) predictably did not collaborate with the LEV educator (being-a-disengaged-teacher). Teachers who taught alone
and did not report collaboration with colleagues (e.g., Ms. Blue and Mr. Red from Unicorn) did not collaborate with the LEV educator inside the MLC (being-an-observing-teacher).

Furthermore, the five teachers who were categorized as being-a-learning-teacher (Ms. Black and Ms. White from Unicorn and Ms. Green from Hestia) or being-a-collaborative-teacher (Ms. Yellow from Tree, Ms. Orange from Unicorn, and Ms. Magenta from Hestia) were all in fact engaged or eagerly desired to engage in high levels of collaboration outside the MLC throughout the three schools under study.

Contradictorily, Ms. Pink from Hestia reported collaborating with other colleagues in planning her units, yet unpredictably did not collaborate with the LEV educator in the MLC (being-an-observing-teacher). Therefore, if teachers’ relationships with colleagues (ways-of-doing outside MLC) were the only reflectors of their ways-of-being within it, then Ms. Pink should have collaborated with the LEV educator in the MLC. Yet, her perceived incompetence as a drug educator teacher (ways-of-knowing) was another factor of her ways-of-being in the MLC.

Ways-of-knowing outside the MLC and teachers’ ways-of-being in the MLC

Teachers’ views of their capacity as drug education facilitators (e.g., propositional or pedagogical knowledge) were associated with the levels of their collaboration within the MLC. Teachers who perceived themselves as competent drug education facilitators (e.g., Ms. Yellow from Tree, Ms. Orange, Ms. Black, and Ms. White from Unicorn, as well as Ms. Green and Ms. Magenta from Hestia) all engaged in collaboration within the MLC (being-a-learning-teacher or being-a-collaborative-teacher, respectively).

Similarly, teachers who perceived themselves as incompetent drug education facilitators (e.g., Ms. Brown from Tree and Ms. Pink from Hestia), did not collaborate with the LEV educator in the MLC (being-a-disengaged-teacher or being-an-observing-teacher).

Paradoxically, Ms. Blue and Ms. Red from Unicorn and Ms. Purple from Hestia, who perceived themselves as competent drug education facilitators, did not collaborate appropriately with the LEV educator within the MLC (being-an-observing-teacher or being-a-takeover-teacher, correspondingly). If perception of competence (ways-of-knowing) was the only predictor of teachers’ ways-of-being in the MLC, then these teachers should have collaborated with the LEV educator within the MLC.
Evidently, teachers’ ways-of-being in the MLC was shaped by a combination of their school environment, their relationship with other colleagues (ways-of-doing outside of the MLC), as well as their perception of competence (ways-of-knowing).

**Implication 1: Education and school policy**

Drug education policy guides educational leaders toward advocating a consistent approach to school-based drug education. This study elucidates the vast discrepancies among schools’ approaches to drug education. These discrepancies resulted in three divergent types of partnerships with LEV, impacting teachers’ ways-of-being in the MLC. Tree’s devaluing of drug education, for example, restricted its teachers from taking full advantage of the resources provided by LEV. Lack of knowledge of drug use among Australian youth and adults led Tree to espouse the myth that high socioeconomic families are invulnerable to drug-related problems. This approach compromised the provision of effective drug education to their students. Drug management policy can stipulate professional and systematic support for principals and teachers, equipping them “with specific skills in the area of drug education” (Midford et al., 2006, p. 222).

**Implication 2: Teacher professional development**

Teachers require continuing PD opportunities, appropriate resources, and ongoing leadership and collegial support to facilitate effective school-based drug education programs (Botvin & Kantor, 2000; Cahill, 2007; Meyer, 2004). However, this study reveals the limited opportunities afforded generalist teachers to participate in health and drug education PD. In fact, teachers recurrently articulated their need for practical and online age-appropriate resources rather than training in drug education knowledge and pedagogy. Since teachers’ collaboration with their colleagues played a substantial role in their ways-of-being in the MLC, their PD training should emphasize and inspire collaborative approaches to teaching. Could LEV offer teachers PD opportunities that demonstrate effective strategies to drug education as well as forge collaborative partnerships with generalist teachers?

**Implication 3: LEV operations**

While LEV espouses to engage in partnerships with schools to facilitate drug education programs, this study exposes the disturbing inconsistencies in these collaborations. In fact, the LEV-faced partnership illustrates an unhelpful and insalubrious overreliance on external providers that “may perpetuate teachers’ own reluctance and vulnerability in taking the lead in drug education” (Stead et al., 2009, p. 17). Correspondingly, LEV’s emphasis on
supporting generalist classroom teachers warrants further exploration, as Astbury (2011, p. 37) probed:

Should more of an emphasis be placed on building a relationship with, and the capacity of teachers and parents/carers, given the pivotal and more permanent role they play in the major domains in which children and young people live, learn and develop?

Rather than merely providing an incursion, or age-appropriate material or online resources, LEV could augment teachers’ capacities to cofacilitate school-based drug education programs. By resourcing and training generalist teachers, LEV could develop its partnership with schools, particularly with the awareness that teachers’ ways-of-knowing (competence) play a considerable role in their collaboration with LEV educators (ways-of-being) in the MLC. Adequate training should illuminate generalist teachers’ occupation (knowing–doing–being) as drug education teachers, as well as clarify their roles in partnering with LEV.

Consistent with previous research, there seem to be confusion and uncertainty surrounding the roles of generalist teachers and specialist educators (Sanders, 2006). Accordingly, generalist teachers in the three schools under study enacted divergent ways-of-being in the MLC. Some, as documented in previous research, assumed a passive role in the programs, inconsistently engaged their students in pre and post program sessions, as well as limited their participation to administrative tasks (Gupta et al., 2010; Kisiel, 2005; Tal & Steiner, 2006; Tran, 2007).

Findings in this study expand our understanding of the “passive” verses “active” role of generalist teachers working together with specialist educators. The collaborative spectrum presented in this study ranged from “disengaged,” to “over engaged,” to “partially engaged,” and finally to “fully engaged” in partnership between teachers and external providers. This expanded classification can address the recommendations of previous research, which called for a mutual understanding between classroom teachers and informal educators (Weiland & Akerson, 2013).

These findings contribute to the drug education literature by providing a clearer description of the nature of the partnerships between schools and LEV, as well as the roles encompassed by the two occupations: generalist teachers and specialist educators. This may inform future decisions and practices of external providers (including LEV) as well as school administrators, leadership teams, and classroom teachers.
References


Midford, R. (2009). Drug prevention programmes for young people: Where have we been and where should we be going? Addiction, 105, 1688–1695.


Webster, P. J. (2001). Teachers’ perceptions of physical education within the K–6 personal development, health and physical education key learning area (Unpublished doctoral dissertation). The University of Wollongong, Australia.


## Appendix i

Table 15: An outline of the LEA professional standards framework for educators (Life Education Australia, 2011)

<table>
<thead>
<tr>
<th>PROFESSIONAL STANDARDS FOR LIFE EDUCATION EDUCATORS</th>
<th>DIMENSIONS</th>
<th>COMPETENCY DESCRIPTOR</th>
<th>CRITICAL ELEMENT*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Professional practice</td>
<td>Educators facilitate purposeful and appropriate learning for students</td>
<td>Employ effective teaching and learning strategies Manage behaviours to maximise students’ participation Monitor and assess student learning</td>
</tr>
<tr>
<td></td>
<td>Professional knowledge</td>
<td>Educators apply knowledge of relevant curriculum and drug and health education to enhance student learning</td>
<td>Demonstrate knowledge of the history, vision, core purpose of Life Education Familiar with curriculum statements, policies and approaches associated with the content they teach Develop comprehensive understanding of the content they teach</td>
</tr>
<tr>
<td></td>
<td>Professional engagement</td>
<td>Educators conduct themselves in a professional manner to provide excellent service to their schools</td>
<td>Fulfil educators’ administrative responsibilities Abide by OH&amp;S requirements in the workplace Adhere to ethical and legal responsibilities</td>
</tr>
<tr>
<td></td>
<td>Professional partnerships</td>
<td>Educators build and maintain relationships with schools, external agencies and the wider community to enhance student health and wellbeing</td>
<td>Engage with schools to provide effective drug and health education Collaborate with classroom teachers as partners in drug and health education Support parents to contribute the health and wellbeing of students Promote Life Education in community based events</td>
</tr>
<tr>
<td></td>
<td>Professional reflection</td>
<td>Educators critically reflect on their professional experience to develop their knowledge, skills and attitudes</td>
<td>Reflect on professional experience Participates in ongoing professional development opportunities</td>
</tr>
</tbody>
</table>
Appendix ii

An overview of the LEV Primary Modules (Life Education Australia, 2010)

**Harold’s Surprise – Prep-Yr 1**

Harold and the class are invited to a party in the park by his friend possum. The children help Harold choose some healthy food to take to the party. They have lots of fun following the map to the picnic spot in the park. Along the way a selection of issues are raised and explored including-
- Health & well being
- Physical activity and the body’s response to it
- Safety awareness, including syringe safety
- Expressing feelings, needs and wants in appropriate ways
Possum thanks all her friends with a special surprise contained in a big wrapped box which the class gets to open at the end of the session!!

**Harold Clued Up – Prep- Yr 1**

Harold has opened a Detective Agency. He enlists the help of the class to help him find Possum’s missing friend Cocky. In their search for Cocky the detectives encounter and solve many problems including-
- Safe/unsafe living, including syringe safety
- Friends and people we can turn to for help and support
- Recognizing similarities and differences
- Cooperation and working together

**Harold’s Mystery Tour – Prep/ 1/2**

Harold has planned a Mystery Tour in a special bus that takes him and the children to amazing places. Many dimensions of health are explored including-
- Emotions experienced when trying new physical activities
- Healthy food choices
- Location and function of important body parts and systems
- Safety with medicines
- Recalling past experiences in decision making and dealing with peer pressure
- Valuing their health and safety and that of others

**Harold’s Heroes – Yr 1/2/3**

Harold has formed a team of super heroes. Harold recruits the class to join the team and assist the super heroes with their mission is to make the world a safer, healthier place. The super
heroes Extinguisher, Mediminder, Emergiman and Littergator fly to the rescue and are helped by the class to -

- solve environmental health issues such as passive smoking, syringe safety
- form ideas for safe use and storage of medicines
- understand and rehearse emergency procedures
- Make healthy food choices for Super Heroes

**Heart Central – Yr 1, 2, 3 or 4 (changed to All Systems G)**

Harold invites the class to travel around the body. Starting at the heart the children travel through the blood visiting a number of body parts and exploring a range of issues

- Things that need to go into and come out of the body to keep it alive and healthy
- The inter-relationships between body systems
- The ways medicines can enter the body and their effects on the body
- Passive smoking issues
- Accepting the importance of physical activity and positive life style choices
- Strategies for maintaining personal safety and resisting pressure from others

**Harold’s Diary – Yr 2/3/4**

Harold shares his weekly multi media diary entries with the class. This provides the back drop for the class to explore a range of topics including-

- relationship and friendship issues relevant to middle year students.
- food choices and the way these choices can affect health & well-being
- the contribution of physical activity to fitness and well being
- services and products that promote health and safety

**Mind your Medicines – Yr 3/4 (New 2009)**

- Describe the factors that influence the way a person values themselves
- Recognises that effective communication is an essential component of maintaining positive relationships
- Identifies medicines as drugs and the consequences of their misuse
- Identifies, people and products that advise, educate and inform the community about medicines
- Investigate and evaluate a variety of behaviours and situations that may be harmful to a person’s health
- Practices strategies to communicate effectively with others in a range of settings

**The Burning Issue – Yr 5/6**

- Recognises that smoking affects all body systems resulting in short & long term consequences
- Identifies services & products that advise, educate & inform people of the facts about tobacco smoking
Identifies both personal & community strategies to reduce harms related to tobacco use
Examines the harmful effects that smoking has on our environment
Describes the laws governing the advertising, sale & use of tobacco products
Increasingly accepts responsibility for personal & community health
Develops & implements strategies to address influences & pressures to smoke

**News About Booze – Yr 5/6 (Changed to Think Twice)**

- Recognises that alcohol is a legal drug which can affect all body systems resulting in short and long term consequences
- Identifies services, that advise educate and inform people of the facts about drinking alcohol
- Examines the harmful effects alcohol can have on our community
- Describes the laws governing the advertising, sale, and use of alcohol products
- Identifies community strategies to reduce alcohol related harms
- Increasingly accepts responsibility for personal and community health
- Identifies, develops and practices personal strategies to reduce alcohol related harms

**It’s Your Call – Yr 5/6**

- Recognises that legal drugs can affect all body systems resulting in short and long term consequences
- Identifies services, products that advise educate and inform people of the facts about(legal) drug use
- Examines the harmful effects that (legal) drug use can have on our environment and community
- Describes the laws governing the advertising, sale and use of a variety of drugs
- Identifies community strategies to reduce drug related harm
- Increasingly accepts responsibility for personal and community health
- Identifies, develops and practices personal strategies to reduce drug related harms
## Appendix iii

Table 16: An example of linking LEA modules to the Australian Curriculum (Life Education Australia, 2016)

<table>
<thead>
<tr>
<th>Life Education Content Descriptions</th>
<th>Post-Visit Lessons</th>
<th>Australian Curriculum Learning Area: Health and Physical Education</th>
<th>Links to Other Learning Areas</th>
<th>General Capabilities</th>
</tr>
</thead>
</table>
| Recognises that legal drugs can affect all body systems resulting in short- and long-term consequences | What is a drug? | YEARS 5 & 6  
Personal, social, and community health  
Being healthy, safe, and active ACPPS054  
YEAR 7  
Personal, social, and community health  
Being healthy, safe, and active ACPPS073 | English: Literacy  
ACELY1796  
ACELY1709  
ACELY1804 |  |
| Identifies services and products that advise, educate, and inform people of the facts about (legal) drug use | Analgesics | YEARS 5 & 6  
Personal, social, and community health  
Being healthy, safe, and active ACPPS053  
YEAR 7  
Personal, social, and community health  
Being healthy, safe, and active ACPPS073 | English: Literacy  
ACELY1796  
ACELY1709  
ACELY1804 |  |
| Identifies factors that influence their health and behavior, e.g., media, advertising, family, friends, laws, digital communication | Influences | YEARS 5 & 6  
Personal, social, and community health  
Communicating and interacting for health and wellbeing ACPPS057  
YEAR 7  
Personal, social, and community health  
Communicating and interacting for health and wellbeing ACPPS074, ACPPS075 | English: Literacy  
ACELY1796  
ACELY1709  
ACELY1804 | LIT  
Composing texts through speaking, writing, and creating ICT  
Applying social and ethical protocols and practices when using ICT |
<table>
<thead>
<tr>
<th>Description</th>
<th>How does it measure up?</th>
<th>Year</th>
<th>English: Literacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describes the laws governing the advertising, sale, and use of a variety of legal drugs</td>
<td>YEARS 5 &amp; 6 Personal, social, and community health</td>
<td>5 &amp; 6</td>
<td>ACELY1796</td>
</tr>
<tr>
<td></td>
<td>Being healthy, safe, and active ACPPS054</td>
<td></td>
<td>ACELY1709</td>
</tr>
<tr>
<td></td>
<td>YEAR 7 Personal, social, and community health</td>
<td></td>
<td>ACELY1804</td>
</tr>
<tr>
<td></td>
<td>Being healthy, safe, and active ACPPS073</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identifies government and community strategies that advise, educate, and inform people how to maintain healthy and safe lifestyles, e.g., laws, campaigns, product labelling, digital communication</td>
<td>Put it on the table</td>
<td>5 &amp; 6</td>
<td>ACELY1704</td>
</tr>
<tr>
<td></td>
<td>Personal, social, and community health</td>
<td></td>
<td>ACELY1714</td>
</tr>
<tr>
<td></td>
<td>Being healthy, safe, and active ACPPS053</td>
<td></td>
<td>ACELY1725</td>
</tr>
<tr>
<td></td>
<td>YEAR 7 Personal, social, and community health</td>
<td></td>
<td>ACELY1702</td>
</tr>
<tr>
<td></td>
<td>Being healthy, safe, and active ACPPS073</td>
<td></td>
<td>ACELY1723</td>
</tr>
<tr>
<td></td>
<td>English: Literacy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**EU Reasoning in decision-making and actions**

**ICT Investigating with ICT**

**CCT Generating ideas, possibilities, and actions**
Appendix iv

QUESTIONNAIRE

TEACHERS PARTICIPATING IN THE LIFE EDUCATION VICTORIA PROGRAM

<table>
<thead>
<tr>
<th>School</th>
<th>Grade/s you teach</th>
<th>Years of Teaching</th>
</tr>
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<tbody>
<tr>
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</table>

<table>
<thead>
<tr>
<th>Your Gender</th>
<th>Years @ this school</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. How many years have you participated in the Life Education Program throughout your teaching career?

________________________________________________________

2. What program/s do you use to facilitate health/drug education? (Pls specify internal/external program)

_____________________________________________________________________________

_____________________________________________________________________________

3. How do you facilitate effective health/drug education in your classroom? (List any strategies/resources)

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

4. What support do classroom teachers need in order to facilitate effective health/drug education?

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________

5. What support do you receive from your school or region to facilitate your health/drug education?

_____________________________________________________________________________
6. How does Life Education **support you** in facilitating your health/drug education program?

7. How **useful** have the following Life Education resources been for you?

<table>
<thead>
<tr>
<th>RESOURCE</th>
<th>How do you use it?</th>
<th>Why is it useful for you?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Session in the Van (MLC)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Students Booklets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teachers’ Booklets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff PD sessions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parent sessions</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. **What future support would do like** Life Education Victoria **provide** you as a teacher?

9. Any **other comments** you would like to make about Life Education?
Author/s: 
Botross, Peter

Title: 
Teaching together as tapestries: teachers’ experiences of partnering with external providers to facilitate school-based drug education

Date: 
2017

Persistent Link: 
http://hdl.handle.net/11343/168280

File Description: 
Teaching together as tapestries: teachers’ experiences of partnering with external providers to facilitate school-based drug education

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