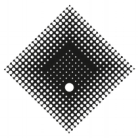
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Bricolage and the Health Promoting School

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Bricolage and the Health Promoting School

Abstract

Purpose – The propositional knowledge about the Health Promoting School (HPS) and how it privileges the health sector, and research through intervention and behaviour change rather than gaining an understanding of how social bases of health impact and influence individuals and the wider school community. The purpose of this paper is to explore how bricolage offers opportunity for understanding complexity, thick description and inter- and multi-disciplinary work. The experience of health promotion and what it looks like at the school level and provides epistemological considerations for reframing research about HPSs for purposes of social justice and equity through bricolage.

Design/methodology/approach – An introduction reveals the challenges of health promotion settings, and schools in particular to achieve social justice and equity. Bricolage is discussed with reference to complexity, thick description and inter- and multi-disciplinary work. Considerations are given to bricolage as research to gain understanding and to contribute to social change.

Findings –As a setting the HPS is a complex site of social interaction and where there is interplay of multiple, casual factors that influence health and wellbeing. The potential for social justice and equity remains latent and new approaches to investigating and researching are required. Bricolage offers substantial possibilities as it recognises the value of researching social contexts but with a deliberate intent to engage with participants.

Practical implications – This paper considers how bricolage can re-focus ontological and epistemological positions to engage in health promotion as a social action.

Originality/value – This paper raises questions about the ability of the HPS model to deliver on social justice under current compliance regimes.

Keywords: Social justice; Health promotion; Bricolage; Health promoting schools

Article Classification: conceptual paper

Introduction

The sole gaze on illness located in an imperfect body has been argued (Antonovsky 1979) to be an inadequate way to view health, as there is a need to also consider the environment that the imperfect body is both located within and subject to. The World Health Organisation's (WHO) perspective on health promotion and specific work around settings for health has been attributed to Antonovsky's consideration of what creates health (Kickbusch, 1996). There is a growing understanding that health is not purely or solely corporeal and consideration of how social inequality not only impacts on those people who are without but also the level of health and quality of life experienced by the total population (Dorling, 2012).

The challenge faced by schools as a "setting" for health promotion and education, lies within the ways in which health is viewed (the ontological) and how knowledge is selected and shared (the epistemological). Unlike many other areas of curriculum, health promotion and education in schools draws from two different sectors – health and education. What the health sector views as required and necessary knowledge to be conveyed about health (particularly) to school students is usually couched in terms of single interventions to facilitate behaviour change (Dooris, 2004; Antonovsky, 1996) because students are presumed to be at "risk" of some (preventable) illness. There is unlikely to be any reference to the health education needs of students that may provide opportunity to advocate, enable or mediate (WHO 1986) what influences their health and wellbeing and that of their family and community.

The propositional knowledge about the Health Promoting School (HPS) as a specific setting and how they are portrayed predominantly privileges the health sector over the social health needs of individuals and the wider school community. This is reflected in research that considers the efficacy of interventions and behaviour change as an outcome but with little or no acknowledgment of health and quality of life as the result of how social determinates impact on health. This paper will explore how the principles of bricolage – complexity, thick description and inter- and multi-disciplinary approaches all provide insights into new ways of looking at health promotion at the school level and offers epistemological considerations for reframing research about HPS for purposes of social justice.

Settings as a focus

The World Health Organisation's (WHO) goal of *Health for All* is based on the idea that health is a human right and that health is a resource that contributes to both quality and length of life. Health of individuals and communities is neither a static concept nor a universally shared experience. Health varies with age, position, income, gender, Indignity, geography and many other aspects of life and living. These concepts arise out of Antonovsky's question about where health is created (1996). In 1986 at a conference of health professionals in Ottawa Canada, a consensus about health being more than medicine emerged. That considerations about individuals as social actors and communities with or without resources for health also needed recognition thus leading to the development of what is termed New Public Health – now encapsulated in the Ottawa Charter (WHO, 1986).

During subsequent WHO sponsored conferences on health promotion the principles of the Ottawa Charter were both confirmed and more closely defined based on experiences and reflections of health promotion practice in the intervening years. Reaffirming these principles in 2009 at the Adelaide conference participants drew on the spirit of 1978 Alma-Ata Declaration to acknowledge "social justice and equity as prerequisities for health" (WHO, 2009, p. 6). At a later conference in supportive environments, both socially and ecologically were seen as being inter-dependent and inseparable with health; that "(e)quity must be a basic priority in creating supportive environments for health" (WHO, 2009, p. 14). In the Jakarta Declaration (WHO, 2009) the settings in which "people live, love work and play" were seen as being critical for building capacity for health and well-being (with the HPS being one model) as they "represent the organisational base of the infrastructure required for health promotion" (WHO, 2009, p. 20). Through the reflections on the intervening years of work in health promotion since Ottawa participants in the Jakarta Conference recognised that that health literacy was an important element in that it was seen as a means for individuals to acquire and use knowledge while also being a resource for engaging in health at personal and community levels.

As a specific area of inquiry health promotion has been growing and evolving since 1986. The shift in understandings about the work of health promotion has also evolved, changing through informed practice and increasingly sophisticated ideas of what is both possible and desirable. The understandings about settings have become broadened to not only include cities, hospital, schools and workplaces but also sites that are less organisationally defined and structured such as the public spaces of streets/neighbourhoods, parks/open spaces, markets/malls and public transport (Dooris, 2010). There has been a research effort targeted at trying to systematise findings to distil understandings about what 'works' in settings and therefore what is the panacea (Bodstein, 2007; Dorris, 2010; Dorris *et al.,* 2007; Whitelaw *et al.,* 2001) but virtually

nothing to understand variability – of health promotion practice and the experiences of 'participants' (Poland *et al.,* 2009).

The expressions and emphasis of how settings are maximised to develop and enhance health varies due to its dependence on political will and systemic foci as well as global and national economic circumstances. While there have been some changes to the ways in which settings have been conceptualised and researched, the principle of health through social justice and equity has remained remarkably consistent – at least in the theory of health promotion.

The HPS as a setting

In Australia the settings approach to health has been readily accepted as a holistic and multifaceted approach (WHO, 1986) and the focus on schools as a setting was well developed in the 1990s (Colquhoun *et al.,* 1997) and continued in the new millennium (O'Dea and Maloney, 2000; Mükoma and Flisher, 2004; Laurence *et al*., 2007) with a renewal of focus affirmed by the State Government in Victoria March 2012. Typically the HPS is presented as having distinctive but inter-related areas of action with indicative aspects. The HPS model is composed of three areas: curriculum, teaching and learning; school organisation, ethos and environment; and services and partnerships. According to the WHO these areas of action aims to foster health and learning with all of the measures available to the school and its community (www.who.int/school_youth_health/gshi/hps/en/). In March 2012 the Victorian government re-launched the HPS model through the Victorian Prevention and Health Promotion Achievement Program (2012). Based on the WHO HPS model it identifies six components of a whole school approach to health promotion and how the model aligns to key learning and accountability structures. The model is presented as a way to improve the health well-being of children and young people. However, it also lays a case for meeting benchmarks for health priority areas. In describing the focus of the intervention a mangerialist perspective is introduced such that health can be used as a vehicle for justifying surveillance about pre- and externally developed criteria (Renwick, 2006). According to Baric (1993) and Grossman and Scala (1993) research about settings for health promotion such as in schools (HPS), predominately utilises a management and systems framework. This Victorian Government's approach (2012) is characterized by consideration of management principles, processes, techniques and elements (Renwick, 2006) of what is defined as health promotion such as policies and procedures. These in and of themselves do not purport to redress any social or environmental determinate of health and they never explicitly articulate a concern for an outcome of social justice or equity. Rather they are a means to measure a school against specific criteria and determine if a school could claim HPS status. Within a school context there are many positions and expectations. Education as a discipline area is positioned in different ways as compared to health. The limited engagement of schools with and for health promotion has been documented (Dooris, 2010; Guggleberger, 2011). There is evidence of care and concern for students and their families as a part of the wider school community; however, there is little or no specific commitment to health as defined by the health sector. Schools are complex social environments with many demands and expectations. Researching schools as a setting where health is created has to embrace complexity and both the subjectivity and agency of individuals; it needs to have explicit the ontological and epistemological positions within the research especially if it is to lay claim to any gain for social justice.

Taking bricolage to school

Levis-Strauss (1966) described how people as subjected actors interrelated with their

surroundings in holistic ways. He used the term bricoleur to describe those people who make use of those resources that are available and can be used in a variety of ways, dependant on need and recognition of possibility. Thus bricolage makes use of the resources at hand including the non-human but also the human, that is something of the person (the bricoloeur), that gives rise to both entrepreneurial and innovative responses. In this sense bricolage is circumstantial as it is dependent on what is available, and it is malleable in how it uses both process and resources in different and presumably unintended ways, generating new purpose and intent (Duymedjian and Rüling, 2010). Hatton (1988) described the work of teachers as being bricolage because it involved "the adoption of ad hoc (coping, survival, dilemma management, etc.) strategies" (p. 348). Building on Hatton's work Scribner (2005) investigated how teachers engaged with their students while under increasing pressure of external accountability and surveillance. Scribner concluded that teachers acted as bricoleurs by necessity and survival, and were active in assimilating "various strategies, melding together past experiences to address a current problem. Teachers are in a continual state of transforming knowledge to make that knowledge relevant to their context. They keep bits of things that work and discard what does not" (p. 307). Teachers drew on whatever they had available to them to engage students in learning rather than for policy or school improvement and accountability rhetoric. This perspective positions the role of teacher as being subjected action by "someone who carefully and thoughtfully makes a series of professional judgements about what and how to teach" (Honan, 2007, p. 614, original emphasis).

The teacher as bricoleur is no less evident than in the teaching of health education. Health education curricula are more often than not presented as a series of considerations about national health concerns and associated behaviour change interventions. While some of these are appropriate considerations for young people about their immediate health, such as prevention of skin cancer through being sunsmart, engagement in physical activity and mental health, others are less so, such as adult onset diabetes and heart disease. Most interventions that are offered as health education programmes, are developed outside the school in a one-size-fits-all, top-down approach (Renwick, 2013) and are constructed in what McCarthy *et al*. (2009) call a social problems/moral panics framework. Teachers are motivated by what they believe is in the best interests of their students (Scribner, 2005; Honan, 2007) and therefore draw heavily on the materials provided to ensure that they provide "accurate" information about health topics that their students presumably need to know and are possibly interested in.

Teachers are, however, not the only ones interested in what students are taught and learn. Yet the work undertaken by teachers is too often misunderstood or ignored in the development of health education programmes by external organisations. Schools have long been a target of agencies and social institutions especially by those with a focus on health. A sampling of health intervention research includes mental health and bullying (Wells *et al*., 2003; Vreeman and Carroll, 2007; Durlak *et al*., 2011); social and emotional health (Bond *et al*., 2004; Patton *et al*., 2006); diet, exercise and obesity (PeÂrez-Rodrigo and Aranceta, 2001; Sahota *et al*., 2001; Bauer *et al*., 2004; Shepherd *et al*., 2006; Stice *et al*., 2006; Sharma, 2006; Brown and Summerbell, 2009; Shaya *et al*., 2008; Harris *et al*., 2009), harm minimisation (McBride *et al.,* 2004), drug and alcohol (Cuijpers, 2002; Dusenbury *et al*., 2003) and peer-led vs adult-lead health education (Mellanby *et al*., 2000). In addition to an intervention approach to specific health problems or illnesses there is also evaluation of interventions for their fidelity to implementation process, pre-determined outcomes, programme achievements and challenges for sustainability beyond the intervention and surveillance period (Durlak and DuPre, 2008).

The literature on HPSs often describes specific interventions, facilitated within the school context (Sobczyk *et al*., 1995; Moon *et al*., 1999; Schofield *et al*., 2003; Mükoma and Flisher, 2004). They range in activity from interference with; involvement in; and intrusion into the explicit and hidden curriculum; and intercession for teachers to change their teaching practices. Further the research describe a plethora of outcomes from specific behaviour changes: physical activity (Crosswaite *et al*., 1996); self-protective behaviours (Jamison *et al.,* 1998); health eating; cancer control and cardiovascular risk reduction (Sobczyk *et al*., 1995; Laurence *et al*., 2007); smoking, alcohol and drug use (Moon *et al.,* 1999; Schofield *et al*., 2003), through to health-related policies, practices and infra-structure (Mitchell *et al*., 2000).

The focus on HPSs as settings to access young people and reach into their families and wider community has a long history (Dooris *et al.,* 2007) and has been driven by a need to intervene about health that may or may not have relevance to the school and its community. Such actions of interference and intrusion are based on population studies and policy requirements as typically seen in interventions described in the Victorian Prevention and Health Promotion Achievement Program (2012). If, as it is widely argued, behaviour change is the aim of health promotion (Baum, 2007) how do researchers know which particular behaviours require change within in any individual setting? And why is it that individuals and communities in specific settings are required to change their behaviour but private enterprises that both produce and market goods and services what contribute to ill health are not? For instance, what about manufacturers of energy-dense and nutrient-poor food; or companies that pollute or makes use of child workers or companies who position fast food and gaming outlets disproportionately in areas of low SES?

Within the context of health promotion schools as setting predominately focus on the prevention of lifestyle diseases, the idea being that if healthy behaviours can be established in childhood then there are both financial saving to be had as well as prospective improvements to quality of life. Baum (2007) puts forward the need for strategies that are equitable and that this requires understandings about the complexity of local knowledge and concepts. In schools this is especially relevant given the biomedical perception that educational epistemology is solely behaviouralist and therefore behaviour modification/change and generation of “healthy” habits is the goal of interventionist approaches. Dewey (1944) has argued that the development of habits is important because they are not just demonstrable behaviours but they are formed through understanding of the situations in which the habits operate and make “sense”. In doing so they form an inclination or an intellectual predisposition for action and thereby becoming a “habit”. This supports the development of the settings approach to health promotion, especially when the major determinants of health are social; and where a community is able to create a healthier environment because its people have the knowledge and skills to do so (Burgher *et al*., 1999).

Not surprisingly then there are limitations on what seems to be achievable in the HPS as a setting. Is the social environment of every school that predictable? What about the impact of SES on communities when “health” is defined according to a privileged class perspective? If, as Wilkinson (2005) contends, health status is closely linked to socioeconomic status and that health differences in populations arise out of the social environment and that more egalitarian societies tend to be healthier, then a one-size-fits-all approach to the HPS is not the best way to advance improvement. In privileging dominant narratives and perspectives in research on HPSs

is to generate a reductionist perspective that according to Steinberg (2012) results in the voices of those living within the settings being muted or silenced.

According to Levis-Strauss (1966) bricolage pays particular attention to the relations of time, space and object, as well as knowledge as a practical reasoning (Duymedjian and Rüling, 2010). Researching social locations and contexts demands that we make use of what is at hand to "actively construct our research methods" (Kincheloe, 2005a, p. 324) in order to understand what is occurring and why it is being experienced in the particular way in that time, space. Thus in accepting that health is socially constructed and that social determinates of health are experienced in inequitable ways, then researching the HPS demands more of us as researchers than passive, correct and universal methodology (Kincheloe, 2005a). Researching the HPS as a setting and social context is limited when linear, step-by-step processes are applied. Rather than be constrained by pre-determined research processes that limit understandings about the construction of health "the bricoleur steps back and works without exhaustive preliminary specifications" (Kinn *et al*., 2013, p. 1287). In developing his conceptualisation of the bricolage and therefore the work of the bricoleur, Kincheloe (2001, 2005a, b, 2006, 2011) identifies three concepts – complexity, thick description and inter- and multi-disciplinary work that challenges and informs understanding about researching social contexts. The following section will examine each of these conceptual components of bricolage and explore what each looks like in context of the HPS.

The HPS and complexity

The use of bricolage is derived from a specific understanding of the world as being interconnected and complex. Duymedjian and Rüling (2010) in their consideration of bricolage argue that everything impacts, so everything matters and therefore deserves both respect and recognition. Rather than becoming overwhelmed and be at risk of inaction or worse driven by "proven" protocols of positivism, the researcher as bricoleur makes use of what is available to both research and consider what is possible at that time. Kincheloe (2005a) describes the work of the bricoleur as recognising rather than ignoring the interconnected nature of social research which therefore requires an "open view of the object of inquiry, it is always a part of many contexts and processes, (as) it is culturally inscribed and historically situated" (p. 333).

According to Tones and Tilford (2001) health promotion is about the pursuit of holistic goals and equity. This ontological position demands attention to research methods that are attentive to, reveal and ameliorate what creates health disparities. Thus complexity is an inherent aspect of health promotion; however, the typical approach to research is the gathering of evidence from interventions that are simplistic, seek demonstrable chains of causation and the manipulation of single factors to produce single and measurable outcomes (McQueen, 2001; McGinnis *et al*., 2002). Antonovsky (1996) in his critique of a pathogenic orientation to health argues that this results in negligently ignoring the person and that focusing on a pathology, disability or particular characteristic of ill health belies the complexity of what it is to be human.

Kincheloe's (2008) critique of positivistic research and it use of singular and linear methods of inquiry and knowledge production and challenging the common sense positioning of the possibility to reveal universal "truths" about the how healthy and healthful lives are created. The development of a setting approach was, according to Kickbusch (2003), a deliberate move to shift health promotion "from focusing on individual behaviours and communities at risk to developing a strategy that encompasses a total population within a given setting" (p. 385).

Health promotion as it is played out in schools as settings needs to focus on prevention and consider what Antonovsky (1996) calls salutary factors: "factors which are negentropic, actively promote health, rather than just being low on risk factors" (p. 14). These require due attention to the complexity that arises out of human, social, political and environmental interrelationships that are "multivariate, layered, dynamic, and synergistic" (Poland *et al.,* 2000, p. viii). In describing the ways in which the bricolage addresses complexity, Kincheloe (2005a, b) identifies a double ontology. The first is the complexity of objects and the second relates to the ways in which "being" human are constructed.

A complexity of objects requires us to consider the ontological. According to Rogers (2012) this means that "bricoleurs examine how socio-historical dynamics influence and shape an object of inquiry" (p. 10) and therefore research is not only about what it mean to be a HPS but also how the HPS persists and changes over time. Thus the bricoleur explores epistemologically how the HPS is neither a universal experience nor a static one and that any research needs to be sufficiently agile and critical to both capture and enable contextual understanding. Schools are social settings whose work is "carried on in the ordinary play of family and community life" (Dewey, 1902, p. 74) and the separation of school life from family/community is improbable as students navigate between them on a daily basis. It is here that Kincheloe's second complexity on how human "being" is produced not only by the HPS experience but also by the bricoleur. Schools are spaces of situated social practice that builds students' knowledge, experience and capacity for health and well-being – both their own and that of their community (Renwick, 2013). For the bricoleur their work requires attention to and deliberate seeking of those "knowledges that are usually silenced in dominant research narratives" (Rogers, 2012, p. 12) and therefore developing capability to disrupt dominant discourse and knowledge production (Kincheloe, 2005b).

The HPS as a social construct has limitations about what it can be. While underpinned by principles of social justice and equity, it would be easy to extrapolate from the research literature that social justice and equity are not necessarily goals of health interventions. Or that they are readily ameliorated for those with least sociopolitical advantage (and therefore reduced health and well-being) through behaving in ways that those with most socio-political advantage think they should. Accordingly the body of research on health promotion and on HPS specifically since the 1990s indicates that this is complex work, there is a substantial amount of research yet to be done and ways to engage with this field are both static in some sections and evolving in others.

Thick descriptions of the HPS

The predominance of research around interventions in the HPS context adds little to our understandings of why particular "common sense" behaviours are not taken up in sustained ways, yet lifestyle illnesses are mutable and the cost of preventable disease in both economic and social terms is substantial (Daniels, 2008). Interventions in schools that focus on heart disease for instance, will typically convey knowledge about diet and activity for prevention of heart health, behaviour change targets and enact the priorities of health professionals that arise out of their moral panic (McCarthy *et al*., 2009). While heart disease is likely to be a concern as students see adult family members and friends living the consequences, the impact of interventions are limited because of their social deficit perspective and the assumption that "they" just do not get the risks (Hillier, 2006). It is here that the value of striving to understand not only what students know about health but what that knowledge means within their lived

environments takes us to the importance of developing thick descriptions from and through bricolage.

Thick descriptions by necessity, engage with local knowledges to gain understanding about the reciprocal relationship between people and place that impacts on their health and well-being while simultaneously locating the deterministic medical paradigm to the side (Dyck, 1999). Bricoleurs do not work to create distance through objectivity; rather they aim for hermeneutical awareness through thick description about the complexity of social life (Rogers, 2012). They are prompted to both acknowledge and work with the diversity that exists within that setting that is derived from "culture, class, language, discipline, epistemology ad infinitum. Bricoleurs use one dimension of these multiple diversities to explore others, to generate questions previously unimagined" (Kincheloe *et al.,* 2012, p. 23). The diversity that exists within schools by its very nature, demands, a research gaze that neither overlooks nor disregards what teachers, students, families and the wider school community do to accomplish daily living, health and well-being (Bechky, 2006).

Ponterotto (2006) defines thick description as being "observed social action and assigns purpose and intentionality to those action. […] (and) captures the thoughts and feelings of participants as well as the often complex web of relationships among them" (p. 543). Bricoleurs utilise opportunities to consider how health and well being are constructed in each school and local community. The experience of health is not the same in all schools as the experience of social determinates of health such as class, gender and race influence health status but not necessarily as a common "good" (Daniels, 2008). Thick descriptions of the HPS requires consideration of what Geertz (1973) called "thinking concretely" about sociological concepts, using creativity with the intent to elicit comprehensive and interesting theories, in this case about health promotion in schools.

Any account of a HPS, its complexity and specificity is by definition a thick description because it provides what Horlick-Jones and Prades (2009) describe as "situationally-specific insights into the underlying social significance of given actions" (p. 417). The bricoleur working in the HPS does not start with predetermined health behaviour to change and concern for why are not these (students) aware of the risks? Instead there is recognition for how meaning-making is a complex, that it is not about "things" per se but about objects-in-the-world and draws on critical theory (Kincheloe, 2001, 2005a, b, 2006, 2011). Thus socially insightful (Horlick-Jones and Prades, 2009) understandings about health not only consider what, for example, a healthy diet might look like. There is also consideration on what is available in the local food supply (e.g. supermarkets) and how availability varies between areas of different socioeconomic status, or why the same item costs more in an area of low socioeconomic status (Renwick, 2013).

The HPS as interdisciplinary and multidisciplinary work

A social perspective of health recognises how schools, as supportive environments, are places to build capacity for health and well-being including social justice and equity. What understandings there might be about what a HPS is will depend on discipline and context. Thus an image of a HPS for a teacher, student or parent will be different to that of a public health worker or social worker because of their particular ontological positions. Additionally schools are located with variable contexts including the local physical and social geography that also makes its impact on the health and well-being of students and wider school community. The challenge for researching the HPS is to avoid the singular gaze of research through the intervention or

behaviour change that arises out of the social problem/moral panic described by McCarthy *et al*. (2009) and promulgated by a hegemonic positioning of biomedical as health. Kincheloe (2011) argues that bricolage is multidisciplinary research that draws from a range of methods and using various theoretical insights sourced from a variety of disciplines. Thus the bricoleur avoids being parochial because they do not rely on mono-disciplinary approaches to their research but make use of disciplinary, interdisciplinary and multi-disciplinary approaches, and thus are able to "open new windows of research and knowledge production" (p. 388). The bricoleur develops epistemological understanding about their knowledge work (Kincheloe, 2005a), seeking thick descriptions in and of complex settings. Bricoleurs working in the HPS consider the development of health as phenomena that are set relationally within the context and constructed with specific social processes (Newbury, 2011). For example, students who smoke, eat energy-dense food or eschew physical activity do so not because they do not know the risks rather and more likely, because the behavior makes (perverse) sense in their physical and social geographic part of the world.

Taking time to engage in bricolage as multidisciplinary work invariably challenges the bricoleur to consider what epistemological assumptions are "working to shape our construction of the world and subsequently our actions in it" (Kincheloe, 2006, p. 228). The bricoleur does not stand apart from their research HPS, instead they are working to understand the HPS and interpret it (Kinn *et al.,* 2013). The bricoleur as a boundary worker (Kincheloe, 2005a) not only uses what is within their disciplinary "field" they also cross boundaries to find "what isn't there", what was 'missing due to neglect ("I don't see how it is important") or censorship ("This is not what I want to see/hear"). Revealing the muted perspectives of those who have least opportunity to have their lived worlds articulated is inevitable and necessary through bricolage (Kincheloe, 2005a). As the bricoleur borrows, collects, commandeers even poaches ideas from different contexts, and placing them into new contexts different or bespoke considerations emerge that generate innovative and entrepreneurial responses and push known limits of knowledge (Newbury, 2011).

The fundamental principles of social justice and equity underpin the Ottawa Charter (WHO, 1986) and therefore health promotion and the HPS model. Engaging in research for and about the HPS seems to require, indeed demand more than research in the efficacy of pre-determined behaviour change interventions that are "helicoptered" into schools. The expectation that researchers remain cocooned and removed from the findings of their research work is not defensible. Researching the HPS in contexts where social determinates of health are working to undermine health and well-being of students, does not give license to simply document and interpret that part of the world (Denzin and Giardina, 2009). Crossing boundaries and engaging in inter-disciplinary and multidisciplinary research undertaken by the bricoleur is not sufficient in and of itself as they are likely to reveal issues around social justice and equity that need attention and action.

"Health promotion is the process of enabling people to increase control over, and to improve, their health" (WHO, 1986) and requires deliberate action to advocate, enable and mediate Health for All. Health promotion research has an obligation to do much more than continue to document intervention projects and health behaviours in and of themselves as monolithic "truth", instead it is the health promotion researcher's responsibility "to change the world and to change it in ways that resist injustice while celebrating freedom and full, inclusive, participatory, democracy" (Denzin and Giardina, 2009, p. 13, original emphasis). Newbury

(2011) argues that if "the purpose of research is to contribute to concrete changes in the social world" (p. 344) then bricoleurs are better placed than most to be able to provide insights because they invite and draw from multiple perspectives.

Conclusion

Health promotion is about social justice where individuals have strengthened personal skills and capabilities, and there is change to social, environmental and economic conditions to support public and individual health (WHO, 1986). Steinberg (2012) argues that scientific research has been able to offer only a limited view of what it is searching for, yet this approach is the most common used in investigating schools as settings for health promotion. The investigation of settings as bounded contexts has been constrained due to the focus on behaviour change related to a predetermined list of health priorities without sufficient considerations of the lived experienced of those living with the setting.

The complex nature and varied interests inherent within a setting for health promotion and especially in schools, suggests a different approach to research is needed that not only acknowledges different ways of knowing but actually accommodates them. Bricolage is a methodological process that, in context of a social situation, changes and evolves not only while but because of the research activity (Kincheloe *et al.,* 2012). By its very nature it is an epistemology of complexity (Kincheloe, 2005a), both of what is being investigated and how it is undertaken. Not only is difference and diversity assumed within the research context, it is actively sought through the use of multiple methods to not only reveal insights, but also to expand and modify existing principles, while re-examining previously accepted interpretations (Kincheloe, 2001) through deep descriptions. To do this requires an approach of interdisciplinarity where usual disciplinary boundaries are not only crossed but the analytical frames of multiple disciplines are actively utilised. What is more, "the bricolage understands that the frontiers of knowledge work rest in the liminal zones where disciplines collide. Thus, in the deep interdisciplinarity of the bricolage researchers learn to engage in a form of boundary work" (Kincheloe, 2001, p. 689).

The experience of each setting is unique and yet investigating the HPS as a setting is usually done in reductionist ways. In trying to distil the fundamental essence of what it means to experience the HPS this has been encapsulated into checklists (e.g. the Victorian Prevention and Health Promotion Achievement Program, 2012); and externally generated interventions for specific health foci (Dooris, 2004). All of this is despite recognition that schools respond to change in different ways (Guggleberger, 2011; Poland *et al*., 2009). Each setting and HPS in particular benefits less from assumptions about universality and more from an embracing of its unique and idiosyncratic nature arising out of the students, staff and families that make up the school and its community, as well as the specific organisational characteristics. Kincheloe (2011) challenges us to engage as critical pedagogues where the world is considered in new ways through the posing of questions that expose different and diverse levels of reality and to consider how the experience of the lived world is influenced.

Settings are complex circumstances. The complexity arises out of the multifaceted interplay of causal factors that impact on health and well-being, together with the involved nature of social interactions and relationships in circumstances that are often the contrary to what people need in a just society. As suggested at the beginning of this paper the challenge for health promotion and education in schools as a setting, lies within the ways in which health is viewed (the

ontological) and how knowledge is selected and shared (the epistemological). Rather than rely on one method of investigation and understanding (Steinberg, 2012) perhaps it is timely to consider other ontological and epistemological positions and thereby broaden the methodologies used to explore settings generally and HPS specifically.

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