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Healthy, happy and ready to teach, or why kids can't learn from fat teachers: the discursive politics of school reform and teacher health

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The idea of using schools for public health ends has a long and complex history. If anything, interest in the public health role of schools may actually be intensifying, perhaps driven by the attention given to a range of health matters affecting young people, notably mental illness, drugs and alcohol, and obesity. This paper deals predominantly with obesity but emerges out of our ongoing research into both the nature and consequences of policies and interventions that seek to use American public schools to prosecute public health goals. In particular, our focus is on the kinds of school-based interventions that widespread panic about childhood obesity has generated and their consequences for teachers. We take up this matter by examining how American teachers' health – and the associated responsibilities and obligations to inspire health among young people – are discursively constructed in legislation, policy documents, and academic articles. Our review and analysis of these texts reveal the presence of three distinct discursive formations: teachers as health role models, teachers as fiscal liabilities, and teachers as instruments of policy compliance. These formations, we argue, suggest a novel and, in some cases, alarming trajectory in school-based obesity policies and interventions.

Keywords: teachers; school; public policy

Introduction

The idea of using schools for public health ends has a long and complex history. If anything, interest in the public health role of schools may actually be intensifying, perhaps driven by the attention given to a range of health matters affecting young people, notably mental illness, drugs and alcohol, and obesity. This paper deals predominantly with obesity but emerges out of our ongoing research into both the nature and consequences of policies and interventions that seek to use American public schools to prosecute public health goals. In particular, our focus is on the kinds of school-based interventions that widespread panic about childhood obesity has generated and their consequences for teachers.

Schools are regularly described as ideally situated to intervene in childhood obesity (see e.g. Trost 2006). Whether or not these hopes are justified is a complex matter, not least because there are some areas in which schools have been relatively effective (although not unproblematic) sites for public health activity; for example, breakfast and

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lunch programs, immunization clinics, and vision and hearing screening programs. There are grounds, in other words, for considering each area of health intervention on its merits and to chart a course between naïve optimism and outright dismissal. At the same time, we think the examples of teacher-focused policy discussed in this paper suggest a novel and, in some cases, alarming trajectory in school-based obesity policies and interventions.

School health in a neoliberal moment

Much of the recent critical scholarship in the area of health promotion directs attention towards the various techniques and strategies employed to regulate behavior and identities, and the tendency for these techniques to invoke normative control (Cederström 2011, 39). For many authors, these prescriptions are partly attributable to the specific rationality of neoliberal societies (McGillivray 2005; Rich and Evans 2009). In this context, the contemporary vision of a healthy, neoliberal subject/citizen is of one who has the capacity to constantly examine and (re)construct him/herself. Subjects are expected to be 'autonomous, choosing and self-invented,' both willing and obligated to continually work on the self and be responsible for the outcomes of this work (Webb and Quennerstedt 2010, 788).

This kind of responsiblization has a variety of effects. On one hand, it influences the form and function of health interventions deemed appropriate and inappropriate (i.e. what can be done to subjects and/or what should subjects do to themselves). According to Greco (1993, 361), neoliberal logic has inspired new monitoring techniques that 'are no longer geared towards eliciting the truth of an objective environment but a subjective truth' located within individuals. This shift carries important discursive consequences for the embodiment of those targeted by these practices, a point that has been developed in empirical research exploring the ways in which young people understand and negotiate their own health (Burrows and Wright 2004; Evans, Rich, and Holroyd 2004; Wright and Harwood 2009; Evans and Rich 2011). Much of this work suggests that even well-intentioned policies and practices are often predicated on a desire to measure, assess, and compare student bodies. For some youth, these imperatives become 'incredibly difficult to resist' and may encourage self-harm or at least extreme forms of self-discipline (Evans et al. 2008; Rich and Evans 2009, 167).

On the other hand, and at the same time, as students are encouraged to work on themselves in particular ways, teachers are often positioned as important facilitators in this process (Welch and Wright 2011). In the war on obesity, the teacher is increasingly seen as a kind of health evangelist, such that they must simultaneously homilize and embody health, while their appearance, behaviors and values all become supposedly important pedagogical instruments and symbols. To be sure, these developments are not entirely unprecedented. The twentieth century was littered with examples in which the bodies of teachers were the subject of instruction, coercion, and regulation. There were also instances in which teachers were explicitly saddled with the task of inspiring healthy dispositions among students (see e.g. Terman 1913; Chancellor 1919; Bloom 1949). We argue, however, that these enduring concerns are being recast via the distinctly neoliberal rationalities of efficiency and value maximization that pervades schools and contemporary educational policy. This logic has the effect of normalizing the ways 'individuals and institutions think of the body and, in particular, how to make one's self more valuable and productive within a highly competitive and market-driven educational culture' (Pierce 2013, 140). According to Ball (2003, 218), the teaching

profession (and teachers themselves) has been profoundly altered by neoliberal logics that foster new styles of management (that stress quality and excellence) and forms of entrepreneurial control (via marketization and competition). Teachers are depicted and encouraged to think about themselves and their professional performance in calculable ways; as enterprising subjects who 'add value', improve productivity and strive for excellence (Ball 2003, 217).

In the following analysis, we examine how teachers' health – and the associated responsibilities and obligations to inspire health among young people – are discursively constructed in legislation, policy documents, and academic articles. A number of critically minded scholars have studied the impact of public health's war on obesity on students and particularly the role of physical and/or health educators (e.g. Leahy and Harrison 2004; Leahy 2009; Webb and Quennerstedt 2010). Welch and Wright (2011) and Burrows and McCormack (2012) are two exceptions. Welch and Wright examined pre-service teacher's attitudes about health, while Burrows and McCormack's study explored teachers' perceptions of their students' health needs and their school's role in addressing these needs. We think this is important work but seek here to widen the analytical lens to examine the various discursive techniques that incite all teachers, not only those officially charged with the task of shaping youth health, to be 'healthy'.[1]

Method

Drawing on the work of Foucault (1972), Nikolas Rose (1997, 238) argues that at certain historical junctures, 'particular issues or problems are *constructed* in certain ways,' and that it is instructive to explore these constructions to understand the 'systems of injunction, of prescription, proscription and valuation' that shape the creation of subjectivities or subjective experiences (242). Rose suggests we consider not only what language and discourses mean, but also what they do; how they inscribe, create, and destroy new possibilities for doing, thinking, and being. In a similar vein, as with Dean (1995), our interest is in the processes of governmental self-formation whereby teachers are encouraged to know, examine, and act on themselves in order to be professionally effective and morally good (see also Kelly and Colquhoun 2005).

In order to offer a sense of the various ways in which the nature and function of teachers' health is being understood, we selected a range of formal and informal policy documents and scholarly articles that explicitly or implicitly articulate a position on teachers' health, particularly with respect to body weight. Data for this analysis comes from a larger project involving the collection and analysis of school health policy-related documents. A central purpose of our larger project is to better understand the ways in which health and American schools are co-articulated within policy texts. The analysis presented here depicts a cross-section of texts chosen specifically because they implicate the role of teachers. We acknowledge, of course, that the American context is specific and that we should be cautious before generalizing the results of this study to other countries. For example, American school systems are somewhat unusual in that they provide health insurance for many teachers. On the other hand, it is absolutely clear that schools and teachers have been and continue to be folded into the anti-obesity public policy milieu across the world.

The cross-section of texts we present in this paper was constructed with a view to including a diversity of sources. We included documents authored by local, state, and federal agencies. We also analyzed texts representing various agencies and interest groups. We did this to better understand how interrelated texts contribute to the

production of new ideas and practices, and how texts work to scaffold reality in particular ways. Above all, texts were selected for their ability to shed light on the following key questions: how is teacher health problematized? What are teachers told to do or be in order to improve their own health and what reasons are used to justify these exhortations? What techniques are used to measure a teacher's commitment, or lack thereof, to health? What consequences are predicted for teachers (and students) if they are not healthy?

In truth, a very large amount of material exists and a robustly representative or comprehensive sample is beyond the scope of this paper. However, our contention is that this discursive space is characterized by a consistently narrow set of intellectual resources, or what we might call rationalities. Our examination attempted to document the pervasive tendencies within these texts to illustrate the ways in which teachers' health has been conceptualised.

Documents were analyzed by applying the broad principles of discourse (or text) analysis as described by Foucault (1991), MacLure (2003), and Gee (1999). This involved examining how texts enable various modes of being as possible (or impossible) through the constitution of particular socially constructed narratives. With this in mind, texts were analyzed for the surfacing of key words, phrases, and ideas. Specifically, we employed a thematic analysis approach in an effort to identify meaningful categories or themes in the data. We reviewed our collection of texts to determine whether any recurring patterns could be abstracted within and across texts. Once patterns were identified they were thematically organized into various sub-categories. This was an interactive process as we continually worked back and forth between the text and sub-categories to refine them. Sub-categories were collapsed into larger categories where we found repetition and overlap. In the end, three relatively distinct discursive formations emerged from our analysis: teachers as health role models, teachers as fiscal liabilities, and teachers as instruments of policy compliance.

We accept that the process of creating and then merging themes in qualitative research is a somewhat subject process and obviously very much driven by the interests of researchers. For the data presented in this paper, we were certainly not innocent in pushing the analysis in a direction that highlighted the responsibilities of individual teachers. Still, we would argue that taken together they correlate with the three over-riding concerns that appear to dominate almost all policy discussion about obesity, whether in relation to schools or not; human health, financial burden, and the vexed matter of whether and how to regulate.

Teachers as health role models

The idea that healthy teachers produce healthy and successful students is not new. In the relatively recent past, a 1988 *American School Board Journal* article written by influential advocates for school-based wellness programs argued that health messages are 'diminished or increased in effectiveness by the teacher's behaviors … A nonsmoking message will have much more clout coming from a nonsmoker (or a former smoker) than from someone who rushes to the teachers' room to light up as soon as class is over' (Wolford, Wolford, and Allensworth 1988, 38). They go on to assert that unhealthy teachers are simply less effective in the classroom and that healthy teachers conduct 'a better academic program' (40).

However, with anxiety about obesity rapidly intensifying post the year 2000, the voices echoing this point of view have proliferated. According to a report by

Hartline-Grafton et al. (2009) in the *Journal of the American Dietetic Association*, greater attention should be directed towards improving the health of educators 'not only for their own health status but also to improve their effectiveness as role models for their students.' Identifying them as 'key target groups' (1548) for improving the health of children, the authors go on to task teachers with providing students with appropriate health knowledge and values. According to the Alliance for a Healthier Generation (2012, 5), an organization partly founded by the William J. Clinton Foundation, 'School employees interested in their own health are more likely to take an interest in the health of their students; students, in turn, are more likely to engage in health-promoting activities when school staff models such behaviors.' A policy document included in the World Health Organization's (WHO) series on school health recapitulates this point. Within the document teachers are advised to 'encourage students to follow a healthy life by demonstrating healthy eating' (Aldinger and Jones 1998, 22). The document also includes recommendations for additional teacher training so teachers can 'improve their own eating practices and make [students] aware of the behavioral messages they give as role models' (Aldinger and Jones 1998, 20). An article in the *American Journal of Public Health* (Resnicow et al. 1998, 250) argues that 'teachers who place greater value on health … may serve as more effective student role models.' Interestingly, by calling for teachers to value their own health, these sources, and many others that echo this notion, help to construct the somewhat curious and (as far as we are aware) undocumented spectre of a class of teachers uninterested in their own health.

According to a United States Department of Agriculture (United States Department of Agriculture, 2011, 1) document designed for middle school teachers, 'every teacher can help' make children healthier. Educators are encouraged to 'walk the talk' by letting students see them 'making healthy food choices and being active at school' (2). Teachers are told they can do this by building nutrition and physical activity into their curriculum, inviting students to join them for a walk, or organizing a vegetable consumption competition for students. Further, teachers must 'use their influence' as 'students will get the idea that' (1) health is important when teachers actively demonstrate their own commitment to it. For Yaussi (2005, 106, 107), demonstrating commitment to health can also take the form of teachers sharing their 'interests in certain sports or activities' or 'tell(ing) students about their own health goals,' examples of which are participating in an athletic race or losing 10 lb. Engaging with students in this way, it is argued, is beneficial as it, 'assists students to achieve their goals' (106). According to Winter (2009), teachers also need to be watchful about what food they consume when students are present. She writes: 'When teachers eat only healthful meal and snack options in view of children, they provide strong modeling that may influence children to choose more healthful snacks' (285).

This imperative is echoed in the WHO's model charter for a health-promoting school (WHO 2000). Under the heading 'We have a policy on healthy food' schools leaders are encouraged to implement one of four 'action' items including policies to ensure: a) locally grown foods are available; b) 'teachers act as role models by eating healthy food in school;' c) healthy food choices are available at school events; d) they comply with food safety standards. The document leaves readers with the impression that there is a kind of policy equivalency between efforts to maintain adequate food sanitation and ensuring teachers consume healthy foods in front of students.

As these examples illustrate, a good teacher is taken to be one who embraces healthy values and dispositions for him or herself and, perhaps just as important, displays this commitment in performative ways.

The inverse is also assumed to be true. According to the Directors of Health Promotion and Education (DHPE), a Washington DC-based policy group, teachers who 'lack good health' are unable to serve as 'healthy role models for their students' (2007, 22). Likewise, a study examining the dietary patterns of school employees noted that, 'Elementary school personnel educate students on healthful eating in the classroom and school cafeteria, and serve as role models. Yet, in this locality, they have high rates of overweight and obesity and consume too much fat and too little fiber' (Hartline-Grafton et al. 2009, 1554).

The public health role of teachers is regularly presented as a matter of acute urgency. Walker (2011, 43), for example, warns that teachers must act quickly and decisively in order to take advantage of their 'window of opportunity to effect change on health outcomes and divert the pathogenesis of disease'. By 'disease' Walker is referring here to obesity among children. This is an interesting case of what we might call the contagion of urgency. While most readers will be familiar enough with the apocalyptic tone that pervades the field of public health's engagement with the 'obesity epidemic', much of the literature we describe in this paper appears simply to have absorbed this sense of panic. Rather than a robust assessment of the evidence for and against, advocates have instead relied on a discourse of impending crisis to justify their recommendations for schools and teachers.

As well as influencing student health, teacher health has increasingly been linked to academic achievement. According to the Connecticut State Department of Education (2007), 'healthy, engaged teachers and staff are essential supports for student learning.' Likewise, the DHPE argues that the health of school employees has the potential to 'improve or diminish students' learning' (2007, 1). Writing for *School Business Affairs*, Herbert and Lohrmann (2011, 18) warn that frequent absences caused by ill-health 'can have a negative effect on student learning, especially among low-income students, due to the lack of continuity.' They also argue that teacher 'presenteeism' – or going to work while one is sick (18) – is just as detrimental as absenteeism. Presenteeism is specifically a problem for 'teachers who are sick, overweight or lead sedentary lifestyles' as these teachers 'do not have the energy to give students the attention or motivation they need to learn' (19). Unhealthy teachers are also said to affect students' academic achievement in circuitous ways. In their document *Fit, Healthy and Ready to Learn,* The National Association of State Boards of Education (Bogden, Brizius and Walker 2011) argues that it is critical for educators to support academic success among students by encouraging students to adopt healthy lifestyles. In other words, academic achievement is best achieved when teachers themselves are healthy and when they can inspire health among children. This is a causal pathway of events that enjoys no empirical support that we are aware of.

Another interesting aspect of a teachers' health obligation is the assumption that health imperatives can and should be seamlessly woven into every academic domain. According to the White House Task Force on Childhood Obesity (2010, 44–45), more policy effort needs to be aimed at encouraging teachers to 'explore interdisciplinary approaches to incorporate healthy eating in the school curriculum.' The report suggests that history lessons may 'have a subject related to healthy diets, math may include how to calculate the needed caloric intake [and] foreign languages may have students design a menu'. These federal recommendations are echoed by Steele (2011, 73–74) who claims that:

> Teachers could suggest that students select topics on fitness when assigning a research paper in an English class, thereby incorporating related ideas while accomplishing the composition goals and objectives. Mathematics examples might include heartbeat monitoring for problem-solving tasks. Integrating lessons on anatomy and physiology related to exercise and nutrition in appropriate science courses can be used to focus on fitness topics. Teachers might clarify the economic impact and public health improvements when individuals and groups increase their fitness and health efforts in a related social studies lesson.

In fact, one of the most striking aspects of contemporary school health discourse is the way it imagines itself logically infiltrating nearly every aspect of school life and, therefore, affecting all teachers (see also Wechsler et al. 2004; Yaussi 2005; Winter 2009; Walker 2011). In addition to teaching about health-related issues, all teachers are encouraged to help students be physically active by providing them with opportunities to move their bodies throughout the day. According to the National Association of Sport and Physical Education (NASPE) (n.d.), all teachers 'have the potential to influence children's healthy behaviors and lifetime choices.' They can do so by 'including bouts of physical activity into the total learning experience, and in turn, maximize student learning during academic activities that are mostly sedentary' (1). Physical activity breaks are not only assumed to enhance achievement, they are advocated as a way for teachers to address childhood obesity. According to a recent CDC (2011) report 'teachers might read a book aloud while students walk at a moderate pace around the room.' The report goes on to suggest 'such activities contribute to accumulated physical activity during the school day. Physical activity within the regular classroom also can enhance on-task classroom behavior of students and establish a school environment that promotes regular physical activity' (32). Likewise, Moll (2013), author of Washington state's school health policy toolkit, instructs teachers on how to play 'mathercise:'

> Teams of students collect one popsicle stick for every lap they run around the perimeter of the playground during their daily 10 min running activity break. When the laps and popsicle sticks for the teams are tallied up and averaged in the classroom afterwards, a math lesson is incorporated in the exercise break.

Taking the idea of a school that inserts health messages at every possible opportunity one step further, Herbert and Lohrmann (2011, 18) suggest that students acquire health messages from every adult working in the school:

> Students spend an average of six hours a day in school surrounded by adults whose actions can influence them profoundly. All school employees, from bus drivers to food service workers, security officers, and custodians have an impact on children.

Taken together, these examples construct a discursive environment in which the bodies and behaviors of all adults at all times are, whether they like it or not, determining the academic and health futures of school students. There is seemingly no escaping one's duty to be healthy and inspire health among children. In this scenario, 'healthy' adults 'create' healthy students either by displaying their health or through integrating health-related initiatives into classroom instruction. In either case, there is the clear sense that students are assumed to have little or no agency in developing their understandings about health and that the transmission of health knowledge and healthy lifestyles by teachers is both a moral obligation and a simple, automatic, and continuous enterprise.

Teachers as fiscal liabilities

Concern with the health of American teachers is regularly articulated as a part of broader anxieties about school district finances. Employee ill health is said to contribute to rising health care and insurance expenditures, negatively influence worker productivity, and increase absenteeism (Mills et al. 2007). In response, workplace wellness programs are frequently advocated as prudent fiscal investments that will help school employees better manage their health and, in turn, help their district avoid the financial consequences incurred by employee ill health (Aldana et al. 2005). According to the results of a survey of officials responsible for monitoring the finances of American public schools, the costs of employee health care average nearly 10% of a district's total expenditures and hinder its ability to provide academic services for students (ASBO 2005). While policies and programs to address employee health vary in range and scope (i.e. level of coordination, sites of intervention, whether they are voluntary or mandatory), most place emphasis on encouraging health through the modification of lifestyle-related behaviours. O'Donnell (2002), for example, makes the dubiously precise claim that individual health care costs are lowered by $153 for every decrease in the number of personal health risk factors and rise $350 with every increase.

In an effort to save money and help employees better 'manage' their health, advocacy groups encourage school districts to implement lifestyle interventions that address issues such as weight, tobacco and drug use, physical activity, and stress (DHPE 2007; Alliance for a Healthier Generation 2012). Some districts intervene in even more specific ways. A notable example is the Washoe County School District's (WCSD) employee wellness program in Nevada. Created in 2001, the initiative encouraged employees to brush and floss their teeth, eat less during holidays, drink water, reduce TV time, get enough sleep, exercise, practice abstinence 'where appropriate' and wear a seatbelt. In documents aimed at increasing participation, employees are told that the district's current financial crisis is 'directly related to lifestyle and irresponsible health behaviors' (Hardy n.d.). Employees are provided various financial incentives to adopt more healthy behaviors. For example, if employees have annual physical examinations and submit the results of their health screenings they are eligible for a $40 reduction in their monthly health insurance costs. The district also runs various seasonally themed wellness programs, such as spring gardening contests and weight loss incentives around the winter holidays. Participation in these activities is encouraged through prizes, small enrollment 'gifts' (e.g. water bottles, gym towels), payment for success (e.g. $10 per pound lost), and other incentives (e.g. gym memberships).

In New York's Utica, school district employees participating in the 'Maintain, Don't Gain Holiday Weight Challenge' are required to have the same weight on January 4th as they did on November 23rd (the Thanksgiving and Christmas period). On the promotional material describing the challenge, employees are shown a picture of two gingerbread cookies. One is lean and happy while the other is fat and sad. To avoid the fat and sad cookie's fate and be eligible for prizes and gift certificates, employees must perform a minimum number of 'health activities' and either maintain or decrease their weight during the challenge's duration (Utica Education Association Staywell Committee 2009). These are just two notable examples, but organizations such as the DHPE and Alliance for a Healthier Generation feature programs like the WCSD and Utica initiatives in their publications and websites which may add to the proliferation of such programs.

The use of financial incentives to promote employee behavior change does have its critics. The American Heart Association, American Cancer Society, American Diabetes Association and the American Heart Association (2009, 1) recently issued a joint policy brief arguing that the evidence in support of incentivized behavior change programs is lacking and that the 'risk that these plans could be used to discriminate against persons who are less healthy than their counterparts is not insignificant.' Their views, however, seem to carry little weight with school districts. A recent article in the *New York Times* suggests that the use of incentives to encourage employee health is a growing trend and increasingly, 'employers are taking the programs a step further, by penalizing employees who do not make healthy choices and linking incentives to measurable results' (Thomas 2013).

Whether or not school-based employee wellness programs do or do not result in significant fiscal dividends for school districts is a complex matter. What interests us here, rather, is the way teachers are positioned as responsible – and therefore potentially irresponsible – for their school district's financial predicament. At the very least, these initiatives send mixed signals about whether the health and happiness of teachers or district finances are the primary motivating concern. What seems less debatable though is that these programs are informed by a number of key assumptions: that one's health can and should be managed by the individual; that districts can and should attempt to shape teachers' health behaviour as well as their subjective feelings and attitudes towards their own health; and that teachers' health decisions directly and substantially determine the fiscal stability of school districts. Alongside the ideas discussed in the previous section, what emerges is a discursive environment in which teachers are constructed as responsible for a huge and diverse range of educational, medical, and economic outcomes. Under these conditions, the professional and personal autonomy of teachers are now a fair game for a torrent of advice, instruction, coercion, and regulation, much of it insulting, trivial and of dubious merit.

Teachers as instruments of policy compliance

In this section, we consider the passage of the 2004 Local Wellness Policy (Section 204 of Public Law 108–265) and its subsequent amendment, the Healthy, Hunger-Free Kids Act of 2010 (Section 204 of Public Law 111–296). The impetus for the 2004 Act was a failed federal attempt to restore the United States Department of Agricultures (USDA's) regulatory authority over food sold in schools. According to Haskins (2005, 17):

> Democrats wanted to exert federal control over vending machines by giving the Secretary of Agriculture authority over all food available in schools rather than just school lunch and breakfast. Giving such authority to the Secretary was expected to result in the removal, alteration in content, or restriction of operating hours for vending machines … Republicans wanted local authorities to figure out their own solutions.

In the end, Congress chose not to exert its federal authority over vending machines and instead required all local school entities to establish 'wellness policies'. Specifically, each Local Educational Agency (LEA) was instructed to form a Wellness Council whose task was to develop a wellness policy for all schools under its jurisdiction. Wellness policies needed to address a wide range of health matters, including nutrition education and promotion, food sold at schools, physical education, and school-based activities to promote wellness. LEAs were also mandated to measure the implementation of their policies and disseminate the results of this evaluation to the public. This assessment needed to include the extent to which schools within each LEA were in

compliance with their wellness policy, the extent to which the LEA's policy compared to 'model' federal policies and any progress made in attaining the goals of their policy. The legislation also charged a local representative (LEA representative or school official) with ensuring compliance. LEAs demonstrating what the legislation deemed 'outstanding' or a 'substantial improvement' are eligible for grant money that can be used to further develop their wellness activities.

On paper – and perhaps somewhat ironically given the legislation's origins in a desire to avoid unpopular federal action – this legislation has the *potential* to significantly expand the reach and scope of federal efforts to combat obesity in schools. For example, one strategy involves connecting LEA's legislative compliance with their school meal program reimbursements. In other words, schools were told that if they did not adhere to the legislation, they risked losing federal funding for their breakfast and lunch programs. Tying the legislation to meal funding potentially accomplishes two interrelated goals. First, it implicates a large number of schools. According to the USDA (2012) more than 100, 000 schools and childcare institutions participate in federally assisted meal programs. Second, as most schools are dependent on federal revenue to run their school food programs, the tactic presumably encourages compliance.

Over the past nine years, the legislation has contributed to the creation (or in some cases the expansion) of a large school-based wellness bureaucracy. Multiple layers of governance at both the federal and local level now exist to implement or assist LEAs and schools implement this mandate. At the federal level, multiple federal agencies including the CDC, USDA, Department of Education (DoE), and Department of Health and Human Services, are involved. Representatives from these agencies have established an Interagency Workgroup to assist LEAs with information and technical assistance. At the local level, the Wellness Councils – comprising parents, students, representatives of the school food authority, members of the school board, school administrators, teachers, health professionals, and members of the public – are responsible for policy creation. On the one hand, it is interesting to note that these policies can be developed in the complete absence of any professional expertise in public health intervention. Closer to the concerns of this paper, though, all school employees – even teachers who had no role in its development – are required to implement whatever measures the Wellness Council decides upon, whether they agree with them or not (Patterson 2011, Project PA 2006).

Teachers, for example, are told to ban, encourage and/or monitor the consumption of certain foods; address issues of nutrition and wellness across the curriculum; and provide regular opportunity for physical activity (see e.g. CDC 2011; Patterson 2011; White House Task Force on Childhood Obesity 2010; Bogden, Brizius, and Walker 2012). Teachers are further required to document these activities in an effort to assist their schools demonstrate wellness policy compliance (Project PA 2006).

At the same time, it is widely acknowledged that the capacity of teachers to fulfill responsibilities associated with school wellness policies is limited. According to the Interagency Workgroup (2011), 'More support is needed from school and district personnel, including teachers, principals, and superintendents, to implement and enforce' wellness policies. Snelling, Belson and Young's (2012) article for the *Journal of Child Nutrition and Management* concurs, while calling for improvements in teachers' knowledge and practice in order to help schools achieve the goals (i.e. obesity reduction) of the federal legislation. Teachers themselves report that they lack the necessary time, resources, and support to effectively implement wellness policies (Belansky et al. 2009).

The passage and subsequent implementation of the wellness legislation do not lend themselves easily to analysis. On the one hand, the legislation is a straightforward example of federal authorities using schools to avoid conflict with the powerful food and beverage lobby over school vending machines while still wanting to appear to be taking action on childhood obesity. Complicating matters is the already crowded anti-obesity policy environment. Across America, in individual schools, districts and states, myriad obesity-related policies, guidelines and rules have been created (see chapter five of Gard 2011) leaving individual teachers and administrators with a complex and onerous set of compliance challenges.

It is perhaps not surprising then that an emerging research literature suggests that while the majority of American schools have attempted to comply with the wellness legislation, some teachers and administrators remain ignorant of its existence (Dyson et al. 2011). Where policies do exist, wellness policies tend to be weak (Metos and Murtaugh 2011; Metos and Nanney 2007) – in many cases woefully so (Moag-Stahlberg, Howley, and Luscri 2008) – and created in haphazard and problematic ways (Probart et al. 2010). At the same time, we are not aware of any LEA being sanctioned under the legislation for not having a wellness policy or having a sub-standard wellness policy.

The picture that emerges from all this legislative and policy activity is one in which the performance of policy compliance has become the main concern of schools and the teachers whose working lives are impinged upon. There are few signs, if any, that the wellness legislation has unleashed a wave of innovative and effective anti-childhood obesity measures. In fact, the bureaucratic structures created in the wake of the legislation appear now to exist solely for the purpose of helping schools to comply with the legislation, a not insignificant problem given the long list of competing priorities (such as high stakes literacy and numeracy testing) with which public schools must grapple, all in the context of increasingly severe budgetary pressures.

While these developments raise different issues to those discussed in the previous two sections, what all three sections share is the chorus of governmental voices – politicians, academics, lobby groups, policy advocates – that school teachers must be healthy, are responsible for student health and that failure in this area will have negative personal, professional, bureaucratic, medical, educational, economic, and moral consequences. And even if, as it appears, many teachers have simply remained ignorant or resisted it, the very existence of the wellness legislation is emblematic of an all too familiar neo-liberal 'carrot and stick' policy dynamic in which goals and targets are set from above and the personal and professional autonomy of teachers counts for little.

Discussion

In a 2005 article published in *Critical Public Health,* Kelly and Colquhoun examined the ways in which professional educators are being seen, and increasingly seeing themselves as psychologically stressed. In their discussion, they question why the self is so widely imagined in terms of stress and, more specifically, inquire into the 'processes that make it possible … to link the success or otherwise of a massive institutional process of state-regulated schooling to the health and well-being of teachers' (Kelly and Colquhoun 2005, 138). In this paper, we have taken up this line of inquiry and broadened it to consider the processes involved in the construction of the 'healthy' teacher as a necessary instrument of educational effectiveness in American public schools. Our review of documents and policies suggests that this is achieved via the deployment of

imperatives about student health and academic achievement, district finances, and policy compliance.

These three imperatives, particularly as they are discursively linked to institutional effectiveness, have the potential to responsibilize teachers in new ways. Teachers are compelled, for example, to *manage* their health and engage in forms of self-reflection and surveillance. Caring for the self emerges as new kind of professional duty, an ethical responsibility and obligation for 'individual teachers and those that govern the work practices of teachers' (Kelly and Colquhoun 2003, 196). Put another way, teachers are receiving the message that they must look over their shoulders *and* into the mirror in an effort to be a good teacher and good employee.

Stephen Ball's work on the subject of teacher identity and performativity is particularly instructive here. Ball argues that performativity acts as a 'technology, a culture and a mode of regulation that employs judgments, comparisons, and displays as means of incentive, control, attrition, and change based on rewards and sanctions (both material and symbolic)' (Ball 2003, 216). He further suggests that contemporary educational reform mandates have contributed to a (re)casting of teacher identity. Reform imperatives provide teachers with new roles, as they are 'reworked, as producers/providers, educational entrepreneurs and managers and are subject to regular appraisal and review and performance comparison' (Ball 2003, 217). In this new kind of professional work environment, teachers experience a kind of ontological insecurity; unsure whether they are 'doing enough, doing the right thing, doing as much as others, or as well as others, constantly looking to improve, to be better, to be excellent. And yet it is not always very clear what is expected' (Ball 2003, 220).

We argue that contemporary health imperatives hold the potential to contribute to the kind of ontological insecurity Ball describes. Thus, while health imperatives provide teachers with new identities, recommendations and rules for living these identities seem to take little account of the material reality of modern schools, ranging from the vague to the onerous and from the impractical to the trivial and insulting. Moreover, we think it is particularly telling that so much research into school-based anti-obesity initiatives is concerned with measuring whether teachers have the 'right' attitudes and dispositions about health and whether or not schools and teachers are doing what the various commentators in this discursive space are telling them to do, rather than whether there is any prospect of schools and teachers being able make children thinner. In fact, the consistent and well-documented lack of success amongst school-based anti-obesity interventions, even under carefully controlled conditions, is very rarely acknowledged (for reviews see Davidson 2007; Harris et al. 2009; Jaime and Lock 2009).

Conclusion

The phenomena we have described in this paper do not point to clear and decisive conclusions or courses of action. The tendencies to hand intractable social problems to schools and invest unrealistic moral and medical faith in the work of teachers are old, widespread and unlikely to disappear any time soon. At the very least, however, we would make the point that critical voices in the research and scholarship of school health are rare and hugely outnumbered by what amounts to an academic-industrial complex devoted to promoting the public health mission of schools. In some respects, the goals and achievements of this movement are laudable. However, we think there is a need for more scholarship which problematizes the very idea of schools as an instrument of public health policy and, closer to the concerns of this paper, takes an interest

in the experience of teachers within the policy maelstrom that now exists. Not only is so much of what is claimed about the ability and responsibility of teachers to magically infect students with good health fanciful and unfair; the wildly disparate reasons offered for why they should do this suggest a determination not to think carefully about some of the health problems that concern us. In their haste to see schools and the work of teachers as mere instruments in their own professional project, public health workers, advocates, and researchers have failed to recognize the suffocating regimes of neo-liberal accountability, sanction and de-professionalization that teachers are already subject to. At the very least, we would call for more professional and scholarly dialogue between health and education workers about the public health role of schools that begins with the material (economic, logistical) and discursive (political, social) realities of modern schools.

Note

1. It is important to stress that we do not deny that material health problems exist for individuals and collectives and that structural inequalities inform access to and distribution of programs and resources that influence individual health trajectories. Following Kelly and Colquhoun (2003), what interests us here though is the manner in which these health states are articulated, discursively legitimated and regulated. Our ultimate aim is to stimulate thought and discussion about the multiple ways in which teacher subjectivities are implicated in contemporary health injunctions.

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