



How How to  
Schools & Work with  
Work Schools

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A PRIMER FOR  
PROFESSIONALS  
WHO SERVE  
CHILDREN  
AND YOUTH

2003

BY JAMES F. BOGDEN, MPH

NATIONAL ASSOCIATION OF STATE BOARDS OF EDUCATION

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PhD, University of  
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Ginny Ehrlich,  
MPH, Team  
Facilitator,  
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Health Programs  
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of Education

Brenda Z. Greene,  
Director, School  
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Nora Howley, MA,  
CHES, Project  
Director,  
HIV/School Health  
Project, Council  
of Chief State  
School Officers

Frances A. Meyer,  
PhD, CHES,  
Comprehensive  
School Health  
Specialist,  
Virginia State  
Department of  
Education

Howard Taras, MD,  
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School Health and  
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# Introduction



This primer is a guide for those who want the education, health, and social services sectors to work more closely together at the local and state levels to improve the health and well being of young people.

It aims to bridge professional cultures and languages and help practitioners find their way through the complex education system. The guide describes how the education system works, how to identify leverage points for action, how to build positive working relationships with

educators, and how to overcome challenges of working together on common goals.

### School and community professionals working together for children, youth, and families

People increasingly recognize that health and education are intertwined; education goals cannot be achieved without attention to health, and health goals cannot be achieved without attention to education.

Educators recognize through personal experience that students who have trouble seeing or hearing, lack energy, are troubled or distracted, have chronic illnesses, or use drugs or alcohol often do

### A shared responsibility

“The health and the education of our children are inextricably linked. Children who are sick, hungry, abused, or using drugs, feeling that nobody cares, and who may be distracted by family problems are unlikely to learn well. Schools are also places where foundations for future health behaviors are laid. The promotion of good health for children and youth in the school setting is a shared responsibility of families, schools, and communities.”

—Joint Statement of the New Mexico Secretary of Health and the New Mexico State Superintendent of Public Instruction<sup>2</sup>

not learn as well as healthy children. Yet, millions of young people and their families lack access or cannot afford needed health, mental health, and social services.

Health and social services professionals also know that good education leads to better health and well-being (see box, “More education better health”). The classroom may be the only place many young people receive health information, build essen-

tial personal and social skills, and have positive behavior consistently reinforced. If children and youth are well prepared for adult life, adopt healthy lifestyles, and avoid behaviors that threaten their health, they, their families, and the nation will benefit.

Schools work to enhance all students’ academic success, career skills, and aspirations; however, few schools operate modern school health programs that are well coordinated, high quality, and cost efficient. Educators may not be prepared to teach health education or establish effective school health programs. With

### Health and education joined

“Health and education are joined in fundamental ways with each other and with the destinies of the nation’s children. Good health facilitates children’s growth, development, and optimal learning while education contributes to children’s knowledge about being healthy.”

—Joint Statement of the Vermont Secretary of Human Services and the Vermont Commissioner of Education<sup>1</sup>

## More education = better health

Increasing the high school graduation rate is an official health objective for the nation for the year 2010 (Number 7.1). Following is an excerpt from *Healthy People 2010: Understanding and Improving Health* from the U.S. Department of Health and Human Services:<sup>3</sup>

“In general, population groups that suffer the worst health status also are those that have the highest poverty rates and the least education. Disparities in income and education levels are associated with differences in the occurrence of illness and death, including heart disease, diabetes, obesity, elevated blood lead level, and low birth weight...

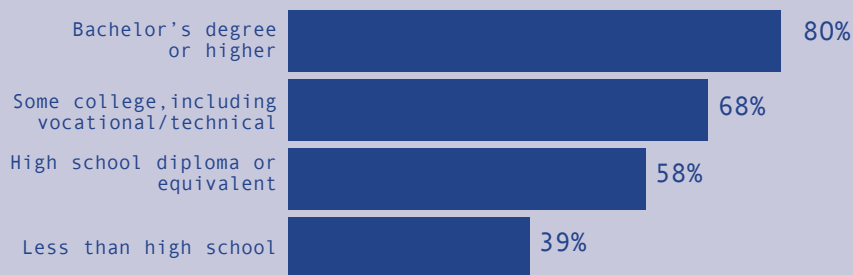
“The average level of education in the U.S. population has increased steadily over the past several decades—an important achievement given that more years of education usually translate into more years of life. For women, the amount of education achieved is a key determinant of the welfare and survival of their children. Higher levels of education also may increase the likelihood of obtaining or understanding health-related information needed to develop health-promoting behaviors and beliefs in prevention...

“Among people aged 25 to 64 years in the United States, the overall death rate for those with less than 12 years of education is more than twice that for people with 13 or more years of education. The infant mortality rate is almost double for infants of mothers with less than 12 years of education compared with those with an educational level of 13 or more years.”

6

### Chart 1

Percentage of U.S. population age 25+ who reported being in “excellent” or “very good” health, by educational attainment, 1997



Source: National Center for Education Statistics<sup>4</sup>

appropriate help, schools can enhance student health literacy and health status and improve family, community, and other supports for lifelong success.

Health, social services, and education professionals who work together can better achieve their respective goals. By addressing students' well being and preparation for adult life in a coordinated way, schools and communities can avoid gaps, collaborate on overlapping functions, eliminate duplication of efforts, and enhance everyone's effectiveness. For example, evidence clearly indicates that school-based efforts to prevent tobacco use are most effective when coordinated with community-wide tobacco prevention and cessation programs.<sup>5</sup>

Yet, for numerous reasons the worlds of health, social services, and education typically remain far apart. Specialized professions sometimes use the same terminology to mean different things (e.g., surveillance in health means to track disease, while in education it refers to school building security). People from diverse professional backgrounds routinely make unexamined, conflicting assumptions (e.g., that helping every young person gain optimal lifelong health is a top priority of every education leader). Effective cross-agency collaboration can be hindered by fragmented governance within and across the education, health, and social services sectors; bureaucratic obstacles (e.g., incompatible budgeting, procurement, and contracting procedures); the absence of multiprogram data systems; and other challenges. Intense pressures for improved academic achievement and public misconceptions about the purposes and goals of school health programs (e.g., the distorted view that school health is mainly sex education) can also hinder efforts. Non-education professionals who want to work with schools often end up puzzled and frustrated. Typical questions include:



## Why work with schools?

- Elementary and secondary schools serve children and youth during 13 developmentally critical years. Schools have more influence on the lives of young people than any other social institution except the family, and provide a setting in which friendship networks develop, socialization occurs, and behavioral norms are developed and reinforced.<sup>6</sup>
- Schools can be a valuable setting for prevention and early intervention services—fully 99 percent of young people ages 7–13 are enrolled in school,<sup>7</sup> and students are in direct sustained contact with professionals who, with appropriate preparation and support, can recognize emerging problems.
- More than 60 million students and staff members, about 22 percent of the U.S. population, can be reached through schools. Add family members and no other social institution reaches as many people.
- Schools can be an efficient conduit for assisting families in poverty or those with undocumented immigrant status.
- Schools are located in every community and are focal points of community life.
- Schools have always had a public health role—health education, physical education, basic health services, attention to safety and sanitation, and food service programs have long been part of the school experience.
- Connections exist between students' immediate health status and academic performance.<sup>8</sup>
- Leading causes of mortality and morbidity among all age groups are related to categories of behavior that are often established during youth, extend into adulthood, and are frequently interrelated. These include behaviors that contribute to unintentional injuries and violence, tobacco use, alcohol and other drug use, sexual behaviors that contribute to unintended pregnancy and STDs including HIV infection, unhealthy dietary choices, and physical inactivity.<sup>9</sup>
- Public health problems associated with obesity among young people are a major economic burden and jeopardize individual health.<sup>10</sup>
- Research shows that well-designed, well-implemented school health programs can indeed promote healthy behaviors.<sup>11</sup>
- School-aged children and youth are often underserved. For example, *Mental Health: A Report of the Surgeon General* stated in 1999 that 20 percent of children and adolescents experience signs and symptoms of a mental health or addictive disorder during the course of a year, and that 70 percent of young people who need treatment do not receive mental health services.<sup>12</sup>

- How does the education system work?
- Who is in charge of what?
- How are services paid for?
- How does a community professional work with a school or district?
- Why doesn't everyone welcome me with open arms and cooperate fully?
- Why are school health topics so frequently controversial?

This primer aims to answer these questions and, by doing so, help school and community professionals work together for mutual benefit and for the benefit of children, youth, and their families.

## The coordinated school health program model—A framework for collaboration

The Division of Adolescent and School Health (DASH) within the Centers for Disease Control and Prevention (CDC), along with many experts in the field of school health, promote a modern coordinated school health program (CSHP) model of education, strategies, and services. The model provides a framework for community professionals to collaborate with schools in ways that support each others' work (see box on next

page; additional models are discussed on page 38).

What distinguishes the CSHP model is *coordination* and *consistency of approach* across all activities so each component supports and reinforces the other. For example, school staff members who participate in an employee wellness program are more likely to be enthusiastic about the value of good health, an attitude that can motivate many students. School food service meals and other foods and beverages available at school ought to complement—or at least not undermine—what students learn about nutrition. The school environment should encourage the enjoyment and practice of daily physical activity. Because a growing number of

schools are implementing the CSHP model in some form, non-education professionals might consider how their expertise can work with the model.

## The Core Mission of Education

It may seem evident that high-quality school health programs help students learn better, yet some education policy-makers, educators, and leaders do not recognize the necessity of school health programs. A community professional trying to strengthen the school health program is more likely to meet with passive non-cooperation than a clearly stated rejection. Non-education professionals offering

### Benefiting from reduced health care costs

“It is true that healthy children make better students. It is also true that healthy students are less expensive to the health [care] system and that they also make healthier adults. School budgets are typically saddled with the largest portion of costs to provide school health [services] programs that improve student health. Yet, it is the public health system and the private health systems that enjoy the benefits of successful school health endeavors, even if some of those benefits may not be enjoyed for years to come. Public health and private health systems can and should step up to the plate more often and accept some of this responsibility—both fiscally and otherwise.”

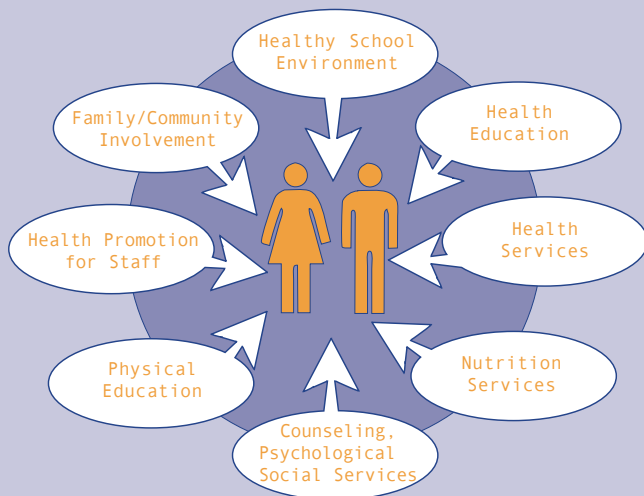
—Dr. Howard Taras, *American Academy of Pediatrics Committee on School Health*<sup>13</sup>



## The eight-component coordinated school health program model

The Making Health Academic website of the Education Development Center (EDC) at [www2.edc.org/MakingHealthAcademic](http://www2.edc.org/MakingHealthAcademic) offers the following definition of the CSHP model:

Health is not just the absence of disease—it is complete physical, mental, and social well being. A school health program that effectively addresses students' health, and thus improves their ability to learn, consists of many different components. Each component makes a unique contribution while also complementing the others, ultimately creating a whole that is more than just the sum of its parts.



The CSHP model has eight components:

- *Healthy school environment:* The physical, emotional, and social climate of the school, designed to provide both a safe physical plant and a healthy and a supportive environment that fosters learning and promotes healthy behavior.
- *Comprehensive school health education:* Classroom instruction that addresses the physical, mental, emotional, and social dimensions of health; promotes knowledge, positive attitudes, and skills; and is tailored to each age/developmental level. The education program is designed to motivate and help students maintain and improve their health and reduce risk behaviors.
- *School health services:* Preventive services, education, emergency care, referral, and management of acute and chronic health conditions. The services are designed to promote the health of students, identify and prevent health problems and injuries, and ensure appropriate care.
- *School nutrition services:* Integration of nutritious, affordable, and appealing meals; nutrition education; and an environment that promotes healthy eating habits for all children, designed to maximize each child's education and health potential for a lifetime.
- *Counseling, psychological, and social services:* Activities that address the cognitive, emotional, behavioral, and social needs of individuals, groups, and families. The services are designed to prevent and address problems, facilitate positive learning and healthy behavior, and enhance healthy development.
- *Physical education:* Planned, sequential instruction that promotes lifelong physical activity, designed to develop basic movement skills, sports skills, and physical fitness, as well as to enhance mental, social, and emotional abilities.
- *Health promotion for school personnel:* Assessment, education, and fitness activities for school faculty and staff, designed to maintain and improve the health and well-being of school staff who serve as role models for students.
- *Family and community involvement in school health:* Partnerships among schools, families, community groups, and individuals, designed to maximize resources and expertise in addressing the healthy development of children, youth, and their families.

Leadership, partnership, and coordination are the glue that holds the pieces together to form a coherent whole. Because individuals, institutions, needs, and resources differ from across communities, no two CSHPs are expected to be identical. In each new setting, a unique group of people and agencies will determine the needs facing young people in their schools and build on existing resources to support positive youth development.

## The school mission

The overwhelming concern of all educators is to ensure that every student demonstrates good performance to challenging academic standards. Community professionals who understand this core mission are more likely to forge productive working relationships with schools.

to help school might encounter a lack of enthusiasm for several reasons:

- Some might think that school health programs duplicate community services.
- Some education administrators might perceive health- and social health-related programs as expensive or as long-term commitments, even if financial help is initially available.
- School leaders tend to be wary of controversy. Because most schools depend on voters' willingness to provide adequate financial resources, school boards and administrators want to avoid alienating influential constituencies and media-savvy interest groups. (Despite the occasional conflict that draws media attention, however, public support for school health programs is strong whenever it is credibly measured. Direct opposition is relatively rare.<sup>14</sup>)
- School staff members might have learned from experience to be suspicious of short-lived school improvement programs that administrators eagerly push one year and abandon the next. As Ronald Brandt, former Executive Editor of *Educational Leadership*, has noted, "The road to educational reform is strewn with the wrecks of many bandwagons."<sup>15</sup>
- Perhaps the most common reason for education leaders' reluctance to embrace school health is the belief that school health program goals are desirable, but not a school's job. Many are concerned about diverting time and resources from academic learning. Community members who consider health and social goals extraneous to the education mission might oppose burdening schools with health-related programs.

Before approaching any school leader, it is critical to recognize that the overwhelming concern of all educators is to

ensure that every student can perform to challenging academic standards. For two decades prominent political leaders have been harshly criticizing the public education system for widespread failure, even though public schools' educational deficiencies are often exaggerated.<sup>16</sup> Some fear that influential groups are determined to discredit and ultimately dismantle the public education system.

With the recent passage of the No Child Left Behind Act, the federal government requires states and school to increase academic achievement for all students; eliminate achievement gaps among racial, ethnic, and income groups; and rapidly improve—or close—every persistently failing school. Beleaguered education leaders have accepted the need for schools to demonstrate greater accountability for results. Every state is at some stage of implementing standards-based education reform, which primarily involves:

- Adopting academic-content and student-performance standards that clearly state what students should know and be able to do.
- Developing challenging assessments aligned with the standards.

- Creating reporting and accountability systems designed to pinpoint failures and spur higher performance from students, teachers, and schools.
- Guiding the recruitment, preparation, placement, and ongoing support of a higher-quality workforce.

In the current climate, education leaders will not permit health and social goals to divert or distract schools from the core mission of education and the ambitious agenda of standards-based reform. Instead, every initiative addressing non-academic goals needs to be cast in terms of supporting the education mission. For example, the Richard David Kann Melanoma Foundation of West Palm Beach, FL worked with the School District of Palm Beach County to implement the SunSmart America curriculum. They did this by delineating for teachers exactly which Sunshine State Standards in science, language arts, and health could be satisfied by using skin-cancer prevention lessons.<sup>17</sup>

The education system's emphasis on academic performance presents an opportunity and a challenge. Community profes-

sionals can help education leaders understand that health- and family-related issues hold too many students back from high academic achievement and that a substantial number of students need help if all are to meet challenging education standards. From this perspective, community professionals should support extensive assessment, reporting, and accountability reforms because these measures will help document and pinpoint barriers to student learning.

School health programs have been perceived as supplementary to a school's core functions—a nice option when money is available but first on the chopping block when budgets are tight. The alternative view is that components of a modern school health program are vital academic and support activities that strengthen student performance and help reduce barriers to student learning. Even if the education accountability system does not hold schools directly responsible for such outcomes, supporters of school health programs argue that it is essential to provide students with programs that support their physical, mental, and social growth.

### Rising to the challenge

“School systems are not responsible for meeting every need of their students. But when the need directly affects learning, the school must meet the challenge.”

—Carnegie Council Task Force on the Education of Young Adolescents<sup>18</sup>

### Helpful resource

- “Making the Connection: Health and Student Achievement” is a PowerPoint presentation that summarizes current research and data on the links between students’ health status and academic performance and includes a full bibliography. It was developed by the Society of State Directors of Health, Physical Education and Recreation (SSDHPER, at [www.thesociety.org](http://www.thesociety.org)), and the Association of State and Territorial Health Officials (ASTHO, at [www.astho.org](http://www.astho.org)), and can be ordered from their websites.

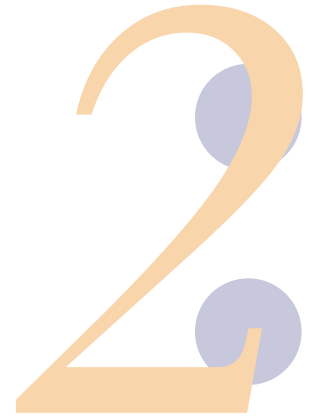
Note: Selected resource organizations are highlighted throughout this guide, though many other organizations also offer high-quality materials and technical assistance. Some of the mentioned organizations maintain hyperlink lists that lead to additional resources.

### Talking points:

#### Why schools need to address health and social goals

- *Schools cannot achieve their primary mission of education if students and staff are not healthy and fit physically, mentally, and socially.*<sup>19</sup> To prepare students to be productive adults, health is “basic to the basics.”
- *To be truly serious about educating all students, it is imperative to take a critical look at the reasons why some do not learn well, then address those problems.* For example, skipping breakfast can adversely affect children’s performance on problem-solving tasks.<sup>20</sup> Studies have long shown that chronically undernourished children earn lower scores on standardized achievement tests, especially tests of language ability. They are often irritable, have difficulty concentrating, have low energy, and are more likely to fall behind in class.<sup>21</sup>
- *Health problems cause poor attendance, and children cannot learn if they are not present in school, alert, and attentive.* For example, chronically undernourished children are more likely than other children to be sick and miss school.<sup>22</sup> In contrast, studies of low-income elementary school students have found that those who participated in the federal School Breakfast Program had reduced rates of absence, tardiness, and psychosocial problems, and greater improvements in standardized test scores and math grades than did children who qualified for the program but did not participate.<sup>23</sup>
- *Schools by themselves cannot, and should not be expected to, address serious health and social problems.* Educators have no choice, however, but to deal with the consequences of students’ illnesses, chronic conditions, crises, and tribulations. As Michael Usdan of the Institute for Educational Leadership has said, “Schools are where the kids are and they bring their problems with them.”<sup>24</sup>
- *Problem behaviors that interfere with learning include poor conduct and attitudes, alcohol and drug use, early sexual activity, delinquency, and violence.*<sup>25</sup>
- *Infusing health topics into the general education–reform agenda does not dilute that agenda, as some suggest, but helps ensure its success.* For example, today’s state-of-the-art health education reinforces important academic skills.<sup>26</sup>

# How Schools Work



The U.S. elementary and secondary education system (i.e., kindergarten through grade 12) is a massive enterprise, spending some \$389 billion in 2000 and employing more than 7.6 million people.<sup>27</sup>

Nearly all school-aged children and youth are enrolled in more than 91,000 public and 27,400 private elementary and secondary schools. This section is a brief guide to the many institutions and people who make major decisions in the complex K–12

## America's great hope and great duty

“Public schools are some of the most important institutions of democracy. They take children of every background, from every part of the world, and prepare them for the obligations and opportunities of a free society. Public schools are America’s great hope, and making them work for every child is America’s great duty.”

—U.S. President George W. Bush<sup>28</sup>

education sector. All are potential points of access for community professionals who wish to work with schools.

**Private schools**, which enroll about 12 percent of children in grades K–8 and 8 percent of high school students, and **home schools**, which account for about 1.7 percent of total enrollment, generally operate with minimal government influence or control. The degree of public oversight depends on the state.

Some 78 percent of private schools are affiliated with religious organizations; the rest are nonsectarian. Volunteer boards of trustees who might be prominent community members or school alumni usually set policies for individual private schools or groups of schools. Community professionals who wish to work with private school populations can usually deal directly with school building principals, or sometimes with regional offices (e.g., Catholic dioceses).

In contrast, governance of **public schools**, which enroll 86 percent of students in grades K–8 and 90 percent in grades 9–12, is much more complex (Chart 2). Determining precisely who has decision-making authority over

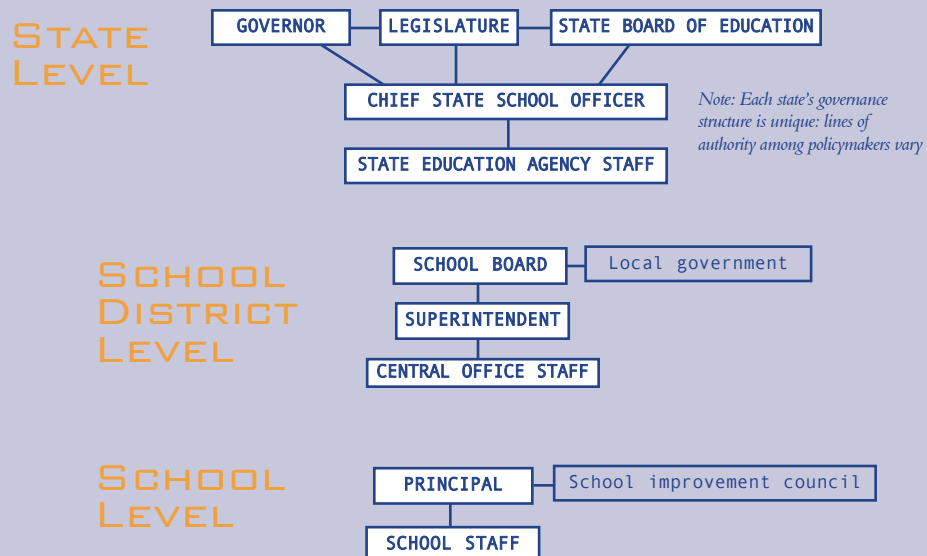
specific facilities, programs, and issues can be a challenge because the public education system is a shared duty of local, state, and federal governments, and has multiple participants, agencies, and organizations (and numerous acronyms) at each level.

Constitutionally, state governments are primarily responsible for public education and local

school districts, and schools are technically agents of the state. The federal government offers national leadership and enforces civil rights laws, but provides only limited program funding. As summarized by former Secretary of Education Richard Riley, “Public education is a state responsibility, a local function, and a federal priority.”<sup>29</sup>

Chart 2

## The public education governance structure, simplified



In practice, this means that schools must operate according to several layers of rules, regulations, and laws, as well as meet expectations of parents, families, and community members. The result is a confusing structural and political web that can be intimidating for educators—and even more so for community professionals—to negotiate. Yet, with a little patience and guidance non-educators can find effective leverage points. Each level of the education system is described below in turn: school, school district, state, and national.

## The school—Helping students grow and learn

No single national model exists for a school’s organization by student grade or age. Perhaps the most common model consists of **elementary schools** that serve students from kindergarten through grade 5 (generally ages 4–11), **middle schools** that serve students in grades 6–8 (ages 11–14), and **high schools** that serve students in grades 9–12 (ages 14–18). In another common model, elementary schools serve grades K–6, **junior high schools** serve grades 7–9, and high schools serve grades 10–12.

Most districts have **alternative schools** for students who for various reasons do not thrive in the regular school environment. Many, but not all, are for students with behavioral or serious academic problems.

Many districts support **magnet schools** that offer specialized courses of study in such areas as technology, the performing arts, or

## How public schools are funded

Traditionally, most funds for K–12 public schools are raised through local taxes on private property. Few people realize that state funds account for less than half the total, and that federal funds account for only about 7 percent of the money spent nationwide.<sup>30</sup>

Although a local property tax is a fairly stable source of funding, disparities in local wealth often directly affect the funds available to schools. Even if voters choose to tax themselves at relatively high rates, low community property values can mean inadequate resources for schools. Legal challenges to the traditional finance system on grounds of assuring funding equity and adequacy for public schools have led some states to smooth out such differences by redistributing locally raised taxes.

States are also accepting a growing share of the financial burden to improve equity and adequacy. On average, states accounted for 49 percent of revenues for elementary and secondary schools in the 1998–99 school year, ranging from 9 percent in New Hampshire to 88 percent in Hawaii.<sup>31</sup> Though more equitably distributed, state funds typically rely on the yield from sales taxes, income taxes, and corporate taxes, sources that vary with the health of the economy and thus are more vulnerable to unpredictable budget shortfalls.

Although schools in many large cities might appear relatively well funded, gross per-pupil expenditure figures tend to understate the higher costs of operating in urban environments and the greater needs of many inner-city students for non-instructional support services. When these costs are accounted for, many inner-city schools are actually underfunded, as evidenced by the challenge of recruiting and retaining highly qualified and motivated staff, and by the poor physical condition of many urban school buildings. A recent analysis of education finance data by the Education Trust documented that, in most states, school districts that educate the greatest number of poor and minority students have less state and local money to spend—an average of \$966 less per student—than do districts with the fewest poor and minority students.<sup>32</sup>

There is a spirited debate among educators and policymakers about the relationship of school funding to student academic performance.<sup>33</sup> The Education Trust argues that adequate funding does make a difference:<sup>34</sup>

“Many argue that fiscal inequities of this sort won’t matter, because the effects of poverty and family background overwhelm anything that schools can do. But our experience and a growing body of research teach us that all children can achieve at high levels when the right combination of tools and strategies are employed. These include: high expectations and clear standards that are applied to all students, rigorous curricula, well prepared teachers supported with high quality professional development, additional instructional time for students who aren’t meeting standards, and more focused resources. And yes, these things cost money.”

even health sciences. Magnet schools are often established as a strategy to better integrate a school district's various populations.

**Charter schools** (also called **community schools**) are a hybrid of public and private schools. They operate with public money but have considerable autonomy. They usually have their own governing bodies and have great latitude in adopting their own policies, curriculum, and programs. They must still conform, however, to certain specified state requirements, health and safety standards, and federal civil rights laws. In some places charter schools report to the local school district or a state-level agency, in others to an authorized sponsoring organization such as a university.

Schools, even those in the same school district, vary greatly in quality and character. The most effective schools have strong administrative leadership, a climate conducive to learning, school-wide emphasis on instruction, high teacher expectations for student achievement, active parent/family involvement, and a commitment to addressing barriers to student learning.

At each school the most important decision maker is the **principal**. This person supervises the school's instructional program; maintains order and disci-

pline; enforces federal, state, and district rules, policies, and laws; evaluates teachers; and represents the school to parents and the community. Some schools have one or more assistant principals.

Principals are key gatekeepers. They can wholeheartedly promote school health programs, passively allow them, or actively undermine them. A principal with vision who exercises effective leadership can inspire and guide the school staff to achieve broad objectives for students' healthy growth and well being. Conversely, a weak principal or one opposed to an expanded mission for schools can be a serious obstacle. Regardless, it is important that the principal stays fully informed of everything that happens in the school. Typically, this is done by the school staff members a community professional is collaborating with. Time-tested advice: consult early and consult often.

In some school districts, individual schools may have considerable autonomy and be managed with significant input from key decision makers on **school-improvement** or **site-based management** teams. The required composition of such governance teams varies, but they generally include parents, teachers, and perhaps other staff members. Influential community members

might also be included. Any of these people might enthusiastically support improved school health policies and programs.

A school may employ a full- or part-time **school health program coordinator** to facilitate harmonization and consistency among staff working on school health program components, or to help carry out school health-related policies.

Some schools establish **school health councils** to assist the principal with oversight, management, planning, and evaluation of school health programs and policies. Such a council often includes parents and community representatives. It might simply be an advisory body, or it could have some designated authority to enhance program coordination among staff members working in school health program components. The school health council can also serve as the advisory body required by federal programs such as Safe and Drug-Free Schools and Communities. In a recent national study, about half of schools reported having a group that helps develop or coordinate one or more school health program topics.<sup>35</sup> Anecdotal evidence abounds, however, that few schools enjoy the benefits of a strong and active school health council. Offering to help establish a school or district-level health council might be a good first step for a community professional.

**Teachers** and other instructional personnel can play important roles in improving student health even if they are not designated health teachers. They can incorporate health topics into nearly any subject's lesson plan, foster healthy

### Helpful resources on principals

- Find out more about the work and concerns of principals at the websites of the National Association of Elementary School Principals ([www.naesp.org](http://www.naesp.org)) and the National Association of Secondary School Principals ([www.nassp.org](http://www.nassp.org)).



## Helpful resources on school health councils

- The American Cancer Society offers *Improving School Health: A Guide to School Health Councils*. Obtain it through your local chapter, call (800) ACS-2345, or download it from the Texas Division of ACS at <http://208.142.197.5/hkn/pdfs>. Browse the Texas Division's useful "Healthy Schools—Healthy Kids" website, [www.schoolhealth.info](http://www.schoolhealth.info).
- The Iowa Department of Public Health offers an online version of *Promoting Healthy Youth, Schools, and Communities: A Guide to Community-School Health Advisory Councils* at [www.idph.state.ia.us/fch/fam\\_serv/advisory.htm](http://www.idph.state.ia.us/fch/fam_serv/advisory.htm).

classroom and school environments, help identify and refer students who are troubled or ill, and personally model healthy lifestyles by engaging in wellness activities.

The degree to which a teacher fulfills these roles depends on the individual and the institutional context. Teachers are held responsible for classroom instruction according to state and district curricular guidelines, which sometimes do not emphasize health instruction. Few teachers have received professional preparation or continuing education in instructional methods particular to health education (although all certified teachers, particularly at the elementary school level, are well

versed in general theories of child development). School or district leaders might counsel—or even require—teachers to avoid certain controversial topics.<sup>36</sup> And few schools or districts operate work-site wellness programs that encourage staff to maintain good health-promotion habits. Nevertheless, examples abound of dedicated teachers who provide exemplary health education lessons with few resources or support.

At the middle- and secondary-school levels, teachers specialize in one or more subject matter disciplines. Most states offer specialist teaching certificates in health education, physical education, or a combination. Nevertheless, health

education responsibilities at the middle- and high-school levels are often assigned to teachers with minimal or no professional preparation or support in health education (Chart 3, page 18). Many teachers who have not received specialized preparation are uncomfortable dealing with such sensitive topics as human sexuality and mental health. Community professionals can also lend their expertise by helping design or implementation an ongoing professional development program for currently employed health education teachers.

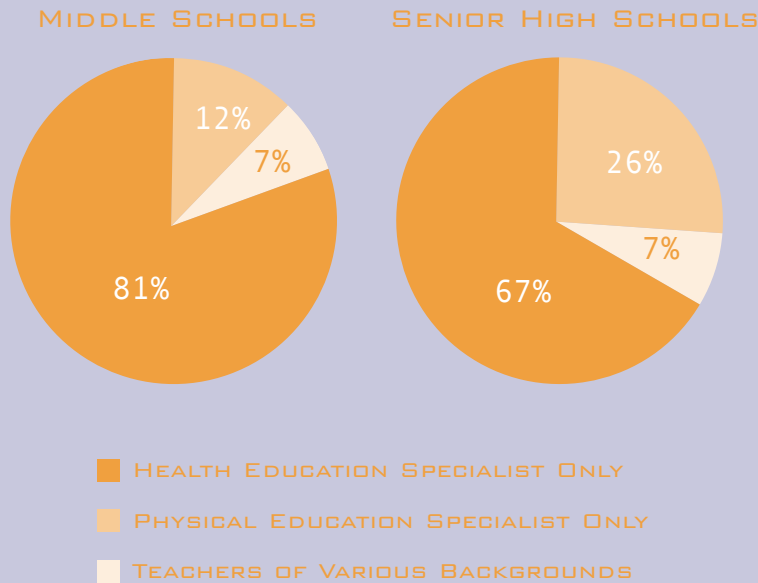
**Resource teachers** are responsible for working with students who require extra attention, such as

## Helpful resources for school staff

- The Health Information Network, a nonprofit health affiliate of the National Education Association (NEA), maintains a regularly updated website of school health information and resources for teachers and other school personnel at [www.neahin.org](http://www.neahin.org).
- The American School Health Association (ASHA) is a multidisciplinary organization of administrators, counselors, dentists, health educators, physical educators, school nurses, and school physicians that offers help and advice on quality school health programs. Go to [www.ashaweb.org](http://www.ashaweb.org).
- The National Middle School Association (NMSA) provides professional development, journals, books, research, and other information geared to the educational and developmental needs of young adolescents; online at [www.nmsa.org](http://www.nmsa.org).

*Chart 3*

In most schools, health education specialists are not the only ones assigned to teach required health education courses



Source: CDC School Health Policies and Programs Study (SHPPS) 2000<sup>37</sup>

typically assigned many critical responsibilities, including:

- Providing first aid and emergency services.
- Monitoring chronic health conditions and health care outcomes.
- Dispensing medication and administering nursing procedures, particularly for students with disabilities or special health-care needs.
- Conducting health screenings and assessing student health status.
- Maintaining confidential health records of students and school staff members.
- Identifying educational difficulties that might have underlying health causes and arranging for referrals.
- Case-managing students with complex health needs, including interacting with physicians and families.
- Helping design special diets and physical education programs for students with special health concerns.
- Providing health education to individual students.
- Conducting direct classroom instruction in the absence of a health teacher.
- Serving as a resource for teachers, curriculum developers, and other school personnel.
- Helping schools and districts develop and implement policies and procedures to prevent the spread of communicable diseases and blood-borne pathogens such as HIV and hepatitis.
- Providing health information and health-promotion activities for staff and family members.

those in special education or bilingual education. These teachers may work with students in self-contained classrooms (serving special-needs children exclusively), in resource settings (requiring special-needs student to leave the classroom to join the resource teacher for a short period of time), or in regular classrooms with a mix of students.

**Paraprofessionals** and **classroom aides** are responsible for assisting the teacher in routine class activities, sometimes working with small groups of students on particular projects or even performing very specialized medical procedures in special-education settings. Aides might be assigned to work in specific classrooms or with specific

subject matter. The number of students they interact with daily is subject to local regulation.

About three-quarters of all schools have access to professionally trained **school nurses**, who can be funded by the education system, public health agencies, local hospitals, or other entities. Some are assigned to one school; many divide their time among multiple schools. As of 2000 only 53 percent of schools had the recommended nurse-to-student ratio of 1:750 or better.<sup>38</sup>

School nurses provide or supervise the management of a range of health services and responsibilities routinely provided on school campuses. They are

- Taking a leadership role in collaborating with community agencies to identify and provide programs that meet the physical and mental health needs of children and families.

Whether school nurses are employed by the school system or a local public health agency, they help bridge the health and education systems, translating policies, legal responsibilities, priorities, perspectives, terminology, and specialized jargon.

A third of schools use part- or full-time **health aides** to help provide student health services. Often, minimally trained and supported school administrative staff members are given some responsibility for keeping health records and administering first aid: 94 percent of school districts allow school faculty and staff to administer prescription drugs to students.<sup>39</sup>

**School health center staff**, who are generally nurse practitioners or physicians' assistants, work in clinics located on school grounds (school based) or nearby (school linked). Such clinics were originally established mainly in middle and high schools, but an

increasing number of elementary schools find them useful for delivering essential primary care services, including diagnostic and treatment services, to children and their families. States may provide some direct funding, but most school health clinics rely on a mix of grant funds from foundations, local hospitals, and health departments. Many also bill Medicaid and private health insurance firms for services provided.

Although only about 7 percent of schools have a school-based health center, 16 percent have a part-time or full-time **school physician** who provides health services to students. In addition, 33 percent report that they have made arrangements with a local health department, local mental health or social services agency, private physician or dentist, local hospital, managed-care organization, or university or medical school to provide student services.<sup>40</sup>

School-based **mental health services** have long focused on students in special education because diagnostic and treatment services are mandated to some extent by the federal Individuals with

Disabilities Education Act (IDEA).<sup>41</sup> In recent years, schools have progressively expanded such **student support services, pupil services, or auxiliary services** (guidance, health, mental health, and social services) to address unmet needs among children and adolescents, and to facilitate healthy growth, development, and educational achievement (Chart 4, page 21). As a recent surgeon general's report observes, "Schools are the primary providers of mental health services for children" and, "offering services in the schools improves treatment access."<sup>42</sup>

**Guidance counselors** are traditionally responsible for providing students with academic support, including class scheduling, assessments, college counseling, and career guidance. Increasingly, they also provide personal and crisis counseling, refer students to needed services, and provide follow-up. Most states require that counselors are licensed or certified and that they have a master's degree in counseling. But because each counselor is typically assigned hundreds of students, there is little time for in-depth student contact.

## Helpful resources on school health services

- The National Association of School Nurses at [www.nasn.org](http://www.nasn.org).
- The Center for Health and Health Care in Schools at [www.healthinschools.org/home.asp](http://www.healthinschools.org/home.asp).
- The National Assembly on School-Based Health Care at [www.nasbhc.org](http://www.nasbhc.org).
- The American Academy of Pediatrics at [www.schoolhealth.org](http://www.schoolhealth.org).
- The American Medical Association's Program on Child and Adolescent Health at [www.ama-assn.org/ama/pub/category/1947.html](http://www.ama-assn.org/ama/pub/category/1947.html).
- The Society for Adolescent Medicine at [www.adolescenthealth.org](http://www.adolescenthealth.org).

Nearly a quarter of schools have no full-time—or even part-time—guidance counselor.<sup>43</sup>

About two-thirds of schools employ part-time or full-time **school psychologists** who are trained in mental health, child development, school organization/administration, learning, behavior, and motivation, and certified or licensed by the state in which services are provided. School psychologists perform duties related to mental and social health prevention, intervention, and education. A key responsibility is assessment of academic skills, learning aptitudes, personality and emotional development, social skills, and eligibility for special education. They are often tasked with establishing collaborative relationships with community-based personnel and families to provide integrated services for psychosocial wellness.

Nearly half (44 percent) of schools employ a part-time or full-time **school social worker**. Working with teams of other school personnel, social workers help children and youth with physical or learning disabilities or emotional problems, or those who face child abuse, neglect, domestic violence, poverty, or other problems. Often the social worker's job

includes interviewing the child and family to determine the appropriate action; facilitating communication between parents and school staff; intervening in problem situations; facilitating school–community relations, and providing a variety of services to students in special education programs.

School pupil services are often underfunded, understaffed, fragmented, poorly coordinated, and marginalized.<sup>44</sup> Simply co-locating community agency services at schools without integrating them into existing school services, however, can cause turf conflicts and exacerbate these shortcomings. Drs. Howard Adelman and Linda Taylor of the University of California, Los Angeles, Center for School Mental Health Services suggest that school leaders, community agencies, and families pool their resources and together plan a comprehensive, multifaceted continuum of interventions designed to address barriers to learning and promote healthy development.<sup>45</sup>

**School food service staff members** include the food service manager and workers. They plan meals, purchase supplies, and prepare and serve meals, guided by U.S. Department of Agriculture regulations and in accordance with

the U.S. Dietary Guidelines for Americans. About one in six schools contract with outside management companies to operate the school food service program.<sup>46</sup>

Virtually all high schools (98 percent in 2000), most middle schools (74 percent), and nearly half of elementary schools (43 percent) have a vending machine or a school store, canteen, or snack bar where students can purchase carbonated beverages and snacks foods such as chips, candy and cookies that have little nutritional value.<sup>47</sup> Typically, these venues are not managed by school food service staff. Revenues often accrue to athletic programs, other student activity programs, or the general school fund. Many educators argue that, in the absence of adequate public funding for education, schools have no choice but to rely on lucrative profits generated by the sale of such items. Most school boards, however, have at least one member who agrees that schools have a responsibility to maintain a healthy nutritional environment. Community health professionals can offer their assistance and help build community awareness and support for school policies that address the nation's epidemic of obesity.

### Helpful resources on mental and social health

- The American School Counselor Association (ASCA) at [www.schoolcounselor.org](http://www.schoolcounselor.org).
- The National Association of School Psychologists (NASP) at [www.nasponline.org](http://www.nasponline.org).
- The National Association of Social Workers (NASW) at [www.socialworkers.org](http://www.socialworkers.org).
- The UCLA School Mental Health Project at <http://smhp.psych.ucla.edu>.
- The Center for School Mental Health Assistance at <http://csmha.umaryland.edu>.

Chart 4

<i>Mental health and social services provided in U.S. schools</i>	<i>Percent of schools</i>
Crisis intervention for personal problems	94
Identification of or referral for physical, sexual, or emotional abuse	93
Identification of or counseling for mental or emotional disorders	85
Stress management	79
Tobacco use cessation	64
Alcohol or other drug use treatment	58
Assistance with enrolling in the state/federal Children’s Health Insurance Program (CHIP)	50
Child care referrals for teen mothers	49
Eating disorders treatment	47
Assistance with enrolling in WIC or accessing food stamps or food banks	42
Services for gay, lesbian, or bisexual students	41
HIV testing and counseling	23
<i>Prevention/education services (provided in one-on-one or small group discussions by mental health or social services staff)</i>	<i>Percent of schools</i>
Violence prevention	87
Suicide prevention	77
Alcohol or other drug use prevention	76
Tobacco use prevention	67
Pregnancy prevention	60
Eating disorders prevention	54
STD prevention	53
HIV prevention	52
Accident or injury prevention	51
Nutrition and dietary behavior counseling	44
Physical activity and fitness counseling	32
<i>Methods of service delivery</i>	<i>Percent of schools</i>
Individual counseling	90
Case management for students with behavioral or social problems	83
Group counseling	76
Peer counseling or mediation	67
Comprehensive assessment or intake evaluation	64
Family counseling	61
Self-help or support groups	60

Source: CDC School Health Policies and Programs Study (SHPPS) 2000<sup>11</sup>

## Helpful resources on school nutrition environments

- CDC’s Division of Adolescent and School Health offers *Guidelines for School Health Programs to Promote Lifelong Healthy Eating* at [www.cdc.gov/nccdphp/dash/guidelines/nutguide.htm](http://www.cdc.gov/nccdphp/dash/guidelines/nutguide.htm).
- The U.S. Department of Agriculture offers *Changing the Scene: Improving the School Nutrition Environment*, a free action kit that can be used at state and local levels to educate decision makers about the critical role of the school environment. Order the kit online at [www.fns.usda.gov/tn/healthy/index.htm](http://www.fns.usda.gov/tn/healthy/index.htm).
- Part I of NASBE’s *Fit, Healthy, and Ready to Learn: A School Health Policy Guide* contains a chapter on “Policies to Promote Healthy Eating at School” that addresses how vending machine contracts can be revised to improve the nutritional value of foods sold without affecting profit levels. Download the sample policies at [www.nasbe.org/HealthySchools/fithealthy.mgi](http://www.nasbe.org/HealthySchools/fithealthy.mgi).
- The National Schools Boards Association (NSBA) has compiled excerpts from key documents and sample district policies in a *Healthy Eating 101* packet. Visit [www.nsba.org/schoolhealth](http://www.nsba.org/schoolhealth).
- California Project LEAN (Leaders Encouraging Activity and Nutrition) is a national leader in promoting healthy eating in schools. Go to [www.californiaprojectlean.org](http://www.californiaprojectlean.org).

School personnel such as **secretaries, custodians, bus drivers, playground monitors, and crossing guards** are often worth consulting about student health status. These individuals have frequent, informal contact with students and often know what is happening in their lives.

Most educators recognize the importance of parents, other family members, and community members in fostering student achievement. Many schools actively seek their opinions on school policies and programs as members of advisory boards and school improvement committees. Where site-based school management exists, family

members may actually participate in school decision making through election or appointment to school governing bodies. Organizations that represent parents and family members include **Parent-Teacher Associations (PTAs)**, which are part of an established national network, and **Parent-Teacher Organizations (PTOs)**, which operate independently.

Families tend to be enthusiastic about and supportive of school health programs. When surveyed, parents consistently rate health as an important topic for schools to address. For example, a 1993 Gallup poll sponsored by the American Cancer Society found that 82 per-

cent of parents of adolescents said health education is either more important or as important as other subjects taught in school.<sup>48</sup> A more recent national poll in 2000 documented that 81 percent of parents of school-age children wanted their children to participate in daily physical education.<sup>49</sup> Even sex education consistently receives solid support from parents and families in credible surveys.<sup>50</sup> Families are natural allies for those who advocate quality support services in schools.

Finally, **student organizations** such as student government, clubs, or honor societies can also be valuable allies in efforts to address issues of health and well being.

## Helpful resources on parent involvement

- The National Parent-Teacher Association maintains a parent involvement section at its website addressing health, safety, and drug and alcohol prevention. Browse it at [www.pta.org/parentinvolvement/index.asp](http://www.pta.org/parentinvolvement/index.asp).
- Resources on parent involvement are available from the U.S. Department of Education at [www.ed.gov](http://www.ed.gov).
- The National Parent Information Network (NPIN), administered by the National Library of Education in the U.S. Department of Education, provides access to research-based information about the process of parenting and about family involvement in education. Go to <http://npin.org>.

## The local school district—Responsive to community needs

The **school district** (also called the **local education agency**, or **LEA**) is the public school system’s primary unit of administration in a designated geographic area. There are nearly 15,000 U.S. school districts. In Florida, Louisiana, and West Virginia, school district boundaries neatly coincide with county lines. More typically, district boundaries do not correspond with those of other agencies and government jurisdictions. For instance, the Los Angeles Unified School District encompasses an area that includes the city of Los Angeles and all or parts of 28 other cities. Illinois has nearly 900 school districts, and sparsely populated South Dakota has 177.

The number of schools and students served in a school district also varies. New York City has more than 1.1 million students, while a great many districts consist of just one school building. Less than 2 percent of the nation’s school districts have 25,000 or more students, but 32 percent of all students attend school in these mostly urban districts and their concerns get the most media attention. At the other end of the size range, more than one-third of school districts had fewer than 600 students; these mostly rural districts accounted for only 3 percent of public school enrollment.<sup>51</sup>

In most districts, primary governance authority lies with the **school board** (sometimes called a **school committee**). On most boards, between five and eight members serve four-year terms.<sup>52</sup> The average length of board service is nearly seven years. Some 93 percent of school boards are composed

entirely of elected members, most of whom are elected on a non-partisan basis and spend less than \$1,000—usually their own money—on their campaigns. Campaigns tend to be more expensive in larger districts, with funds raised from unions and businesses. Some large cities have moved toward systems of appointment by other office holders.

Although two-thirds of school board members are college graduates, fewer than one in seven are professional educators (Chart 5).

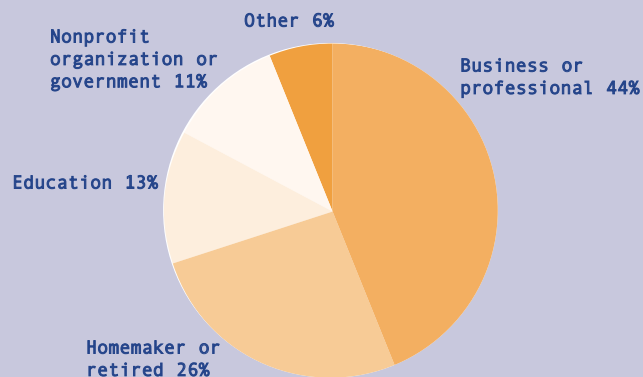
All are public-spirited volunteers—two-thirds serve without compensation and spend an average 25 hours per month on board business. Substantial numbers, especially in large districts, spend 20 or more hours per week on this challenging community service. Though a great many are working parents, three-quarters of board members also serve on another community board or committee, and a third report serving on three or more.

### Local school board demographics

- Male board members comprise 56 percent of the total in large districts (more than 25,000 students) and 63 percent in small districts (fewer than 5,000 students). The average among all districts is 61 percent.
- School boards are somewhat less racially diverse than the nation as a whole (86 percent white, 8 percent African American, 4 percent Hispanic)—but are more diverse than most state and national elective bodies.
- Three-quarters of board members are between 40 and 59 years old. Another 20 percent are older than 60.

### Chart 5

Occupations of local school board members



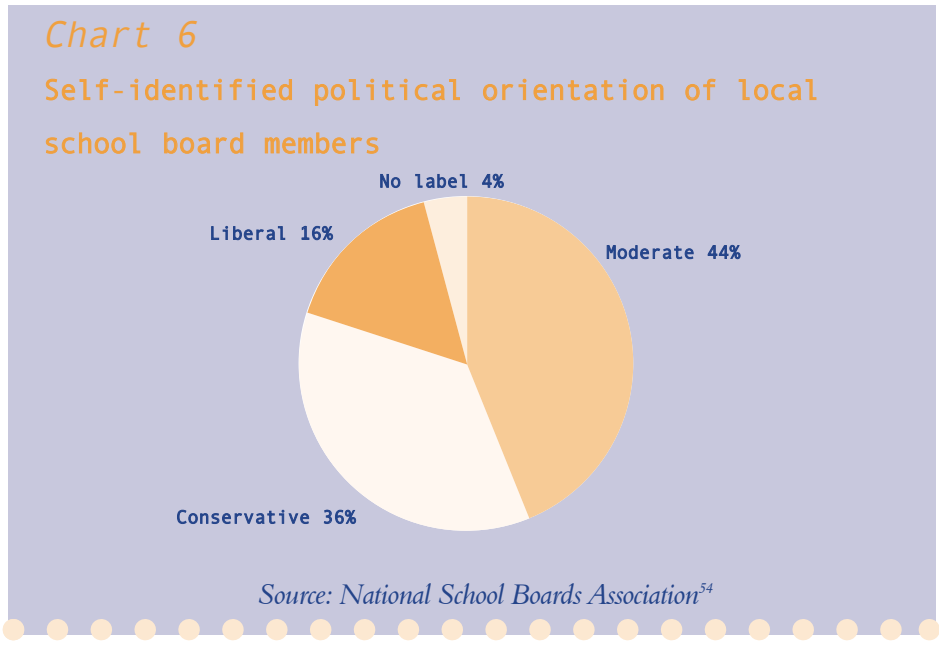
Source: National School Boards Association<sup>53</sup>

- Visit the website of the National School Boards Association (NSBA) at [www.nsba.org](http://www.nsba.org) for more information about the work of school boards.

The school board’s role in establishing and maintaining a school health program is critically important because the board sets a district’s guiding vision, makes budget choices, chooses curriculum, and determines many policies that guide daily decisions of the local education agency and its schools. Local school board authority is not complete, however. According to every state constitution, public education is primarily a state responsibility. Local districts are subject to state laws and policies that may direct, limit, or otherwise influence local policy-making and implementation.

Similarly, school boards that accept federal funds are required to adhere to federal policies and regulations.

School boards were founded on the belief that local citizens should control policies that determine



how their children are educated. Ideally, they are an expression of grass roots democracy, representative of and accountable to the whole community. Every school board member wants to do what is

best for children, but members often disagree about what that means. In addition to their personal views, which tend to be politically moderate (Chart 6), school board members can be strongly

**Helpful resources on legal issues**

- Contact the state education agency or state health department to learn about state-specific laws that govern the provision of education.
- Find federal legislation, regulations, and policy guidance online at the website of the U.S. Department of Education at [www.ed.gov](http://www.ed.gov).
- The Council of School Attorneys (COSA), an affiliate of the National School Boards Association (NSBA), offers many publications and links to other sources of information on specific laws and legal issues. Go to [www.nsba.org/cosa/index.htm](http://www.nsba.org/cosa/index.htm).
- NASBE’s *Someone at School has AIDS: A School Health Policy Guide Concerning HIV Infection* (2001) offers explanations and lists of resources on several important federal laws that affect school health programs, including:
  - Section 504 of the Rehabilitation Act of 1973, which mandates that every public school student with a disability—including chronic health diseases

- or conditions—be provided a “free, appropriate public education” that meets his or her educational needs to the same extent as other students.
- The Americans with Disabilities Act of 1990 (ADA), which extends Section 504’s provisions to private non-religious schools and protects adults in every workplace
- The Civil Rights Act of 1991, which also prohibits discrimination and harassment based on a disability.
- The Family Educational Rights and Privacy Act of 1974 (FERPA, also known as the Buckley Amendment), which places certain privacy restrictions on student records maintained by schools that receive federal funds.
- The Protection of Pupil Rights Act of 1994, which requires written parental consent before using federal education funds for some kinds of student surveys.



## Helpful resources on local interagency collaboration

- The American Academy of Pediatrics offers the valuable manual *Moving from Principle to Practice: A Resource Guide* at [www.aap.org/advocacy/washing/rguide.htm](http://www.aap.org/advocacy/washing/rguide.htm).
- The Council of Chief State School Officers (CCSSO) has practical resources for interagency collaboration at [www.ccsso.org/collpub.html](http://www.ccsso.org/collpub.html).
- The UCLA School Mental Health Project/Center for Mental Health in Schools offers many free resources to help build school-community partnerships at <http://smhp.psych.ucla.edu>.
- The Public Education Fund (PEN) is a national association of local education funds (LEFs), which are nonprofit community-based organizations independent of the school districts in which they operate that collaborate with school principals, teachers, administrators, boards and districts, businesses, community organizations and local citizens to develop and implement whole-school improvement strategies, create model programs, leverage resources, award grants, and enhance the standing of public schools in the community. Go to [www.publiceducation.org](http://www.publiceducation.org).
- The National Center for Education in Maternal and Child Health (NCEMCH) and Georgetown University operate the Bright Futures project, which has produced sets of expert guidelines on health care for children and adolescents based on the principle that optimal health involves trusting relationships among the health professional, the child, the family, and the community, all as full partners. Visit [www.brightfutures.org](http://www.brightfutures.org).
- The National Association for the Education of Young Children (NAEYC) position statement, “Principles to Link By: Integrated Service Systems that are Community-Based and School-Linked,” contains useful practical guidance at [www.naeyc.org/resources/position\\_statements/pslink98.htm](http://www.naeyc.org/resources/position_statements/pslink98.htm).
- The Institute for Youth, Education, and Families, a special entity of the National League of Cities (NLC), helps municipal leaders take action on behalf of children, youth, and families in their communities. Visit [www.nlc.org/iyef](http://www.nlc.org/iyef).

influenced by the values and interests of those they consider their primary constituents. Organized special interest groups or vocal minorities (e.g., teacher unions, ideological groups) can have a disproportionate influence on board policies and programs. While a democratic system allows interest groups to form and compete for influence, diverse constituencies can make it difficult for board members to reach consensus on a common vision and strategy, particularly with regard to controversial, value-laden issues. Some school boards may therefore prefer to avoid dealing with these matters.

Local school boards operate in most jurisdictions with full fiscal

independence, often with their own taxing power. Approximately 15 percent of local school boards are required to work with the mayor, city council, or county supervisors where those bodies have budgetary authority. Relations among local school boards and city or county government can sometimes be strained.

The relative independence of local school districts from other government agencies and community power structures can pose challenges for collaborative policymaking. For example, jurisdictional boundaries that do not align can result in critical gaps or wasteful duplication of services.

Nevertheless, there are many

examples of school districts and other agencies engaging in collaborative policymaking to provide more efficient and effective services for children and families.

A practical obstacle to collaboration is that school boards continually address an overwhelming number of issues within tight fiscal and scheduling constraints. Their tasks include budget planning, contract negotiations, personnel decisions, school closures, redistricting, facilities construction, and more. During the 1990s, boards reported spending an increasing amount of time on student achievement issues. School boards may be reluctant to add new issues to a full agenda unless

they perceive the issues as urgent or critically important.

Some school boards delegate oversight authority on specified health-related issues to a **school health coordinating council** (similar to that described earlier at the school level) that includes parents and community representatives. Such a council might operate as a standing committee of the board or as a distinct body. It might simply be an advisory body, or have authority to enhance program coordination among staff members working in school health program components. If such a council exists, is active, and has real influence, it is a natural forum for community professionals to become involved with the school district. The states of Virginia, South Carolina, and Texas require all their districts to maintain school health councils. Non-education professionals might wish to offer their help to establish and operate a well-functioning school health council with a broad mandate. (See page 17 for helpful resources).

The **school district superintendent** is the chief executive officer of the local district. In most districts, the superintendent is hired by the school board.

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**In theory...**

The school board makes policy;  
the superintendent implements it.

● ● ● ● ● ● ● ● ● ●

Superintendents are responsible for providing educational leadership, translating policy into practical operating procedures, managing district personnel, and serving as the district’s public spokesperson. In any sort of crisis, the superintendent is the official in charge.

Several gray areas exist between a school board’s policy-making authority and a superintendent’s administrative responsibilities. The superintendent or a senior aide usually develops the school board’s agenda in consultation with the board chair and typically drafts policy for the board to consider. On the other hand, boards sometimes become immersed in the daily administration of their districts. Overlapping authority and competition for leadership can result in tension between the superintendent and the school board.

About a third of superintendents are promoted from within

the school district.<sup>55</sup> Some 84 percent are male and 90 percent are white. The average superintendent serves for about five years; turnover is more rapid in large urban districts, where the average tenure is about 2.5 years. A high turnover rate can cause problems with program continuity because new superintendents tend to want to make their own marks.

The term **central office** often refers to the superintendent’s administrative and support personnel who help develop and implement district policies and programs. The size of the staff depends on the district’s size and resources; many employ **school health program coordinators, school nursing coordinators, or school food service coordinators** who provide guidance and technical assistance to school staff members. A district might also employ **curriculum specialists** or **instructional specialists** in health education, physical education, drug prevention, or related fields. Such central office experts are natural points of contact for community professionals who want to work with schools. A call to the central office should lead to the right person.

**Helpful resources for school administrators**

- The American Association of School Administrators (AASA), which primarily represents district superintendents, offers online information and resources on Safe and Healthy Schools at [www.aasa.org](http://www.aasa.org).
- The Association for Supervision and Curriculum Development (ASCD) is one of the largest professional education associations in the world. Their 160,000 members include superintendents, supervisors, central office staff, principals, teachers, professors of education, school board members, students, and parents. Visit their Health in Education website at [www.ascd.org/health\\_in\\_education/index.html](http://www.ascd.org/health_in_education/index.html).



Many health-related staff positions and school health programs are paid for with state or federal categorical program funding. Larger districts might have specialists in tobacco-use prevention, special education (for students with handicapping conditions), school safety, or HIV prevention. Categorical funds can only be spent on specific populations or program areas. Staff and programs supported through such restricted funds are generally protected from local budget cuts but tend to be eliminated if the federal or state funding stream ends.

### The state— Authority tempered by respect for local control

State governance of public education is complex; the precise participants and arrangements vary from one state to another. The United States does not have a uniform education system. Rather, distinct state, territorial, and tribal school systems differ in substantive ways but work in parallel. The governance structure is spelled out either in the state constitution or the education code adopted by the legislature.

Every jurisdiction has unique features, relationships, dynamics, and tensions arising from different demographic profiles, circumstances, and historical traditions. The following description of major players and institutions is necessarily generic.

The **governor** proposes a state budget and new programs, while the **legislature** has the final word on all state laws, budgets, state staff positions, and distribution of state funds. In recent years, activist governors and legislators of both major parties have discovered that attending to systemic educational reform can bring popularity and support. By commanding media attention, these high-profile leaders can be valuable, constructive shapers of public opinion and can mobilize broad support for needed changes.

On the other hand, these officials understandably want to demonstrate dramatic results during their brief terms of office. Some are therefore prone to simplistic, politically expedient reforms that appear meaningful but might distract the public from more substantive (and costly) long-term issues in education and children's welfare.

Rapid turnover due to term limits in these political offices can also challenge policy continuity.

Often, the most influential shapers of policy initiatives are staff members in governors' offices, legislators' offices, and legislative committee offices. Advocates of school health policies, education, services, and programs should not be distressed if, on a visit to the state capitol, they get appointments only with staff members. These might be precisely the people who can best advance school health-related goals.

In most states, policy responsibility for elementary and secondary education is shared by the legislature with the **state board of education** (SBE). The precise scope of authority of these boards varies widely, but state boards typically adopt education goals and standards, set graduation requirements, establish teacher certification requirements, adopt textbooks, and develop assessment programs to ensure that school districts and schools perform at acceptable levels.

The governor appoints state board members in about two-thirds of the states. Members are directly elected in most of the

### Helpful resources for state policymakers

- Learn about issues addressed by the National Governors Association (NGA) at [www.nga.org](http://www.nga.org).
- The National Conference of State Legislatures (NCSL) offers policy guidance on child and adolescent health issues at [www.ncsl.org/programs/health/health.htm](http://www.ncsl.org/programs/health/health.htm).
- The National Association of State Boards of Education (NASBE) offers policy assistance and advice to state education leaders. Go to [www.nasbe.org](http://www.nasbe.org).
- The Council of Chief State School Officers (CCSSO) provides assistance to senior officials in state departments of education. Visit [www.ccsso.org](http://www.ccsso.org).

## The concept of local control

Compared with most public health, social services, and youth services agencies, the U.S. public education system is **highly diffuse** and **radically decentralized**. The concept of local control is strong in every state.

State governments are constitutionally responsible for assuring that every young person is educated. In practice, however, much authority is usually granted to local communities. Principals of individual school buildings are key gatekeepers for day-to-day programs, and local school boards take responsibility for everything that happens in the schools. Though they are technically agents of the state, local board members frequently object to oversight or interference by state and federal governments. This state/local tension is institutional and exists nearly everywhere.

Local control has obvious benefits, including democratic responsiveness and programmatic flexibility. But one disadvantage is that altering standard operating procedures or adding new services often depends on building relationships and influencing decision makers one school at a time. States cannot simply impose policy mandates and expect immediate results. Changing the education system can be a long, incremental process.

completely tobacco-free (12 states have such a policy).<sup>56</sup>

State boards might stay silent on many school health-related issues, deferring decisions to local districts or schools. For example, only 29 states have policies on inspection or maintenance of playground facilities and equipment, and only nine require schools to assign someone to oversee or coordinate mental health and social services. State funding might not be available for many worthwhile services. As the value and importance of school health programs have received greater recognition in recent years, however, a growing number of states are adopting policies in this area.

Most state boards are assigned a **state board executive officer** (the specific job title varies) to coordinate the board's work and handle administrative tasks. This person tends to be well-informed about who does what and how to get things done in the state education agency. Many executive officers are closely involved with the policy-development process.

Depending on the state, the **chief state school officer** (commonly called "the chief") goes by several titles: state superintendent,

rest. A few states have hybrid elected/appointed boards, while Minnesota and Wisconsin have no state boards of education. Like local board members, few state board members are professional educators and they represent every point on the political spectrum. Yet all are public-spirited volunteers and many are receptive to broad ideas about what is best for children and families.

State boards set many policies related to school health programs. For example, by establishing competitive grant opportunities, state boards can encourage schools to establish school-based health centers or staff wellness programs. State boards can

require that all students be taught health education (as of 2000, some 40 states require health education at some level), that all students participate in daily physical education (only Illinois requires daily P.E. in every grade), or that all school grounds are

## A state board takes action

In August 2002, the Michigan State Board of Education unanimously adopted a set of policy recommendations from its Task Force on Integrating Communities and Schools to "create a connected community so that all students achieve by making collaborative use of the efforts and resources of all community partners/stakeholders." View the task force report at [www.michigan.gov/documents/Integrat\\_35279\\_7.doc](http://www.michigan.gov/documents/Integrat_35279_7.doc).

commissioner, secretary, or director of education. In any case, this powerful official is a prominent education leader who functions as the chief executive officer over the state education agency and is responsible for translating state laws and policies into programs and regulations. The chief is also the primary public spokesperson for the state public education system.

Typically, the chief is hired by the state board of education, but in 14 states the chief is an independently elected politician (Chart 7). In other states the governor appoints the chief.

The chief plays an important policymaking role by bringing timely issues to the attention of the public

### Strategic partnerships are essential

“Education reforms alone will not overcome deprivations of nutrition, child care, housing, health, family support, and other conditions which impede successful student progress. We are committed to strategic partnerships among community, business, faith institutions, and educators as essential to overcome poverty and deprivation and assure success in education.”

—2001 Statement of Priorities from the Council of Chief State School Officers<sup>57</sup>

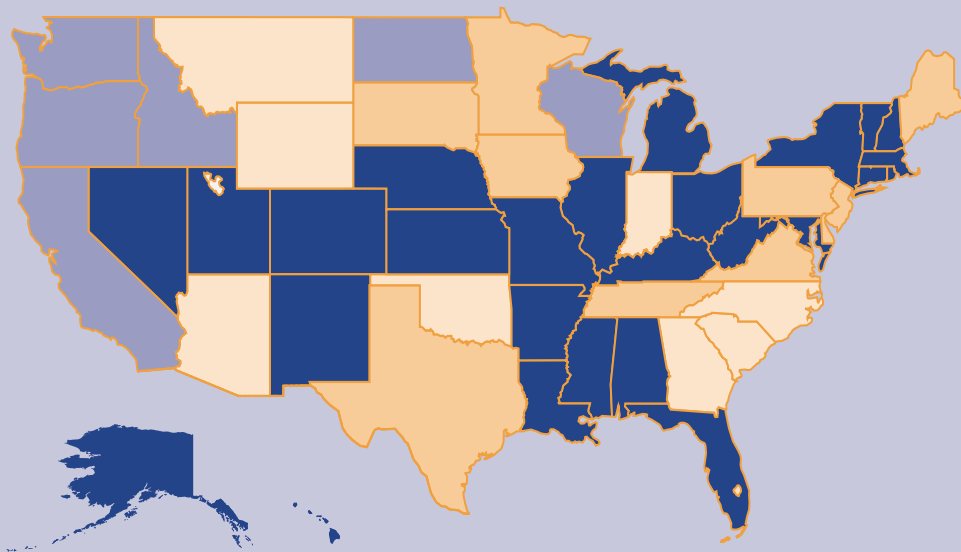
and key state leaders, and by proposing draft policies for consideration by decision makers. The governor and legislature often consult the chief about possible legislative policies and programs.

States have different names for the **state education agency (SEA)**,

such as the state department of education or state department of public instruction. Career public servants who staff the SEA write and monitor regulations that govern many federal and state programs, develop standards and curriculum guidelines, measure results, distribute

Chart 7

#### Method of selection of the chief state school officer



- Appointed by the state board of education (26 states)
- Appointed by the governor (10 states)
- Elected on a partisan ballot (8 states)
- Elected on a non-partisan ballot (6 states)

A description of each state’s education governance structure is available online at [www.nasbe.org/Educational\\_Issues/Governance/Governance\\_chart.pdf](http://www.nasbe.org/Educational_Issues/Governance/Governance_chart.pdf).

state and federal funds to local school districts, and implement state policies.

SEAs are often viewed by local education officials as intrusive regulators and adversarial compliance monitors. Yet in recent years most SEAs have worked to change their roles and be helpful providers of technical assistance and professional development while administering a flexible system of support and accountability for results. Complicating this shift, however, is radical downsizing in many states. A significant proportion of SEA positions are now supported with federal, not state, dollars. Many SEAs have repeatedly reorganized as a result of changing leadership and political climates.

An increasing number of SEAs participate in interagency initiatives that address the comprehensive needs of children and families. For example, many SEAs and state health departments work together on outreach activities for Medicaid and the

### SEA school health staff

- The Council of Chief State School Officers (CCSSO) maintains direct links to school health program offices within state education agencies at [www.ccsso.org/seahealth.html](http://www.ccsso.org/seahealth.html).

State Children’s Health Insurance Program (SCHIP), or participate together on state coalitions to improve children’s health. Collaboration can be horizontal across state agencies (e.g., interagency initiatives), or vertical across multiple levels (e.g., aligned policies and procedures). Sometimes the greatest need for collaborative relationships is *within* an education, health, or social services agency.

Most SEAs employ **education specialists** in health education, HIV and AIDS education, physical education, child nutrition, substance abuse and violence prevention, and health services. They generally are paid by and supported from federal categori-

cal (topic-specific) funds to encourage and help districts and schools. Some SEAs have resources to build local capacity for school health programs by providing model policies, guidance documents, and staff who provide professional development and technical assistance. SEAs can be particularly influential in rural districts that cannot afford their own specialists.

Although most public education services are provided in traditional schools overseen by school districts, many states provide direct instructional services through certain programs. These might include, for example, education for young people in the juvenile justice or prison systems, schools for

### Helpful resources on state interagency collaboration

- The Policy Exchange project of the Institute for Educational Leadership (IEL) offers resources for state level interagency collaboration at [www.iel.org/programs/policy.html](http://www.iel.org/programs/policy.html).
- CDC’s Division of Adolescent and School Health funds several states to build state-level infrastructure to support coordinated school health programs. Learn about the initiative at [www.cdc.gov/nccdphp/dash/about/healthyyouth.htm#3](http://www.cdc.gov/nccdphp/dash/about/healthyyouth.htm#3).
- The Robert Wood Johnson Foundation established *Covering Kids: A National Health Access Initiative for Low-Income, Uninsured Children* to help states and local communities increase the number of eligible children who benefit from health insurance coverage programs. For online research, policy recommendations, and project descriptions visit [www.coveringkids.org](http://www.coveringkids.org).
- The Council of Chief State School Officers (CCSSO) offers *Building Bridges to Healthy Kids and Better Students: School-based Outreach and Enrollment for the State Children’s Health Insurance Program and Medicaid* online at [www.ccsso.org/healthpublications.html](http://www.ccsso.org/healthpublications.html).
- Additional resources about interagency collaboration are on page 25.

students who are deaf or blind, or state-sponsored virtual schools that provide supplemental instruction via the Internet.

For efficient delivery of technical assistance and other services, some larger states maintain **regional education service agencies**, which go by different names (e.g., intermediate school district). Programs that provide support for local school health programs, such as professional development services, sometimes operate at this level.

### The national level—Limited but influential

The federal government has only constrained, narrow influence over education policy because the U.S. Constitution assigns it no responsibility for public education. Instead, education is primarily a state responsibility. The federal government provides only about 7 percent of all K–12 education dollars nationwide, most of which is channeled through the **U.S. Department of Education (ED)** under the terms of the **Elementary and Secondary Education Act (ESEA)** originally passed by Congress in 1965. The **Individuals with Disabilities Education Act (IDEA)**, originally passed in 1975, is another major piece of legislation that channels resources to schools.

Federal assistance is usually distributed to states, districts, and schools in two ways. **Formula grant programs** make funds available to school districts and schools based on specified factors such as the number of students

eligible for free or reduced-priced school meals (states keep a small percentage of funds for administrative costs). Despite the automatic distribution of funds, formula-grant recipients must submit applications and conform to program regulations.

In contrast, **competitive grants** are awarded after a process of ranking the quality of applications received. The process is administered by the state for some programs, directly by the federal government for others. An advantage of a competitive grant system is that it awards scarce funds to programs that are most likely to make an impact and that will serve as positive examples to others. A disadvantage is that underperforming schools or districts might lack the staff to submit high-quality applications that include credible evaluation plans. Helping a school prepare a sound competitive grant proposal is a valuable way that community professionals can help a school and its students.

Health education, physical education, food services, and other aspects of school health programs have never been central responsibilities of ED. Over the years, Congress has focused the department's role on three major tasks:

- Enforcing civil rights laws that prohibit discrimination and ensure equity.
- Providing partial funding to states and local school districts for educational programs for economically disadvantaged children and children with special needs, such as those with limited proficiency in English.

- Exercising policy leadership by sponsoring education research and pilot programs.

The federal role expanded significantly with the 2001 reauthorization of ESEA, referred to as the **No Child Left Behind Act (NCLB)**, which represents a groundbreaking federal initiative to improve the education of *all* children. Though the proportion of federal dollars has not appreciably increased, Congress established a national accountability system that affects all schools, districts, and states and involves serious consequences for persistently failing schools. A key provision is that states must operate extensive student academic assessment (testing) programs. The pressure on schools to ensure that every student achieves according to high academic standards has never been greater.

Nevertheless, another recent trend has been to grant greater flexibility to states, districts, and schools in choosing how best to use federal funds. Health and social services are allowable activities in many major education grant programs included in NCLB, including the following:

- ED's largest formula grant program is called **Improving Academic Achievement for the Disadvantaged** (commonly called **Title I** or its previous designation, **Chapter 1**), which channels funds to districts and schools with large concentrations of students of families living in poverty. Although the pro-

gram’s main emphasis is on improving students’ reading and math proficiency, schools designated for targeted assistance are permitted to use Title I funds for comprehensive health, nutrition, and other social services “as a last resort” if such services are “not reasonably available from other public or private sources.”

- The most direct ED involvement in school health education and programs is via the **Safe and Drug-Free Schools and Communities** formula grant program (Title V of NCLB). Program dollars must focus on violence or substance use prevention, but such efforts can be part of a coordinated school health program.
- **21<sup>st</sup> Century Community Learning Centers** is a competitive grant program administered by SEAs for school districts, community-based organizations, and other public or private entities. Funds can be used for

before-school, after-school, and summer recess activities that advance student academic achievement. The list of allowable activities includes recreation.

Program flexibility goes two ways: states, districts, and schools may choose to spend federal funds *solely* on direct academic instruction. Those who wish to strengthen school health programs must make their concerns heard by those who make these decisions.

The **U.S. Department of Health and Human Services** (DHHS) has no direct policy authority over state or local education agencies. Some grant funding for school health efforts, however, comes from agencies within the large department:

- Most notably, the **Division of Adolescent and School Health** (DASH) within the **Centers for Disease Control and Prevention** (CDC) encourages and helps states support the widespread implementation of coordinated school health programs. DASH provides

school health, chronic disease prevention, or HIV/AIDS prevention funds to most state education agencies and some large cities. Some funding programs are formula-based, others are competitive. DASH also provides valuable guidance and collects useful data on youth risk behaviors and school health policies and programs. Go to [www.cdc.gov/HealthyYouth](http://www.cdc.gov/HealthyYouth) for a full description of their activities and services.

- The **Maternal and Child Health Bureau** (MCHB) operates numerous programs that serve children and youth. State-by-state examples of MCHB-funded programs in adolescent health are available online at [www.mchb.hrsa.gov/programs/adolescents/programexamples.htm](http://www.mchb.hrsa.gov/programs/adolescents/programexamples.htm).
- The **Bureau of Primary Health Care** (BPHC) provides some competitive grant funding for school-based and school-linked health

### Helpful resources on federal education funding

- A more complete description of opportunities for school health in the No Child Left Behind Act of 2001, prepared by Nora Howley of the Council of Chief State School Officers (CCSSO), is in the May 2002 online edition of *School Health Program News* from the Education Development Center (EDC) at [www2.edc.org/MakingHealthAcademic/PDF/shpn502.pdf](http://www2.edc.org/MakingHealthAcademic/PDF/shpn502.pdf), pages 7-9.
- The ED home page contains a section devoted to “Finding Grants and Contracts” at <http://ed.gov/index.jsp>.
- CDC’s Division of Adolescent and School Health maintains the Healthy Youth Funding Database (HY-FUND), a searchable source of information on federal, foundation, and state-specific funding sources for school health programs. Explore it at [www.cdc.gov/nccdphp/dash/funding.htm](http://www.cdc.gov/nccdphp/dash/funding.htm).
- Many association newsletters alert members to federal grant opportunities.



centers, including the **Healthy Schools, Healthy Communities** program that supports comprehensive school-based services for high-risk children. The bureau's Center for School Based Health offers online resources for school-based health centers at [www.bphc.hrsa.gov/Center](http://www.bphc.hrsa.gov/Center).

- The **Centers for Medicare and Medicaid Services** (CMS) operates the **Medicaid** program, which can reimburse qualified school-based health centers for certain health services provided to eligible children, and the **State Children's Health Insurance Program** (SCHIP), which subsidizes the purchase by low-income families of basic health insurance and enlists schools to help identify eligible families. Learn more at [www.cms.hhs.gov](http://www.cms.hhs.gov).
- **Head Start**, a preschool program for economically disadvantaged families, stresses health, nutrition, and family support, as well as school readiness. The Head Start Bureau maintains a website for service providers, parents, volunteers, community organizations, and others at [www2.acf.dhhs.gov/programs/hsb](http://www2.acf.dhhs.gov/programs/hsb).

The **U.S. Department of Agriculture** (USDA) provides funding support and supplies for school food services through the **National School Breakfast Program**, the **National School Lunch Program**, and several

similar programs. Regulations require these programs to offer meals that conform to the U.S. Dietary Guidelines for Americans. Learn about the various school food programs at [www.fns.usda.gov/cnd](http://www.fns.usda.gov/cnd). The **Healthy School Meals Resource System** provides information to persons working with school food programs at <http://schoolmeals.nal.usda.gov>.

The **Office of Juvenile Justice and Delinquency Prevention** (OJJDP) of the **U.S. Department of Justice** supports state and community efforts to develop and implement effective and coordinated prevention and intervention programs, and improve the juvenile justice system so it promotes public safety, holds offenders accountable, and provides treatment and rehabilitative services. Numerous resources about healthy youth development are available online at <http://ojjdp.ncjrs.org>.

In addition to federal government programs at the national level, many private, nonprofit **national associations** address dues-paying members' needs in various ways. Associations are generally charged with:

- Representing member needs and interests at the national level.
- Providing advice, assistance, and professional development to members.
- Developing state-of-the-art standards for best practice.
- Disseminating news, research findings, and other current information to members and the public.

Some associations are organized according to profession (e.g., the National Association of School Nurses), others focus on a broad range of education policy issues (e.g., NASBE), some represent particular constituencies (e.g., the National Alliance for Hispanic Health), and some are organized to promote specific policy goals (e.g., the Campaign for Tobacco-Free Kids). A complete list of associations that partner with the CDC Division of Adolescent and School Health is available online at [www.cdc.gov/nccdphp/dash/partners/index.htm](http://www.cdc.gov/nccdphp/dash/partners/index.htm).

Some **private foundations** provide leadership on school health and youth-development policy issues through grant-making activities and sponsorship of original research. Among the most notable at the national level are:

- The Carnegie Corporation of New York ([www.carnegie.org](http://www.carnegie.org)).
- The Robert Wood Johnson Foundation ([www.rjwf.org](http://www.rjwf.org)).
- The David and Lucile Packard Foundation ([www.packfound.org](http://www.packfound.org)).
- The Annie E. Casey Foundation ([www.aecf.org](http://www.aecf.org)).
- The William T. Grant Foundation ([www.wtgrant-foundation.org](http://www.wtgrant-foundation.org)).

# How to Work with Schools



How a non-education professional works within the education system depends on the magnitude of the goal:

- *Applying specialized skills.* A community professional might want to use specialized skills to assist with, for example, an after-school program or school-based health center, help an individual student in need of special support, or establish a referral linkage to an adolescent-friendly HIV/STD testing and counseling pro-

gram. Such small-scale, straightforward objectives might be easily achieved with a simple phone call to the right person. An administrative staff member at the district or school office should be able to provide the appropriate contact person.

- *Partnering on a survey, research, or materials-development project.*

University programs and non-profit organizations might seek to enter into agreements with schools or districts on specific projects. School administrators will want to know that any undertaking demanding time or energy from students or staff has tangible benefits for the school, its students, or their families.

- *Improving specific policies, programs, or services.* Some health, mental health, and social services professionals might want to engage



**Many ways to become involved with schools**

Young people are more likely to adopt health-enhancing behaviors if they receive consistent messages from many sources. Individual volunteer professionals, state and local government agencies, private businesses, youth-serving organizations, and other community organizations can add value to school health programs by:

- Participating on school health coordinating councils at the school, district, or state levels.
- Sitting on other education advisory boards and task forces.
- Helping existing programs by offering specialized services in the school setting.
- Coordinating school and community health promotion efforts, services, referral procedures, or emergency response plans.
- Providing expert advice and assistance to school health program planners.
- Conducting professional development activities for school personnel.
- Helping educators navigate complex health and social services systems.<sup>58</sup>
- Encouraging educators to join community advisory boards, such as HIV prevention community planning groups.
- Educating policymakers about the rationale and goals of school health programs.
- Offering to serve as a guest speaker or resource for student learning within a full education program (but avoid one-time special events, which research shows have little or no lasting effect).
- Offering opportunities for student service in the community.
- Helping raise funds to support specific school health program activities.

schools as partners in achieving their agencies' objectives. They could work collaboratively with school or district administrators to fill gaps in existing services or establish or strengthen particular policies or programs. Initiatives to change policies or establish new programs will likely take time and effort, and might involve building trust and support among a variety of people.

- *Becoming involved with a systemic restructuring initiative.* Community professionals might want to participate in a long-term effort to systematically restructure a school or district so that physical, mental, and social health goals join academic learning as essential aspects of its core mission (see box, "Restructuring school systems to promote health and development"). Fundamentally revamping an education institution would almost certainly require an extended commitment of time and energy and involve participation in a broad, ongoing coalition.

Following are suggestions for approaching, engaging, and influencing education decision makers to achieve the above goals. Crucial points are to understand the decision-making context, be well prepared, garner widespread support, and strategically engage the decision-making process. Each topic is addressed on the pages following.

### Understanding the context—Politics and priorities

From the start of any initiative to strengthen the emphasis on school health and social goals, an effort should be made to understand the current political dynamics of the community, the school board, and the schools. Topics that might seem straightforward can raise unexpected passions, such as instituting guidelines on school vending machines, assuring that recess is not squeezed out of the elementary school day, assuring the right of students with HIV to attend school, or banning tobacco from all school premises.

### Restructuring school systems to promote health and development

In addition to the coordinated school health program (CSHP) framework (page 9), several complementary models of school organization integrate comprehensive health and social goals:

- The Full-Service Community School (a.k.a. Caring Communities, Beacon Schools, Healthy Start, Schools of the 21<sup>st</sup> Century) model envisions schools that are open to students, families, and community members before, during, and after school throughout the year. Working in full partnership with non-education agencies, medical, dental, mental, and social health services are readily available. Family support centers can help with parent involvement, child rearing, employment, and housing; community residents might participate in adult education and job training programs. Information, policy guidance, and examples of programs in 17 states are available online at [www.communityschools.org](http://www.communityschools.org).
- The UCLA School Mental Health Project/Center for Mental Health in Schools promotes the concept that school decision makers add an enabling component to instructional and management components. This component consists of an integrated set of comprehensive services that address barriers to learning. For more information visit <http://smhp.psych.ucla.edu>.
- The School Development Program, developed by Dr. James Comer of the Yale University School of Medicine, is a school- and system-wide intervention that aims to bridge child psychiatry and education. The program is designed to address six developmental pathways of children's growth—physical, cognitive, psychological, linguistic, social, and ethical—and includes a process for mobilizing adults to support student learning and overall development. For online information go to <http://info.med.yale.edu/comer/index.html>.

## First questions

- What do I *want* from schools as part of a partnership effort?
- What can I *offer* schools as part of a partnership effort?
- How does my proposal fit the educational mission of schools?

To lay the groundwork for a support-building effort, and to anticipate and deal with controversy, become familiar with key education leaders and the relationships among them. The best way to learn how to work effectively with decision makers is to ask a knowledgeable insider such as an administrative staff member. A friend might be able to provide a connection to someone who can offer candid information and advice.

If school board action is necessary, seek advice on the best ways

to approach individual board members and the board as a whole. Ascertain who should introduce issues to crucial players, and who should make policy recommendations. Find out who is particularly respected and how much influence is held by parent organizations, professional associations, school councils, community interest groups, and other bodies. Find out how various school board factions, if any, influence policy. Anticipate who is likely to be supportive and who might oppose a policy proposal.

This essential research can help in deciding how best to frame, introduce, and steer a proposal.

Attending board meetings can provide insight into board members' interests and the current issues; many school boards publish their agendas on the district webpage. Another suggestion is to identify an influential champion for the proposed initiative. At least one member of every state or local board of education has a broad vision of the education system's role in fostering the healthy growth and development of children and youth. This person can help shepherd a proposal for a new or revised program or policy through the policy-making process. Alternatively, a widely respected, influential community member can also be an effective champion.

## Helpful action planning resources

- The online Community Tool Box is a website created and maintained by the University of Kansas Work Group on Health Promotion and Community Development in Lawrence, KS, and AHEC/Community Partners in Amherst, MA. How-to sections use simple language to explain tasks necessary for community health and development, including leadership, strategic planning, community assessment, advocacy, grant writing, and evaluation. Go to [http://ctb.ukans.edu/tools/EN/section\\_1045.htm](http://ctb.ukans.edu/tools/EN/section_1045.htm).
- *Get Organized: A Guide to Preventing Teen Pregnancy* from DHHS and the National Campaign to Prevent Teen Pregnancy is a three-volume practical manual for those interested in taking action in their schools and communities. Download it free at <http://aspe.hhs.gov/hsp/get-organized99/index.htm>.
- The National Campaign to Prevent Teen Pregnancy offers many other resources for professionals, including guides to involving the faith community and dealing with conflict, at [www.teenpregnancy.org](http://www.teenpregnancy.org).
- The National Heart, Lung, and Blood Institute (NHLBI) and the National Recreation and Park Association (NRPA) have developed a Hearts N' Parks community mobilization guide, available online at [www.nhlbi.nih.gov/health/prof/heart/obesity/hrt\\_n\\_pk/hnp\\_resg.htm](http://www.nhlbi.nih.gov/health/prof/heart/obesity/hrt_n_pk/hnp_resg.htm). Additional community mobilization guides, including guides for working with religious congregations and Latino communities, are available through the online NHLBI Educational Materials Catalog at <http://email.nhlbihin.net>.
- For an international perspective, the World Health Organization (WHO) offers *Local Action: Creating Health-Promoting Schools*, which provides practical guidance, tools, and tips from schools around the world. Download it from the Internet at [www5.who.int/school-youth-health/download.cfm?id=0000000088](http://www5.who.int/school-youth-health/download.cfm?id=0000000088).

## Preparation—Key to credibility

Careful and thorough preparation enhances personal credibility and raises the likelihood of success, particularly when attempting a major initiative. Following are key matters to address:

- *Document the extent of the problem and align it with existing education goals.* Gather relevant data and information from the public health department, the juvenile justice system, or child advocacy organizations. The school or district might have pertinent data; for example, attendance and tardiness records could be relevant to a physical, mental, or social health problem. Statistics that are local and population-specific have the most impact. Youth culture is fairly uniform across America, however, so statewide or even national data can be used if good local records are unavailable.
- Survey and anecdotal informa-

tion gathered from school staff, community members, family members, or students can also help build a case for action. Preparing children to live healthy lifestyles is often among the top priorities of parents and business leaders—if anyone takes the time to ask them. Enlist a health education or civics teacher to use a class project to plan and conduct an opinion survey of family members, the business community, or the general public. This could also be a task for graduate students.

- *Research best practices on the proposed policy or program.* Assemble information on current scientific and medical findings; useful resource materials; relevant federal, state, or local laws; sample policies; and examples of successes elsewhere. The state department of education or department of health might be a source for model policies and guidance documents. Access professional associations and

resources listed in this guide.

- *Assess existing policies and programs.* Working with the school health council or a school staff person, determine if existing policies or programs already address the issue. Are they adequate to the task? Can an existing effort be revised and improved? It is often easier for education leaders to rework a policy or program than to adopt a new one. It could be that the issue is already being quietly addressed. In other cases, there could be a significant gap between official policies and programs and school practice. Discreetly consult with teachers, school and district-level administrators, and school health program staff such as the school nurse to learn the extent to which schools are implementing state or district policies and programs. Ask how effective they think these policies and programs are in improving students' lives, and what more could be done.

## Helpful needs assessment resources

- CDC's *School Health Index: A Self-Assessment and Planning Guide* provides a practical, detailed checklist of the elements of exemplary policies and programs on physical activity, healthy eating, and tobacco-use prevention. Designed for use by school health councils or teams of teachers, community members, students, and family members, this tool helps schools identify strengths and weaknesses in their policies and programs and develop action plans for improving student health. Download it free at [www.cdc.gov/nccdphp/dash/SHI/index.htm](http://www.cdc.gov/nccdphp/dash/SHI/index.htm).
- CDC's Youth Risk Behavior Survey System (YRBSS) provides scientifically credible national data on the prevalence of six categories of priority health risk behaviors. Data are also available for most states and local data are available for some large city school districts. For more information go to [www.cdc.gov/nccdphp/dash/yrbs/index.htm](http://www.cdc.gov/nccdphp/dash/yrbs/index.htm).
- KIDS COUNT, a project of the Annie E. Casey Foundation, is a national and state-by-state effort to track the status of children in the U.S. and provide benchmarks of child well being to policymakers and citizens. In addition to national and state data, county-level data is available for many jurisdictions. Visit [www.aecf.org/kidscount](http://www.aecf.org/kidscount).
- State Health Facts Online, an Internet resource from the Kaiser Family Foundation, provides current data on nearly 50 topics. Go to [www.statehealthfacts.kff.org](http://www.statehealthfacts.kff.org).

## Helpful policy and program guidance resources

- The school district central office, state education and health agencies, and state affiliates of health and education associations might have model policies, useful data and information, or direct technical assistance.
- CDC produced a series of school health program guidelines developed from exhaustive reviews of published research and input from experts. Each guideline document includes detailed recommendations that will help states, districts, and schools implement effective health programs and policies. For online information go to [www.cdc.gov/HealthyYouth](http://www.cdc.gov/HealthyYouth).
- The book *Health Is Academic: Creating Coordinated School Health Programs*, from the Education Development Center (EDC), contains detailed information on the roles of professionals at all levels in developing and implementing school health programs. Contact Teachers College Press at (800) 575-6566 or visit EDC's online support website, [www2.edc.org/MakingHealthAcademic](http://www2.edc.org/MakingHealthAcademic).
- NASBE's *Fit, Healthy, and Ready to Learn: A School Health Policy Guide* contains a complete orientation to "The Art of Policymaking" and offers sample policies that schools, districts, and states can adopt or adapt. Call (800) 220-5183 or go to [www.nasbe.org](http://www.nasbe.org).
- The National School Boards Association (NSBA) provides consultation and technical assistance to school districts on school health policies and programs. NSBA offers a series of policy issue briefs on foundation policies and other school health issues, and maintains a database that includes sample district policies and important research information. Call (703) 838-6722 or visit [www.nsba.org/schoolhealth](http://www.nsba.org/schoolhealth).
- The federal Safe and Drug-Free Schools and Communities program requires grantees to use "one or more strategies of the proven strategies for reducing underage alcohol abuse...whose evidence of effectiveness includes scientifically based research." The Center for Substance Abuse Prevention (CSAP) lists approved model programs that have been tested in U.S. communities and schools and proven to prevent or decrease substance abuse and other high-risk behaviors. Go to <http://modelprograms.samhsa.gov> for online descriptions.
- Child Trends, in partnership with the John S. and James L. Knight Foundation, has identified programs and approaches that experimental research studies have found to be successful in improving youth outcomes and behaviors. Visit [www.childtrends.org/whatworks\\_intro.asp](http://www.childtrends.org/whatworks_intro.asp).
- The American School Health Association (ASHA) offers *School Health: Findings from Evaluated Programs*, which summarizes evidence of program effectiveness and implications for practice for 51 school health programs. Order it at (330) 678-1601 or online at [www.ashaweb.org](http://www.ashaweb.org).
- The Office of the Surgeon General has produced several major reports on critical physical, mental, and social health needs of American youth that are available online at [www.surgeongeneral.gov](http://www.surgeongeneral.gov).
- CDC's online *Guide to Community Preventive Services* provides recommendations on health topics important to communities, public health agencies, and health care systems. It summarizes what is known about the effectiveness and cost-effectiveness of population-based interventions designed to promote health and prevent disease, injury, disability and premature death, and exposure to environmental hazards. Browse through it at [www.thecommunityguide.org](http://www.thecommunityguide.org).
- Healthfinder, operated by DHHS, is a guide to online publications, clearinghouses, databases, websites, support and self-help groups, and government agencies and non-profit organizations that produce reliable information for the public at [www.healthfinder.gov](http://www.healthfinder.gov).
- Federal Resources for Educational Excellence (FREE) is a one-stop website for hundreds of federally supported teaching and learning resources from more than thirty Federal agencies. Visit [www.ed.gov/free](http://www.ed.gov/free).
- A large number of school health program resources are available online at the School Health Resource Center of the University of Colorado Health Sciences Center at [www.uchsc.edu/schoolhealth](http://www.uchsc.edu/schoolhealth).

- *Research the legal issues.* In our litigious society, decisions of principals and school boards are often influenced by concerns about legal liability and rising insurance costs.<sup>59</sup> For example, schools are legally obligated to provide adequate supervision at high school proms and prevent foreseeable injuries. This means the school must recruit enough chaperones, abide by curfew laws, enforce drug and alcohol prohibitions, and even ensure that the entertainers indemnify the school for negligent actions or intentional misconduct.<sup>60</sup> Liability concerns can interfere with community use of school recreation facilities,<sup>61</sup> limit sports and cheerleading activities,<sup>62</sup> or influence sex education class content.<sup>63</sup> Cautious principals approached by a community professional to institute a new program will want to be fully informed about applicable laws, potential liabilities, and how to steer clear of potential lawsuits.
- *Design the policy or program.* In collaboration with the appropriate education staff members, draft a specific proposal based on the information assembled above. Gather ideas from a variety of school personnel. Call on colleagues, local community experts, professional associations, and other state and national agencies and organizations. The state department of education, regional school district, or state school boards association might be able to provide policymaking advice and sample policies. Be open to ideas for filling gaps, meeting needs, solving problems, and making essential improvements.
- Policies and programs tend to be most effective when they are based on scientifically grounded theories and carefully researched evidence of effectiveness. They also need to reflect the unique characteristics and circumstances of a state, district, and community. Proposed policies and programs must be consistent with community standards and sensitive to the considerable racial, ethnic, and cultural diversity in today's schools. In some cases, a school board might have to balance professional best-practice recommendations with community opinion to find a workable compromise.

### Garnering broad support—Power in numbers

Arguably, the most important step in promoting any school health policy or program is to enlist widespread backing for its goals and strategies. Education policymaking in the United States is grounded in democracy, and policies reflect local opinions and priorities. To a great extent, a policy's quality and usefulness depends on who proposes and supports it.

A community professional's influence with schools depends in part on intangible factors, including

### Helpful resources for building public awareness and support

- The Council of Chief State School Officers (CCSSO) and the Association of State and Territorial Health Officials (ASTHO) jointly produced *Why Support a Coordinated Approach to School Health?: A Starter Kit*, which contains easy-to-use, research-based tools and materials to educate and motivate school administrators and the public. To order call (202) 408-8072 or go to [www.ccsso.org/starterkit.html](http://www.ccsso.org/starterkit.html).
- The American Cancer Society is very active at promoting school health programs in many state and local jurisdictions. Among their publications is *Improving School Health: A Guide to Developing Targeted Awareness Campaigns*. Contact your state or local chapter, call (800) ACS-2345, or visit <http://creatinghealthyschools.org>.
- *Building Support for School Health Programs: An Action Guide*, developed by NASBE with help from professional social marketing firms, provides step-by-step guidance on how to encourage state and local businesses to support school health efforts. To order call (800) 220-5183 or visit [www.nasbe.org/NASBE\\_Bookstore/Safe\\_Healthy.html](http://www.nasbe.org/NASBE_Bookstore/Safe_Healthy.html).
- HealthComm KEY is a database of health-communication research and practice maintained by CDC's Office of Communication. Browse through it at [www.cdc.gov/od/oc/hcomm](http://www.cdc.gov/od/oc/hcomm).
- CDC's HIV Prevention Marketing Initiative was a successful community-level strategy for promoting abstinence and safer sex to adolescents in five cities. Learn about it online at [www.cdc.gov/hiv/projects/pmi/index.htm](http://www.cdc.gov/hiv/projects/pmi/index.htm).



personal prestige, standing (e.g., as an expert, parent, or civic leader), and constituency. In some cases, an individual may want to enlist the support of one or more medical societies or professional associations, public agencies, community groups, or faith-based organizations to bolster a cause. A school health coalition in the state, city, or community could provide valuable backing. A process that includes many viewpoints takes time, but the energy expended to develop broad support is usually a worthwhile investment.

Key constituencies to involve might include:

- *Health and social services providers* such as physicians, nurses, social workers, pharmacists, dentists, optometrists, and their professional organizations; health clinic administrators and staff; mental health practitioners; and staff from juvenile justice and child welfare agencies.
- Influential *community groups* such as local chapters of the American Cancer Society, the American Heart Association, the American Lung Association, the American Red Cross, and individuals who conduct community health promotion efforts; plus other voluntary organizations, including sorority and fraternal groups (e.g., Elks and Lions Clubs, Veterans of Foreign Wars, Greek letter groups), and faith-based and seniors' organizations.
- *Youth-serving community agencies* such as the YMCA, YWCA, 4-H, and Boys Girls Clubs; recreation departments; and social services agencies that could help improve coordination and consistency among initiatives.
- *Business leaders*, who are often influential in the education-reform debate. Many recognize that school health programs that foster development of healthy behaviors during childhood and adolescence can help prevent substance abuse, smoking, poor nutrition, disease, and violence in employees' families—and the future workforce. Many companies support causes that create goodwill in the community and enhance their corporate image.
- *Private-sector employees*, many of whom have school-age children. They often play a large role in determining internal

corporate priorities for community action. Their discussions in and out of the workplace can help promote the need for school health programs.

The support of those affected by the policy or program should also be enlisted. No education initiative will be effectively carried out without significant acceptance from those who are expected to implement it. School staff members, parents, students, and others need to participate in its development, revision, or review.

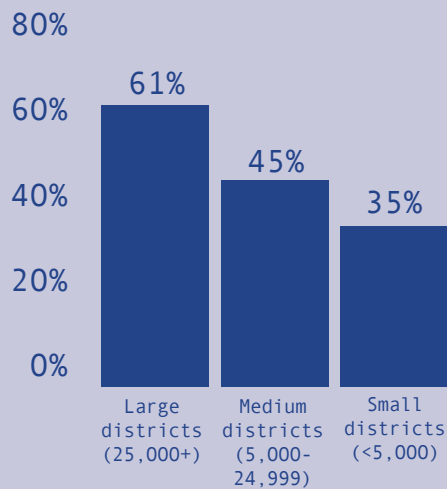
Education decision makers are more likely to attend to a proposed new policy or program that has a groundswell of public support. Those who want to strengthen school health programs might have to conduct well-organized communications efforts to increase public awareness about the value of school health programs. Proven marketing processes, principles, and techniques can be harnessed for such comprehensive communications and media plans. For example, the Healthier Schools Coordinating Committee in New Mexico used a campaign theme: "Healthier schools are the heart of our community—put your heart into it."

### Helpful resources for locating program funding

- CDC's Division of Adolescent and School Health maintains the Healthy Youth Funding Database (HY-FUND), a searchable source of information on federal, foundation, and state-specific funding sources for school health programs. Explore it at [www.cdc.gov/nccdphp/dash/funding.htm](http://www.cdc.gov/nccdphp/dash/funding.htm).
- Many family- and business-related foundations at the state and local levels provide direct funding for specific school health activities. The Foundation Center in Washington, D.C., provides useful guidance on how to search for funding assistance, conducts workshops in different cities, and offers access to an online nationwide directory of foundations. Its Foundation Finder at <http://fdncenter.org/funders> is a search tool for basic financial and contact information on more than 67,000 private and community foundations in the U.S.
- Fundsnet is dedicated to providing nonprofit organizations with online information about financial resources available on the Internet at [www.fundsnet.com](http://www.fundsnet.com).

Chart 8

Local school boards that provide formal opportunities for community input on policy formation



Source: National School Boards Association<sup>64</sup>

Getting decisions made—Engaging the process

The next tasks are to determine the most effective way to formally bring the proposed program or policy to the attention of decision makers, and devise appropriate strategies for getting their approval. Crucial decision makers might be a school, district, or state administrator; a site-based management council; or a committee of the local or state school board. Rely on key informants to learn about the formal and informal decision making processes. For example, a school board might provide formal opportunities for community input, such as conducting an open public hearing (Chart 8).

Suggest that the entire school board hold study sessions prior to any vote on the issue. Arrange for brief presentations by trustworthy experts who use language that is

simple, clear, accurate, and free of jargon (discipline-specific terminology). Effective champions that often have an impact with policymakers include physicians, parents, prominent business people, and well-prepared students. Written materials should be concise and to the point.

Education decision makers, who continually deal with an overwhelming number of concerns, may be reluctant to consider school health topics unless the problem is urgent and can be addressed at an acceptable cost. From the outset, be forthcoming about anticipated costs, legal considerations,

and potential implementation problems. It helps to offer several policy options for consideration.

Depending on current policies and attitudes, incremental steps might be more appropriate than a major push for an ideal policy or program. For example, it could ultimately be more effective to initially add a daily physical education requirement in a few grades, or tackle the issue of vending machine

contents in elementary and middle schools, where parental support for action is likely to be higher than it is in high schools. It might be prudent to establish an after-school personal counseling program in a single school and add schools gradually rather than trying to establish such programs everywhere at once.

Some complex topics, such as implementing HIV, STD, and teen pregnancy-prevention programs, might need extra time for extensive study, deliberation, or building community support. Determining what is politically feasible requires good judgment and a solid understanding of the school and the community.

It is wise to anticipate, respond to, and involve potential critics. Decision makers need to be made aware of would-be opponents and controversies that could arise during the policymaking process. They might want speaking points provided in advance. Inviting thoughtful challengers into the development process can have positive results. Opponents' constructive criticism could strengthen a proposed policy; they might even be persuaded to support the effort.

User-friendly information

Information is often most useful to decision makers when:

- Brief oral presentations (5–10 minutes) cover only the most important points and are accompanied by written summaries.
- Documents are succinct without sacrificing accuracy or context.
- Research summaries on major policy questions address disparate findings from credible organizations in balanced ways.
- Information is clearly written in language that policymakers, parents, and other laypersons can understand (i.e., a minimum of academic, public health, and social services jargon).
- Unadorned charts and graphs illustrate key findings.
- The information is timely.
- Specific conclusions and policy options are presented.

## Some final considerations

- *Respect the hierarchy.* Most administrators dislike surprises and want to know about policy and program initiatives being planned, especially if the matter might come to the school board. An eager professional who works without the cooperation of the principal or superintendent can create a new set of problems.
- *Stay focused on the ultimate goal.* As the fine points of a proposed policy or program are being worked out, it can be difficult to find an acceptable balance among competing objectives. It can help to refocus the discussion on overall goals and the best interests of children and youth.
- *Compromise does not mean defeat.* Professionals who feel strongly about their proposed program might be upset when policymakers implement it piecemeal, institute only a modest pilot program, or otherwise fail to fully adopt best-practice recommendations. Compromise is an inherent feature of the democratic political process. Rather than considering it a defeat, view compromise as a partial victory that lays a foundation for future efforts. &
- *Do not expect quick or easy success.* School health supporters who have successfully implemented new policies or programs routinely report that their accomplishments took more effort than they anticipated—and much more time. Be patient, yet persistent. As noted by an anonymous sage, “Organizational change occurs through gentle pressure, relentlessly applied.”
- *Sustain the effort.* Skeptical school personnel are familiar with programs that are instituted one year and eliminated the next. After the initial push for implementation of a new policy or program, attention may flag as compelling new issues arise. To sustain the effort, periodically note how well the policy is managed and enforced. Bring lapses to the attention of appropriate school officials. Note unanticipated problems—and benefits—of the policy. Help ensure that evaluation and feedback processes built into the policy work smoothly.

## Tips for engaging policymakers

- Note serious problems and needs but emphasize proposed solutions and policy options.&
- Articulate measurable short-term benefits such as effects on student and staff attendance.&
- Use current data from credible sources as justification.
- Stress how the proposal is consistent with existing policies and programs and helps advance state and district education goals.&
- Use current terminology used by policymakers, such as “education reform,” “ready to learn,” “student achievement,” and “leave no child behind.”&
- Highlight the coordinated school health program model as an emerging trend supported by an increasing number of boards.
- Enlist highly respected community members to express their support.
- Enlist the endorsement of the business community.
- Help students research issues, prepare presentations, and be included on public-hearing agendas.
- Make presentations at meetings and conferences attended by policymakers.
- Suggest a pilot study or other alternatives if a broad-based policy or program does not gain support.
- Help sympathetic policymakers by briefing them on answers to difficult questions and arguments that might arise in public meetings.

# Conclusion



Taking the time and effort to work with schools can be extremely rewarding, both professionally and personally.

As this document highlights, there are many opportunities for health, social services, and other professionals who work with youth to lend expertise to those in the education community.

Armed with the tips in this guide on navigating the complex education system, community professionals can move forward in their efforts to work with schools. Only by working together can health and education professionals effectively support the healthy growth and development of all children and youth.



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