CSHI Lessons from the Field

Comprehensive School Health Initiative

PUBLIC EDUCATION NETWORK

Part Three:

Creating and Managing Change through Comprehensive School Health Programs

In 1994, Public Education Network (PEN) entered into a cooperative agreement with the Centers for Disease Control and Prevention, Division of Adolescent and School Health (CDC/DASH) to integrate comprehensive school health programs (CSHP) into a larger, systemic school reform effort at the local and national levels. Under this agreement, PEN worked with and provided funds ($20,000 each year over a three-year period) to five local education funds (LEFs) to conduct local projects that would establish, enhance, and/or institutionalize school health programs within their districts—and in the case of one LEF, throughout the state. This report documents the process by which the LEFs were able to create and manage changes in the community brought about by their local school health programs.

Introduction

On August 27 and 28, 1998, PEN convened a meeting, in Washington, D.C., of representatives from LEF sites participating in the CDC/DASH Comprehensive School Health Initiative (CSHI). The purpose of the meeting was three-fold:

- to update the LEFs on the status of CSHI implementation at each site;
- to identify indicators of the CSHI success at each site; and
- to create a framework for the evaluation of CSHI efforts at each site.

All five CSHI program sites were represented at the meeting: the Academic Distinction Fund of Baton Rouge, Louisiana; the Education Alliance of Charleston, West Virginia; Lincoln Public Schools Foundation of Lincoln, Nebraska; the Public Education Fund of Providence, Rhode Island; and the Mary Lyon Education Fund, Inc. of Shelburne Falls, Massachusetts.

The development of the evaluation framework involved an interactive process, the outcome of which was a model that the participants could use to describe the CSHI activities that link school health with school reform at their respective sites. The evaluation framework was to serve as a guide for each site to develop a plan for monitoring, documenting and evaluating the continuous improvement of their comprehensive school health efforts during the 1998-1999 program year.

In using the framework, the site representatives were to consider four questions: (1) what efforts in school health and school reform existed in their communities before the CSHI was introduced; (2) what efforts exist as a result of the CSHI; (3) given what is, *how they can be improved*; and (4) *how sites will know they were improved*. The following report presents a summary of the each CSHI site's assessment of what changed in its community, as a function of the school health initiative, and what it did to create those changes.

What Changed in the CSHI Local Sites

The feedback from the five CSHI sites revealed that a variety of changes have occurred in their communities as a result of the initiative. The **Academic Distinction Fund** in Baton Rouge, Louisiana for example, reported having established in-school health clinics in two schools as a result of the CSHI, whereas, prior to the CSHI, they were only periodically serviced by school nurses. Now, the schools share a doctor, nurse, psychologist and social worker who provide services to the students through part-time clinics at both schools. The **Lincoln Public Schools Foundation** in Lincoln, Nebraska reported that Comprehensive Health Education Teams (CHET) have been instituted in all its CSHI schools. This change has served to encourage site-based ownership and goal-setting for the CSHI in Lincoln.

Other sites reported greater involvement of their various stakeholders and the broader community in CSHI projects and activities. For example**, The Education Alliance** in Charleston, West Virginia reported that many of their CSHI partners are actively engaged in other coordinated school health projects as a result of the CSH initiative. In addition, this West Virginia site reported that schools outside of the original ten Healthy Schools counties, through efforts of other partners such as the State Departments of Education and Health, are engaging in coordinated school health activities of their own. The **Mary Lyon Education Fund** in Shelburne Falls, Massachusetts reported that it now has major private and federal funding sources that partially sponsor various aspects of the CSHI.

The sites created changes in the professional development of their teachers, in school curriculum, in the involvement of parents and the broader community, and in leveraging financial and other resources to support the CSHI.

Photograph by Jim West

The **Public Education Fund** (PEF) in Providence, Rhode Island reported the creation of an advisory council for health issues where previously none had existed, and where a local network for health-related issues among education agencies and community organizations was nearly non-existent. As a result of the initiative, PEF now plays a significant role in a state-level school health advisory council and participates in shaping the efforts of the State regarding school health issues. This includes Rhode Island's newly revised State testing program, in which performance assessments in health are conducted in fifth and ninth grades. The Providence site also reported greater involvement of the CSHI with local universities. For example, students worked with chefs from Johnson and Wales University's culinary arts school on the development and testing of healthy school lunches. The program has since been expanded statewide, and has become part of the state's Team Nutrition Program. In addition, the site also reported that during the 96-98 school years, the CSHI brokered a relationship between the Brown University Community Health Advocacy Program (CHAP) and Veazie Street School to place medical students, seeking to fulfill their community service requirements, at Veazie Street, to work with the crisis team (1996) or with the school nurse (1997) on health education activities.

Avenues for Change

The reports from the five CSHI sites revealed that the changes resulting from the school health initiative took place in several areas. Specifically, the initiative led to changes in the professional development of their teachers, transformation of the school curriculum, increased involvement of parents and the broader community, and the leveraging of financial and other resources to support the CSHI. The following discussion presents examples of some of the more noteworthy changes that the sites have brought about in their communities (see Table One for a summary).

Teacher Professional Development

A variety of activities have been implemented at the CSHI sites to improve the professional development of their teachers. For example, Providence modified its Innovative Grants to Teachers (IGT) mini-grants program to make funding up to $300 available to teachers to support innovative teaching practices in health and physical education. The Baton Rouge site now offers workshops, during regularly scheduled professional development opportunities, in CPR and first aid, child abuse prevention, teacher leadership training, grant writing, and communication skills. Baton Rouge also provides training for Master

Teachers to assume responsibility for training other teachers, at each elementary grade level, on strategies for integrating health into core subject areas.

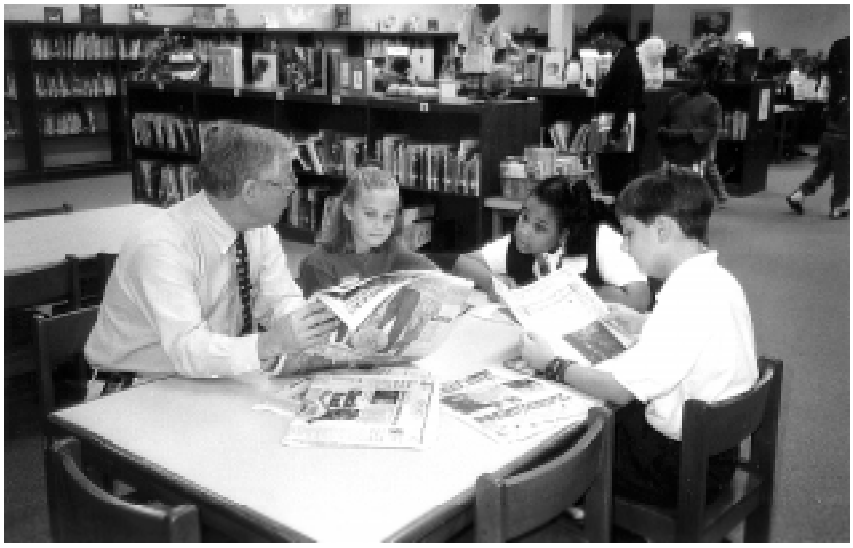
Professional development in the CSHI sites now incorporates awareness of health and physical well-being. Teachers can begin to evaluate students not only based on academic performance, but also by their over all well-being. Teachers in these sites also serve as mentors to each other, as they collectively address the needs of children, both inside and outside the classroom setting.

School Health Curriculum

Efforts to incorporate health issues into school curricula have led Lincoln, Nebraska school district to develop materials for use by all school staff that enable and encourage the infusion of health-related topics into the public school's curriculum.

Prior to the introduction of the CSHI, the public schools in Lincoln had no coherent or consistent method for incorporating comprehensive health education into the school curriculum, and "only two elementary schools out of 37 included health educators among the staff." In addition, this site reported that considerable headway was made by the CSHI in gaining acceptance among school district administrators of the concept that a student's personal health and well-being are intrinsic to academic success. This increased openness among the administrators has resulted in greater success by the CSHI in integrating the health curriculum into all academic areas.

In Providence, Rhode Island, the PEFs CSHI director, a health educator, was primary author of the State's standards-based health education performance descriptors. She now conducts professional development workshops around the State to help teachers design teaching and learning opportunities



to ensure that all students in the school system can learn and apply critical health topics.

In West Virginia, each school applying under the Education Alliance's *Working on Wellness* program develops or adopts a curriculum that addresses a specific health topic. These topics usually include the six youth risky behaviors (YRBs) identified by CDC/DASH. Together with the State Departments of Health and Education, the Education Alliance has built *Healthy Schools* throughout West Virginia, by highlighting curriculum changes, and by mobilizing local school improvement council buy-in and support.

Parent and Community Involvement

The involvement of both parents and the broader community in CSHI activities has been an important contributing factor in the initiative's success. Students involvement has also contributed to the success of the initiative. For example, the Shelburne Falls, Massachusetts site reported that many seg-

Table One: Level of Community Engagement

Site	# of Schools	# of Volunteers	Health Curriculum Changed or Modified	Money Leveraged Over Two Years
Baton Rouge, LA	2	34	yes	$50,000
Charleston, WV	47	28 + local school volunteers	yes	$65,000
Lincoln, NE	12	230	yes	$1,175,000
Providence, RI	6	<100	yes	$50,000
Shelburne Falls, MA	7	<200	yes	$1,000,000

For more information on each CSHI site, please contact the following:

Jan Melton
Executive Director
Academic Distinction Fund
Baton Rouge, Louisiana
Phone: (504) 922-4560
Fax: (504) 922-4562

Margaretta Edwards
Executive Director
Andrea Ferreira
Project Director
Public Education Fund
Providence, Rhode Island
Phone: (401) 454-1050
Fax: (401) 454-1059

Susan Silvester
Executive Director
Mary Lyon Education Fund
Shelburne Falls, Massachusetts
Phone: (413) 625-2555
Fax: (413) 625-0065

Barbara Bartle
Executive Director
Laurie Sutter
Project Director
Lincoln Public Schools Foundation
Lincoln, Nebraska
Phone: (402) 436-1612
Fax: (402) 436-1620

Monica Twyman
Program Director
The Education Alliance
Charleston, West Virginia
Phone: (304) 342-7850
Fax: (304) 342-0046

PUBLIC EDUCATION NETWORK

601 13th Street, NW
Suite 900N
Washington, DC 20005
Phone: (202)628-7460
Fax: (202)628-1893
www.publiceducation.org

Richard Tagle
Program Director

Melissa Zack
Program Assistant

Design and Layout
Nicolas F. Shi
Wow! Designs

ments of the community are involved in the CSHI (e.g., Board of Health, government, school administration, teachers, parents, and students). The Clinical Psychology Department of the University of Massachusetts has formed a series of discussion groups at high schools to provide counseling and address rural health issues identified by teens. The Rhode Island CSHI site reported that a series of workshops for families on HIV/AIDS and *Talking to Your Kids about Sex* was offered through the family center in the winter of 1997. These were scheduled independently from the CSHI.

Finally, a peer-mentoring program for students in grades 9 through 11 is being established at the Baton Rouge site where, prior to the CSHI, a school counselor had worked exclusively with a small group of seniors. In addition, students at this site currently receive credit for participating in a club for mentors that is offered in school during one of the regular school periods. All of the students have input into the selection of the club members.

CSHI has generated important changes within local communities by strengthening the communities' understanding of the connection between school health and school reform.

Leveraging Financial and Other Resources

Finally, the CSHI sites have been very successful in leveraging additional financial and other kinds of resources to support school health issues. For example, the Nebraska site reported that grants by the Corporation for National Service have provided funding for 18 full-time and 36 part-time AmeriCorps Members to work in CSHI schools to provide tutoring, mentoring and family outreach services to identified at-risk students and their families. In addition, after-school and summer programs developed by CSHI AmeriCorps Members have provided safe and intellectually stimulating environments for children during non-school hours.

The Providence site reported a number of successes in leveraging financial and other resources as a result of the CSHI. For example, the CSHI schools are now on the state HS!HK! [Healthy Schools! Healthy Kids!] mailing list. A significant outcome is that in 1997, Mt. Pleasant High was awarded $30,000 to transform its gymnasium into a fitness center for staff and the community. Another participating school, The Alternative Learning Project School, received a $10,000 grant from the Mayor's Office for Substance Abuse Prevention to develop a student leadership program.

Through its own CSHI community planning committee, Shelburn Falls was able to successfully apply for a separate federal grant to establish a much needed health center. The grant, totalling over $1 million, will allow the creation of a health center that is not only accessible not only to students and school personnel, but also to other citizens. This is certainly a great example of how collaboration, shared vision, and leveraged resources benefit everyone.

Summary and Conclusions

The Comprehensive School Health Initiative has had a tremendous impact on the local communities in which it has been implemented. It has generated important changes within local communities by strengthening their understanding of the connection between school health and school reform. It has also been used to improve professional development, change curricula, increase parent involvement and of other stakeholders, and increase the ability of communities to leverage additional financial and other resources in support of student health issues.

In addition, the CSHI sites now have a framework within which to plan for monitoring, documenting, evaluating, and ensuring the continuous improvement of their comprehensive school health efforts.

Three critical lessons were highlighted in the process:

1. *Local organizations need to be open and flexible enough to adjust to unexpected changes and outcomes*. Regardless of how much planning and foresight have been put into the program, its outcomes or activities may yield results other than those foreseen. LEFs were able to maximize the benefits of these unexpected changes by being flexible in their planning and able to modify their activities to accomodate unexpected developments.
2. *To bring about needed changes, community and school district support is essential*. LEFs in all sites have benefited from the strong support of their communities and school partners. This support may take the form of volunteers or additional funding. It is also important to create community ownership over the process and outcomes of these programs in order to make CSHI a truly collaborative effort.
3. Finally, the changes that are created may come in the short or long term, but it is important to focus not on the changes themselves but on *the benefits of comprehensive health services to children*. The LEFs have been able to incorporate this focus in every aspect of the CSHI and have, therefore, been able to leverage resources and support more effectively.