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Healthy Learning Environments

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Healthy, properly nourished students who feel safe are better able to concentrate on their work, attend school on a regular basis, and perform well in class and on tests. Despite such research findings, however, discussions about improving student achievement often occur separately from discussions about schools' roles in addressing health and safety concerns. Federal, state, and local policies are being formulated to address each concern, yet policymakers frequently fail to consider intersecting student health and achievement as they develop school improvement policies.

Although academic achievement is a key mission for schools, it is not the only goal. Public schools also prepare students to be healthy, productive, moral citizens with an appreciation for a range of knowledge and dispositions, including culture and the arts. By including such knowledge and skills as well as a supportive environment, schools help students develop physically, socially, emotionally, and cognitively. Those that satisfy these basic needs find it easier to help students improve their behavior, attitudes, and achievement (Learning First Alliance, 2001).

Schooling affects lifelong health; in general, people who attain higher levels of education tend to live longer. In recognition of this connection, the national health objectives outlined in the U.S. Department of Health and Human Services' Healthy People 2010(2000) include

- Increasing the high school completion rate to 90 percent.
- Increasing the proportion of schools that provide health education to 70 percent to reduce risk behaviors that lead to injury, chronic disease development, and death.
- Increasing to 50 percent the proportion of schools that have a nurse-to-student ratio of at least 1:750.

Without these improvements, poor health-related behaviors and conditions will continue to impede the ability of students to learn. Many students miss valuable educational opportunities because of asthma and upper respiratory infections or are inattentive in class because of poor sleep habits and inadequate nutrition. Some students cannot concentrate because of pain from dental problems or preoccupation with family conflicts, or because they experience real or perceived threats to their safety or lack the interpersonal and social skills needed to function in a modern cooperative classroom. In secondary schools, students who abuse alcohol and other drugs underachieve and cause disruption in the learning

environment (McKenzie & Richmond, 1998). Until these and other preventable and treatable health problems are addressed, the ability of most students to master even the best-designed curriculum and perform well on high-stakes tests is compromised (Lohrmann, 2003).

Analyses of 1999–2002 data from the California Healthy Kids Survey indicate a significant relationship between the annual secondary schools' standardized achievement test scores and factors related to students' health and safety, including physical exercise, nutrition, substance use, and safety at school. Over time, the data show that health risks and low levels of resiliency assets—the ability to be resilient in the face of challenges generally associated with risky behavior—have a negative effect on a school's ability to help students raise test scores (Hanson & Austin, 2003). Schools in which the mental, social, and physical health of students is protected have been able to significantly increase achievement (Marx, 2003).

Health, Education, and Accountability

Despite benefits associated with positive school health, some educators are reacting to key testing and accountability provisions within the No Child Left Behind (NCLB) Act by narrowing their focus along academic lines.

The results of three studies indicate such narrowing of the curriculum is unnecessary. Two of the studies show that students who participated in physical education programs did not experience a drop in standardized test scores, even though these programs reallocated some time from academic subjects (Sallis et al., 1999; Dwyer et al., 1983). The third study showed that 3rd and 4th grade students who received comprehensive health education scored significantly higher in math and reading than their peers who had not received such comprehensive health education (Schoener, Guerrero, & Whitney, 1988).

As a result of this and other research, most states have established requirements for health education and physical education; however, the requirements are not consistently met or enforced (NASPE, 2002) and many states do not meet the most recent K-12 guidelines issued in the National Health Education Standards' Surgeon General's Report on Physical Activity and Health, the CDC's guidelines on physical activity, and recommendations from the American Academy of Pediatrics (Kann, Brener, & Allensworth, 2001; Burgeson, Wechsler, Brener, Young, & Spain, 2001). Although schools may not be meeting the requirements their states have established, teachers, parents, and the general public still believe schools should address health issues. In a survey conducted by the Mid-continent Regional Educational Laboratory (Marzano, Kendall, & Ciccinielli, 1999), 73 percent of U.S. adults felt that health education in schools was "definitely necessary." Another survey conducted for the Center for Health and Health Care in Schools (2003) found that eight in ten parents of school-age children support health care in schools. More than 90 percent of the parents and

teachers surveyed for the Robert Wood Johnson Foundation (2003) and the National Education Association favored converting the contents of vending machines in schools to healthy foods and beverages, and more than 80 percent of parents and teachers believed students should be required to take physical education every day at every grade level.

Policymakers are also legally accountable for student health issues such as preventing sexual harassment, bullying, accidental injuries, assaults and armed attacks; ensuring toxic materials are handled properly; deciding procedures for severe weather; monitoring student immunizations; safely addressing the needs of students with symptoms of communicable diseases transmissible via casual contact; and ensuring appropriate services for students with chronic diseases (Lohrmann, 2003).

Despite these often-competing calls for action, policymakers must be careful to avoid fragmented, uncoordinated, and haphazard approaches to addressing health issues. Without a systemic approach, individual programs may compete for resources, overlap and duplicate services, or serve isolated purposes that limit the efficiency of programs to support each other and the larger purposes of education.

A Coordinated Approach

A coordinated school health program (CSHP) is a systematic approach schools use to meet the needs of the whole child and maximize the positive effect on students, schools, and communities. CSHPs generally consist of eight components, coordinated and supported through policy and planning at the local or district level (see Components of Coordinated School Health Programs, p. 3).

The goal of CSHPs is to support behaviors that enhance the health and well-being of students and staff through learning opportunities that help students acquire not only the knowledge, attitudes, and skills of a health-literate individual, but also the motivation to behave in healthy ways. CSHPs establish an environment within the school that extends to the family and community and enables, motivates, supports, and reinforces healthy behaviors. CSHPs bring together schools and the resources of other public institutions including voluntary health and youth-serving agencies, the medical profession, the faith community, and local governments—all of which are responsible for providing the community with assets to help children become healthy, happy, productive adult citizens.

Coordinating these diverse agencies and organizations allows for a greater, more cost-effective and efficient delivery of services. Generally, staff from each of the component areas, with family and community representatives, comprise a school health advisory council or committee that oversees the CSHP. Policy supports for councils may be local or state-level and frequently delineate the composition of the council. In Texas, for example, the state requires that elementary schools

establish coordinated school health programs with school health advisory committees whose members include parents.

Services provided within CSHPs include health services—such as asthma and diabetes management—that help students stay in school; nutrition services that reinforce what students learn about healthy eating in health education classes; and counseling services that support students and staff. When these resources are united, they can have a significant positive effect:

- Students who participated in school breakfast programs had significantly higher grades and test scores in mathematics, fewer absences, and less tardiness than those who did not participate (Meyers, Sampson, Weizman, Rogers, & Kayne, 1989; Murphy et al., 1998).
- Multiethnic urban children reduced their incidents of violent behavior, heavy drinking, and sexual intercourse while participating in the Seattle Social Development Program—an elementary intervention program that included teachers, parents, and children (Hawkins, Catalano, Kosterman, Abbot, & Hill, 1999).
- In four northwest urban high schools, test scores increased in schools where students experienced high expectations and caring relationships at school and participated in meaningful activities in the community—values that are inherent in fully developed school health programs (Eggert, 1994).

Local Programs

Coordinated school health programs have been established in rural, urban, and suburban schools across the country. A recent publication, *Stories from the Field*, describes lessons learned from CSHPs around the country. Many local success stories include increased student achievement, decreases in student behavior problems, and improved student and staff morale. Additionally, local resources are more effectively and efficiently used and community support for the school increases. For example, an elementary school in Louisiana experienced increased standardized test scores, decreased numbers of discipline referrals, and improved student and staff attendance after implementing a schoolwide life skills program (Collaborative for Academic, Social, and Emotional Learning, 2003).

A coordinated school health program allows for local flexibility in the way it is organized and the issues it addresses. For example, a school health advisory council may use the School Health Index, developed by the Centers for Disease Control and Prevention's Division of Adolescent and School Health, to assess its program and to determine components that need improvement. Or, a local pediatrician concerned about the number overweight children she is seeing may approach the school health advisory council to initiate coordinated interventions to address this problem (for a detailed discussion of school nutrition issues see *School Nutrition Environments and Obesity*, p. 6). Another example of how a

CSHP can address health issues is the Healthy School Report Card—currently under development by ASCD—will also help schools and communities identify and measure their school health strengths, weaknesses, and needs as part of a larger school improvement effort.

Although schools cannot be responsible for the health and safety of their students at all times (such as when they are at home or out in the community), they can ensure that students learn the knowledge and skills needed to make healthy decisions. School leaders can encourage students to make healthy choices and can adopt policies and practices that create a school environment that supports clear expectations for healthy behavior by faculty and staff, as well as students (Lohrmann, 2003).

For expanded Web coverage of local approaches to school health, visit the Emerging Issues page in the Health in Education section.

State Policy and Consultative Support

State departments play a key role in initiating and facilitating local school health activities by providing consultation and support to local program staff. Although funding requirements may locate school health programs within different state departments, structures should be created to encourage department staff to coordinate their efforts and use their limited resources more efficiently. CDC-DASH provides funding to 23 state or local education agencies for the development of state-level infrastructure to support CSHPs (CDC, 1997).

Maine and South Carolina are two states that have used CDC-DASH resources to develop sophisticated comprehensive school health programs. Maine used CDC-DASH funding to develop infrastructure that allowed staff in the state's departments of education and human services to create, advance, and sustain the coordination of school health programs across all agencies. Its coordinating school health program offers guidelines for schools to use for developing and assessing their school health programs, and as well as a toolbox for school health coordinators and a leadership network that further assists the local programs. South Carolina used its CDC-DASH resource to develop its Healthy Schools initiative after a 1989 act required the establishment of healthy school advisory committees and the provision of K-12 health education. The initiative recognizes local programs through healthy schools awards for schools that successfully document quality school health programming that has been implemented using coordinated efforts and an interdisciplinary team approach. Approaches to school health programs such as these have encouraged local school districts to undergo assessment, planning, and development of coordinated efforts to meet their students' needs.

NCLB and Student Health

Within NCLB, Title V funding may be spent for programs and services that support student health and safety. Within the U.S. Department of Education, health and safety programs are supported by the Office of Safe and Drug Free Schools, which administers discretionary grants that support programs promoting the health and well-being of students in elementary and secondary schools. Among these discretionary programs are the Carol M. White Physical Education Program (PEP), which helps local districts improve physical education programs, and a discretionary program of counseling grants for elementary and secondary schools. In 2003, 256 schools received PEP grants to help them meet state standards, and another 60 districts received counseling grants to initiate or improve school counseling programs (U.S. Department of Education, 2003a). Secretary of Education Rod Paige has praised these programs, noting that "studies show that high-quality counseling can prevent students from turning to violence, drug or alcohol abuse as well as improve grades and reduce classroom disruptions. Under No Child Left Behind, we're not only holding schools accountable for improving student achievement, we're also giving schools funds to make the classrooms, the schools and the school grounds safe and secure learning environments" (U.S. Department of Education, 2003b). Unfortunately, with state and local school budgets under pressure, many more districts applied for these federal discretionary grants than could be funded.

Additional Support for School Health Activities

In building school health programs, policymakers must look at a variety of federal offices and agencies because the responsibility for addressing such issues is not limited to the Department of Education, but spread across several agencies, including the departments of health and human service, education, agriculture, justice, and transportation, as well as the Environmental Protection Agency. Within each agency, myriad programs exist that focus on a specific area of health promotion or disease or injury prevention. Additionally, these agencies administer grant and research programs that come with specific requirements with varying degrees of flexibility. This "silo" style of funding could lead to duplicating efforts on the federal level and confusing local schools and districts seeking to address their students' needs through federal programs. To help federal departments and national organizations support the health and education of children and adolescents, the federally sponsored National Coordinating Committee on School Health and Safety works with national policymakers as they attempt to integrate health, education, nutrition, human, social, and youth services; juvenile justice; and other child-focused initiatives and programs.

Many national organizations also provide information about addressing student health needs, curriculum standards, and policy recommendations.

- Action for Healthy Kids: This nationwide initiative (<http://www.actionforhealthykids.org>) is dedicated to improving the health and educational performance of children through better nutrition

and physical activity in schools and offers success stories from schools that have made changes to support good nutrition.

- The Association for Supervision and Curriculum Development (ASCD): ASCD has helped connect policymakers with best practice information for the positive development of whole school environments. With funding from the Robert Wood Johnson Foundation, ASCD's Health in Education Initiative raises awareness among educators about the intersection between education and health, assists schools in addressing barriers to learning, and will soon release its Healthy School Report Card. This report card will allow schools to assess their environment and use the results as part of their school improvement plans and to work with the community to make positive changes for their students' health and well-being. For more information, visit the Health in Education Web area:
http://www.ascd.org/health_in_education.
- Council of Chief State School Officers (CCSSO): The CCSSO's State Collaborative on Assessment and Student Standards Health Education Assessment Project is available to guide school improvements in health education planning and delivery.
- Friends of School Health: This coalition of non-governmental education and health organizations works to educate federal policymakers about the benefits of coordinated school health programs in advancing education and health outcomes for students.
- National Association of State Boards of Education (NASBE): Between the spring of 2002 and the spring of 2003, the NASBE collected data on state-level school health policies. Its Web site, <http://www.nasbe.org/HealthySchools/index.html>, includes a repository of these policies as well as model school health policies on issues that affect student health.
- National School Boards Association (NSBA): The NSBA offers policy development consultation for its members.
- Society of State Directors of Health, Physical Education, and Recreation (SSDHPER): Members of the SSDHPER are coordinated school health program experts who, together with state departments of education and health, can assist with implementation of CSHP.

Where state-level school health advisory committees or councils exist, staff members can be sources of information about the status of CSHPs. They can also provide sample policies that support a coordinated approach to addressing student health and achievement.

Taking Action

Resources and a federal, state, and private framework for supporting comprehensive school health programs are available to policymakers interested in supporting programming that addresses the whole child's developmental

needs. Local school decision makers can ensure that the school environment supports increase student achievement several ways: by developing a school climate that supports the physical, social, emotional, and cognitive needs of students and staff; by facilitating the integration of efforts for positive student outcomes through supporting a coordinated approach to addressing student and staff physical, social, emotional, and cognitive needs through policy development, funding, and staffing; and by adopting policies and practices that create school environments that establish and support clear expectations for healthy behavior in all areas of health and safety.

If our nation is to have an economically viable, healthy, moral future, we must attend to not only the academic knowledge base of our students, but also their social, physical, and mental health needs. Coordinated school health programs are cost-effective and efficient ways to attend to the holistic needs of all our children.

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Components of Coordinated School Health Programs

Coordinated school health programs, as conceived and promoted by the Centers for Disease Control and Prevention's Division of Adolescent and School Health (CDC-DASH), consist of eight interactive components.

1. Parent and community involvement: An integrated school, parent, and community approach for enhancing the health and well-being of students. Schools actively solicit parent involvement and engage community resources and services.

2. Comprehensive school health education: A planned, sequential, K-12 curriculum that addresses the physical, mental, emotional, and social dimensions of health.

3. Physical education: A planned, sequential K-12 curriculum that provides cognitive content and learning experiences in a variety of activity areas and promotes each student's optimum physical, mental, emotional, and social development.

4. School health services: Services to appraise, protect, and promote health provided for students.

5. Counseling and psychological services: Services provided to improve students' mental, emotional, and social health through individual and group assessments, interventions, and referrals.

6. School nutrition services: Access to a variety of nutritious and appealing meals that accommodate the health and nutrition needs of all students.

7. Healthy school environment: Promotion of a healthy school environment through the physical and aesthetic surroundings and the psychosocial climate and culture of the school.

8. School-site health promotion for staff: Opportunities for school staff to improve their health status through activities such as health assessments, health education, and health-related fitness. These opportunities may improve productivity, decrease absenteeism, and reduce health insurance costs. (CDC-DASH, n.d.)

School Nutrition Environments and Obesity

Many schools depend on the revenue produced by food and beverage sales, which may generate as much as \$100,000 for a school's activities budget. Cafeteria managers depend on a la carte sales to keep their food services program operating within budget. To counter the rise in childhood obesity, schools must be held accountable for the access they provide to foods of minimum nutritional value.

One in five school-age children in the United States is overweight or obese. Childhood overweight and obesity have significant negative physical, emotional, and social ramifications. The increased incidence of childhood diabetes and asthma are related partly to overweight and obesity. In addition to increasing the risk of chronic disease development, findings from a Canadian study found that obese boys and girls are more than twice as likely than normal-weight youngsters to be victims of relational bullying—being intentionally left out of social activities (Janssen, Craig, Boyce, & Pickett, 2004).

Legislative proposals on the use and contents of vending machines have been introduced in more than 19 states. Arkansas has banned vending machines in elementary schools and recently introduced student weight and nutrition report cards. California restricts schools from having foods of minimum nutritional in the vending machines.

Local school boards—including New Haven, Connecticut; Montgomery County, Maryland; and Seattle, Washington—also regulate vending machine use, promoting a change to healthful options in vending machines, resulting in increased revenues. The Vista Unified School District's Child Nutrition Services program (San Diego, California) found that changing to healthy food vending machines generated \$200,000 more in sales (Action for Healthy Kids, 2004).

ASCD's Healthy School Report Card defines a healthy school nutrition environment as one in which the school culture supports, promotes, and reinforces healthy eating patterns and food safety. In addition to making changes in access to vending machines and their fare, schools should also provide education to families about nutrition and food safety guidelines for classroom snacks, sack lunches, field trips, and other events. Additionally, school fund-raising activities should involve only non-food items or healthy foods.

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