Promoting Public Health and Education Goals through Coordinated School Health Programs

Since 1928 the Arizona Public Health Association has adopted numerous resolutions and policy statements that address public health. This position paper seeks to provide a contemporary, science-based school health program model for promoting healthy children, families and communities. This position paper models an American Public Health Association (APHA) position statement adopted by APHA membership in 2004.

I. The Role of the Education System in Promoting Public Health Goals

According to Healthy People 2010, 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.[1]

Of the 107 Healthy People 2010 objectives related to adolescents and young adults, 10 focus on the role of schools in improving the health of young people.[2] Adult health status is directly associated with higher educational levels, regardless of income.[3] Children who do not learn to read in the first few grades, who read poorly, or who are retained in grade more than once are more likely than their peers to be drawn into a pattern of risky behaviors.[4] People who acquire more education not only are healthier and practice fewer health risk behaviors, but their children also are healthier and practice fewer health risk behaviors.[5] Increasing the high school completion rate, a major goal of the education system, is also fittingly a health objective for the nation (objective 7.1).

Preventable health risk behaviors that are often formed in childhood, persist into adulthood and are frequently interrelated include poor dietary choices; inadequate physical activity; behaviors that can result in violence or unintentional injuries; engaging in sexual behaviors that can cause HIV infection, other sexually transmitted diseases

and unintended pregnancies; and the use of tobacco, alcohol and other harmful drugs.[6] Certain risk behaviors are more likely to occur among particular subpopulations of students defined by sex, race/ethnicity and grade.[6] These behaviors can lead to serious health problems and disabilities that are costly burdens on individuals, families, and the nation. For example, annual hospital costs for obesity-related conditions among youth aged 6 to 17 increased from $35 million to $127 million from 1979 to 2000.[7]

Well-prepared and supported school staff can provide credible health information and direction on forming healthy attitudes, beliefs and habits. Students who participate in health education classes that use effective curricula have been found to increase their health knowledge and improve their health skills and behaviors.[8] School-based programs have proven effective in significantly reducing student binge drinking,[9] tobacco use,[10,11,12] physical inactivity,[13] unhealthy dietary patterns[14] and obesity.[15] For many young people, schools might be the only place they ever receive accurate information and guidance to prevent workplace injuries and other adult health problems.

Elementary and secondary schools are also valuable settings for the provision of public health services. The 53.8 million students and 3.6 million staff members in nearly 129,000 public and private elementary and secondary schools comprise 20 percent of the U.S. population.[16] More than 95 percent of children ages 5-6, 98 percent of children ages 7-15, and 93 percent of children ages 16-17 are enrolled in school and thus in easy reach of public health agencies. Schools often provide services that might not be available elsewhere. For example, schools provide most of the mental health services provided to children.[17] Many agencies work with schools to help provide critical health services,[18, 19] particularly for students with disabilities[20] and those from families in poverty.[21]

II. The Central Role of Health in Promoting Education Goals

It has long been clear that education and health are inextricably intertwined.[22] Schools

cannot achieve national educational goals if students and staff are not healthy and fit physically, mentally and socially.[4, 23] As the U.S. Department of Education has acknowledged, "Too many of our children start school unready to meet the challenges of learning, and are adversely influenced by...drug use and alcohol abuse, random violence, adolescent pregnancy, AIDS, and the rest." [24]

Student learning and academic achievement can be inhibited by poor nutritional status,[25, 26,27] poor indoor air and environmental quality,[28,29,30] uncontrolled asthma. and other chronic health conditions, undiagnosed and untreated oral health, vision and hearing problems, injuries, unaddressed social and mental health troubles, early pregnancy, alcohol and drug use and other health problems.[29,30] Educational institutions at all levels are coping with increasing prevalence of chronic health conditions that require ongoing monitoring and care by trained health professionals.[31] One child in four has been estimated to be at risk of failure in school because of social, emotional and health problems.[32] School health programs can improve education outcomes.[30,33,34] For example, a school health program designed to teach low-income elementary school students and their parents how to better manage asthma significantly increased effective asthma management behaviors, reduced asthma episodes and improved school grades.[35] School-based mental health services provided in partnership with community organizations can help elementary and secondary students succeed in school.. Parents and the general public consistently demonstrate strong support for promoting health[36, 37] and fitness[38] goals in schools.

III. The Coordinated School Health Program Model

The twin goals of education and health inspire the Coordinated School Health Program (CSHP) model, which is designed to purposefully integrate the efforts and resources of education, health and social service agencies to provide a full set of programs and services without fragmentation or wasteful duplication.[4,30, 39] The CSHP model, which is more comprehensive than prior approaches to school health,. provides a practical,

systematic and cost-efficient approach to the provision of prevention education and services. Staff interviewed from schools with a coordinated approach to school health associated this approach with higher test scores, more alert students, more positive attitudes, skill development, and readiness to learn.[40]

The CSHP model involves the active coordination of the following eight components such that each component reinforces the other.[41]

1. **A Healthy School Environment:** School buildings and the area surrounding them are safe, secure and free of tobacco and biological and chemical agents that are detrimental to health; physical conditions including noise, lighting, temperature and air quality are conducive to learning; the psychosocial climate and culture of the school promotes academic achievement and overall well-being while preventing violence and bullying; and the school facilitates and actively promotes physical activity, healthy eating and other lifelong health habits.
2. **Comprehensive Health Education:** A planned, sequential, PreK-12 curriculum taught by qualified, proficient teachers addresses the physical, mental, emotional and social dimensions of health and allows students to develop and demonstrate increasingly sophisticated health-related knowledge, attitudes, skills and practices. The curriculum is consistent with the National Health Education Standards[42] and incorporates a variety of topics including personal health, oral health, family health, community health, consumer health, environmental health, sexuality education, mental and emotional health, injury prevention and safety, nutrition, prevention and control of disease, tobacco-use prevention and substance abuse prevention.
3. **Physical Education**: A planned, sequential PreK-12 curriculum taught by qualified, proficient teachers provides cognitive content and learning experiences in a variety of activity areas such as: basic movement skills; physical fitness; rhythms and dance; games; team, dual, and individual sports; tumbling and gymnastics; and aquatics. A quality physical education program is consistent with the National Physical Education Standards,[43] promotes each student’s optimum physical, mental, emotional,

and social development, and involves activities and sports that all students enjoy and can pursue throughout their lives.

4. **School Health Services:** Services provided for students at school or in school-linked clinics by qualified professionals such as school nurses, healthcare providers, oral health professionals, health educators, optometrists and other allied health personnel are designed to ensure access or referral to primary health care services, conduct diagnostic screening, manage chronic health conditions, provide emergency care for illness or injury, prevent and control communicable disease and other health problems and provide educational and confidential counseling opportunities.

5. **School Nutrition Services:** Qualified child nutrition professionals provide access to a variety of nutritious and appealing meals that accommodate the health and nutrition needs of all students and are provided in pleasant settings with adequate time to eat and socialize. All foods and beverages sold or served at school reflect the U.S. Dietary Guidelines for Americans and other criteria to assure nutrition integrity. Also included are classroom nutrition and health education to foster lifelong habits of healthy eating, and linkages with nutrition-related community services.

6. **School Counseling and Psychological Services:** Professionals such as certified school counselors, psychologists and social workers provide services to improve students' mental, emotional, and social health and remove barriers to students' academic success, through such means as individual and group assessments, interventions, referrals, tobacco cessation programs and consultation with other school staff members.

7. **Health Promotion for School Staff:** Opportunities are provided for school staff to improve their health status and morale through such activities as health assessments, health education, tobacco cessation and health-related fitness activities so as to reduce health care costs and motivate staff to model a healthy lifestyle to students.

8. **Family and Community Involvement**: The school health program is enhanced with an integrated school, family and community approach through such means as school health advisory councils, the active solicitation of parent involvement, and the engagement of health-related community resources and services such as after-school recreation programs.

The CSHP model provides an organizational framework for school districts and state education and health agencies to use in planning, coordinating and evaluating school health initiatives, synchronizing comparable public health and school health programs, and efficiently using multiple funding sources to improve the health and education of young people. The CSHP model also addresses the national goal of eliminating health disparities in youth by addressing unmet needs in infectious and chronic health conditions as well as mental health.

Further, it informs the professional preparation and continuing education of teachers and other school health program professionals. For example, the National Council for Accreditation of Teacher Education (NCATE), in cooperation with the American Association of Health Education (AAHE) and the National Association for Sport and Physical Education (NASPE), has developed program standards for health education[44] and physical education teacher preparation programs.

In recent years, a growing number of states including Arkansas, California, Florida, Kentucky, Maine, Maryland, Michigan, New Mexico, New York, North Carolina, Oregon, Rhode Island, Tennessee, West Virginia, and Wisconsin have adopted the CSHP model and actively promote it. Numerous scientifically rigorous, practical resources have been developed by the Division of Adolescent and School Health (DASH) within the Centers for Disease Control and Prevention (CDC),[45] state education and health agencies,[46] and health and education professional organizations[47] to guide the establishment of CSHPs. Such resources can prove valuable to schools that already provide some of the components of the CSHP model, though perhaps with insufficient scope, quality or coordination.

IV. Recommendations for Implementing Coordinated School Health Programs

AzPHA supports the implementation of effective coordinated school health programs in every public and private elementary, middle, and high school across Arizona and gives

the following recommendations:

1. **Establish support infrastructure:** Each school and school district should adopt policies, employ a qualified school health coordinator, provide guidance and assistance, and assure adequate financial resources for the establishment of a coordinated school health program in each school that is managed by a school health team, school health advisory council or individual coordinator.

2. **Conduct needs assessments:** Education administrators should conduct needs assessments to identify undiagnosed health conditions or other unmet health or mental health needs that inhibit student academic success.

3. **Tailor the CSHP to the local community:** Every school should ensure that its school health program addresses the identified needs of students, is consistent with community values, is hospitable to the cultures and languages of the school population, and builds on community assets.

4. **Establish school health advisory councils:** Each school and school district should establish and support a school health advisory council (SHAC). An example of SHAC membership includes: school health program staff members, public health officials, parent representatives and members of the community to assist with the oversight, management, planning and evaluation of school health policies and programs.

5. **Increase Federal & State resources:** The federal and state government should expand support for school health coordinator positions in each state health and education agency to facilitate communication and coordination of programs among key players; coordinate school and state-level data-gathering and data-analysis for evaluation, public health surveillance and research; and provide technical assistance, professional development and other forms of support for the widespread implementation of CSHP.

6. **Improve coordination among Federal and State agencies:** The U.S. Departments of Education, Health and Human Services, Agriculture and Justice at the Federal and State level should strengthen collaboration on integrating funding streams, collecting and analyzing data, and sponsoring research on best practices to support the widespread adoption of CSHP.

7. **Improve coordination** among voluntary, health professional, and educational organizations in support of CSHP.

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