

Life Before Tests

Chronic illnesses, depression, abuse of drugs, alcohol and tobacco. Sugary snacks and drinks, vending machines, obesity and bullying. Guns, gang violence, school shootings and test scores. Teen-age birth rates, one-parent households, lack of health care or dental care and dropouts.

All of these issues are interconnected and intertwined with education reform and accountability. All must be addressed if we are to truly leave no child behind. All must be addressed if we are to salvage public schools and our society as we know it.

Letting the above issues remain unattended means school system leaders today should consider themselves trapped. On the one hand, we are expected to produce results in a variety of areas, some of which are student related, parent related, community related, test score related, teacher related and even personally related. Not only are we to achieve results in these arenas, but these results must be extraordinary.

The trap comes into the picture because all of this achievement must be attained in spite of whatever emotional, physical and mental shape children come to us in each day. This achievement must be made regardless of the ed-

A district's coordinated health approach for addressing children's full range of needs

ucation level of the parents. This achievement must occur alongside family turmoil and neglect, disease and misfortune, apathy and abuse. And, oh by the way, you can't allow any student dropouts.

Such is the monumental responsibility of a superintendent today. Don't mistake the reality check for whining. We must accomplish what often seems like the impossible—our society depends on it. Yet caught in the middle as we are, educators can and do look a little beleaguered.

The high expectations for exemplary test scores and monumental pressures for overall excellence are ever-present for school administrators. Unfortunately, the imperfect societal conditions are ominously just as present. The adminis-

trators and teachers are caught in the middle...trapped without the needed interventions being put in place. Needless to say, this trapped feeling can cause one's state of health and morale to deteriorate.

That was the dilemma we found ourselves in as the school year began in 1997 in McComb, Miss.

The Direction

As a new superintendent, the view was dismal, but the solution was clear. We had to create an atmosphere in the schools that would enable the professional educators in McComb to feel empowered and hopeful. We had to get ourselves in a position that didn't leave us feeling as though we were trapped and powerless. We had to tap into the assets and resiliency research that looked at children finding a niche and being successful in spite of not so perfect lives.

First, school leadership met with community members to look at three questions: what we didn't like about our present school district status, what we wanted our schools to be and how we could get there. As one can imagine, the answer to the first question was wide-ranging, and generally included the same demons: lack of caring, lack of instruction, lack of leadership, little



parental involvement, discipline and safety problems, dirty and outdated facilities, etc. While exasperating at times, overall it was a good exercise and very cathartic.

The answers to the second question basically meant addressing the shortfalls identified from the first question and creating a new and better product. The answers to the third question quickly became the most important. How do we do this?

The school leadership, with input from McComb citizens, collected and studied data and anecdotal evidence about our schools and our community condition. We determined with our 3,000 students (80 percent of whom qualified for free and reduced lunch) that the mental and physical health deficits had to be addressed. Students deserved the chance to learn free from as many physical and mental burdens as possible, and our teachers deserved the opportunity to teach as healthy a student as possible.

We replaced the old slogan, “It takes the entire village to raise a child,” with something we heard at the North Carolina Closing the Achievement Gap conference: “We have to change the way we do business in the village.” The change in the way we conducted the

business of educating children in McComb, with physical and mental health at the core, had dramatic implications for our school operations, but this coordinated school health approach seemed promising.

It was to be a “no excuses” approach that used improving the health of our students and teachers as the basis on which all other materials, training and leadership rested. One can have the shiniest, fastest sports car in the world, but if the road upon which it must travel is not safe, is not smooth and has potholes and rickety bridges, the car will not reach the expectations one has for it. It is doomed for failure.

The Fix

Educators in McComb, as in many other communities, were working hard. We were using great materials and the latest computer technology, but we were not reaching all of our students. No individual educators were at fault. Instead, we were failing as a system. There were too many dropouts, too many discipline referrals, test scores that too low, and teacher and community morale that wasn’t good.

The major reason for these shortcomings wasn’t that we had bad teachers or administrators. Instead, the reason was

that the road upon which we traveled (the health of our students and teachers) was in disrepair. No reading kit or math program we tried would reach its potential for all of our students as long as the students themselves were not prepared to learn. We knew our children had to be healthy to learn, but, in addition, we had to create programs in schools so that our students could learn how to be healthy.

To fix education, we had to work with the community. To fix our children, we had to reach parents. That task was not one most of us figured on in education nor is it what we were trained to do. But the reality was staring us in the face. We could moan and groan and then quit or retire, or we could work with a different and smarter approach.

The overriding premise was this: Even when we work our hardest to maximize learning for children, we sometimes fail. We fail many times because the basic physical and emotional ingredients of success are not present. Most of us know to feed our children the proper foods, to take them to the dentist, to ensure they go to bed at a decent hour, to monitor their activities to keep negative influences away, to listen and counsel and to help them find their niche in life and support them. We provide for their

safety and we make sure they know we love them.

This is second nature for most of us in middle class America, but not so for many of the parents of children we serve in our schools. The chance for success in life for these deprived children is greatly reduced without efforts to enhance their physical and emotional well-being. They will surely be the ones left behind.

A Range of Needs

The solution and focus of our efforts was simple. The solution we came up with was two-fold.

First, we had to supply a roadmap or pattern for our restructuring of schools. Maslow's Hierarchy of Needs seemed to represent the goals we held for all of our children. And besides, this concept really wasn't new. Many of us in our pre-service training had been exposed to Maslow in at least one of our educational psychology courses. Maslow supplies

us with a direction and set of goals for every child.

Next, we needed the vehicle in which to travel that road, a methodology. The logical answer was the Coordinated School Health Model, which was developed by Diane Allensworth and Lloyd Kolbe of the Centers for Disease Control. Within the original eight components were the school-based programs that would allow us to apply Maslow to every child regardless of the economics of their lives, their race, color or community status. As a school district, we agreed to apply Maslow's needs to every student through the implementation of coordinated school health. We would level the playing field enough for our children and teachers so that all children really could have a chance at succeeding.

We tried to simply the model so everyone in the community could understand our approach. (See figure be-

low.)

The school district implemented the eight components of the coordinated school health program, and we also added a ninth called "academic opportunity." The ninth component, unique to McComb, addresses early childhood, teen parenting, after-school programs and unique approaches to academic teaching and learning needed by the few children who don't respond to our district initiatives.

It has taken us six years to implement fully the Nine-Component McComb School Health Model. Each of our seven schools has programs representative of all nine components that address the needs that Maslow laid out in his hierarchy.

School and community safety go hand in hand as responsibilities shared with the city. We added nurses and mental health therapists and phys-ed teachers at each school. We have teen parent-

Indoor Air and Student Health

BY ERICKA PLATER TURNER

Poor indoor air quality compromises the ability of students to learn and teachers to teach. Students in schools in poor condition can be expected to fall 5.5 percentage points below those in schools in fair condition and 11 percentage points below those in excellent condition.

Taking a proactive stance on indoor air quality in schools is imperative for all school leaders and ultimately beneficial for our nation's school children.

AASA has been involved in indoor air quality issues since 1992 and has a cooperative agreement with the Environmental Protection Agency. AASA's indoor air initiative helps school leaders improve the school environment and reduce the negative effects of poor air quality on children's health.

The initiative, *Clearing the Air: Engaging School Leaders in Improving Children's Health*, provides training, technical assistance, exhibits, webcasts and stories of superintendents' effort at state and national conferences.

Urban Attention

AASA places special emphasis on schools serving disadvantaged and minority children in urban communities

through our Urban Resource Coalition because urban schools enroll 24 percent of all public school students, 35 percent of poor students and 43 percent of minority students nationwide.

This growing coalition is composed of 16 urban school districts ranging in size from 4,000 to nearly 750,000 students. Coalition members, including superintendents and other administrators, facilities managers and school health personnel, convene annually to discuss strategies to improve indoor air quality. The coalition has produced exceptional projects, ranging from an asthma pilot program to a science project to build broader awareness of school health.

Poor indoor air quality can aggravate asthma and other respiratory problems and can impede the core mission of educating students. Failure to maintain a healthy school environment can result in increased absenteeism of students and staff; reduced productivity for teachers and staff; increased potential for health problems; mold infestation; strained relationships among parents, staff and the community; potential liability problems; and negative media coverage leading to damaged reputations and loss of public trust.

Practical Help

AASA's initiative has identified common practices for school leaders to follow to create healthy school environments. These practices include controlling temperature, humidity and pollution sources such as art supplies and laboratory activities. Schools also should control moisture, clean up spills immediately, ventilate classrooms; provide regular housekeeping and maintenance; and use integrated pest management to minimize the use of pesticides.

The EPA has voluntary guidance that addresses indoor air quality in schools. The *Tools for Schools* kit outlines no-cost and low-cost approaches for healthier school environments. AASA provides this kit free to all interested school districts and has distributed more than 4,000 copies, resulting in more than 500 adoptions of indoor air management plans in schools.

AASA strives to raise the visibility of indoor air quality as a serious risk to children and to promote holistic solutions.

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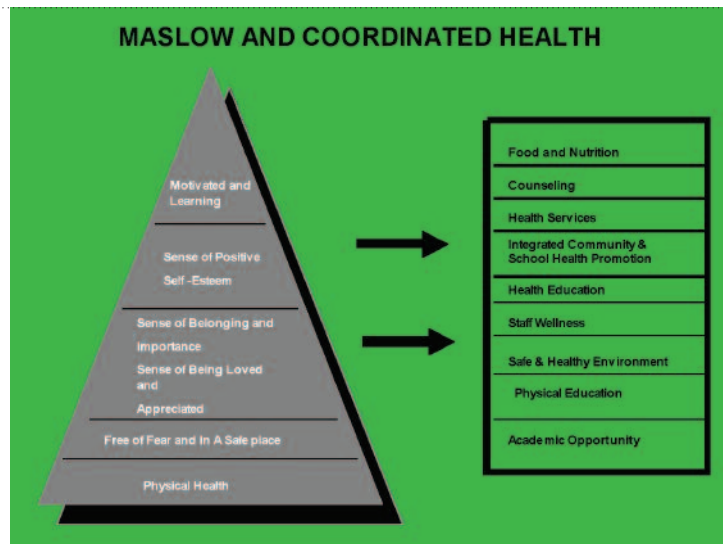
ing support groups at the junior high and the high school. A district-run preschool program and day care for teen parents has been established. Teachers and staff emphasize health education and nutrition with our students. Staff wellness is always promoted.

Formal and informal inter-agency agreements with various entities interested in the welfare of children—ranging from a formal agreement with the juvenile justice system to provide assistance with parents who commit educational neglect to an informal agreement with the local Junior League to provide school uniforms. We don't do it alone.

Sources of Support

Funding came as we built the program. Sources included the usual suspects (our local and state and federal funding) used in unusual ways, as well as some unexpected sources that came about over time.

The first action we took as a district was to call all the caretakers of funding (any person who was responsible for a



budget) together. I asked them to put their money on the table (figuratively) and then announced "It is not your money anymore, it is our children's money, it is our teachers' money." The point was that we had to first use existing dollars to our best advantage before looking somewhere else.

The other point made was that we needed to concentrate on buying people, not stuff. Real, live, caring human beings were going to make the difference with our children and families, not the

latest computer software or reading kits. Nurturing professionals were needed to implement coordinated school health, not distribute red ribbons.

So we made the decision that each principal and the school's core committee of key teachers (selected by their peers and the principal) would come to the budget meeting with all of the caretakers of funds. Jointly, they would be responsible for putting in place at least one of the

components every year until all nine components of our coordinated school health program were intact in every school for every child and every teacher.

Many of our positions and programs were funded piecemeal. For example, portions of a nurse's salary came from Title I, the federal Drug Free Schools program and district coffers. We didn't have enough money to go around that first year using this process, so interagency collaboration, the next source of funding, came into play.

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Medicaid Backing

We looked at the fact that some agency personnel, such as the health department and the local mental health agency, were having a tough time getting access to children and youth because they could not get them to come to their offices. We opened up our school to them. We not only provided access and space, we offered full cooperation so that all of our children could receive needed services.

Some of the personnel needed to initiate each component were given to us, loaned to us or leased to us by the local hospital, local mental health agency, public health agency or university med-



Caption here

ical school. We just had to open ourselves up to them.

Since that time we have been able to gradually work all of our positions into our own budget, and that occurred because of the emerging funding that appeared.

The new funding came about because of two things. One was the rise in attendance rates for our schools. The higher the average daily attendance rate, the higher the reimbursement from the state. Not so obvious at first was that we had to corral those dollars and pump them back into school health rather than football fields. We could not let them get lost in the general fund.

The second emerging fund catalyst was our implementation of Medicaid clinics in each school. Each of our nurses operates a clinic with a Medicaid number and we receive the reimbursements for screening, treatment and counseling, as well as administrative costs.

Three funding streams to Medicaid exist in the schools. One is for special education needs, another is for those children who qualify for Medicaid and who are not eligible for special education, and the third funding stream is called administrative claiming. The latter covers those staff in the district who oversee the health programs. Their salaries are reimbursed based on the hours they spend in direct health services supervision as well as the percentage of Medicaid-eligible children attending the schools.

This mechanism has allowed us to hire our own staff at each school, and this makes the creation of school-based "families" much more achievable.

Positive Signs

The successes started with us addressing the needs of the whole child and then working toward the larger system change for our school district and the community of McComb. We want to change a generation of students in spite of poverty, illiteracy, unhealthy environments and the violence all around them. Eight years later, it seems to be happening.

The dropout rates have decreased to less than 2 percent. The graduation rates are in the 90 percent range. The juvenile violent crime arrest rates for our students have dropped by 65 percent since the program's inception in 1998-99. Our discipline referrals, suspensions, expulsions and alternative school placements have significantly declined.

We have the same housing projects, the same number of one-parent households, the same poverty, the same teachers and the same reading program, but we have different children as demonstrated by much more positive behavioral and academic data. The common denominators for this success are Maslow's hierarchy of needs, coordinat-

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ed school health, an empowered staff and a believing community. ■

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