

**Defining a Comprehensive
School Health Program:
An Interim Statement**

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Committee on Comprehensive School Health Programs

Division of Health Sciences Policy

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Preface

Education and health are often said to be inextricably linked: a familiar axiom declares that students must be healthy in order to be educated, and they must be educated in order to remain healthy. In this era of interest in **educational** standards and concern for the social and health problems confronting children and young people, the pivotal role that schools can play is receiving increased attention. Schools are the community institution that touch all families-schools are "where the children are." Schools have the potential to provide more than traditional academic preparation. They are also well situated to assist in protecting and promoting students' health and well-being and to make a significant contribution to producing a new generation of healthy, productive adults.

A new concept of school health programming-the comprehensive school health program-has emerged that may hold special promise for promoting the **health** and education **goals** for our nation's children and young **people**. The Institute of Medicine has appointed a **17-member** committee to examine the structure, function, and potential of these programs. The committee represents a diversity of backgrounds- and includes physicians, nurses, health educators, science educators, social scientists, school administrators, and experts in public and child health policy.

At its first meeting, representatives from various federal agencies presented their programs and priorities in the area of school health. The committee would like to express special thanks to the following agency representatives from the U.S. Department of Health and Human Services, Public Health Service: Linda Johnston (Health Resources and Services Administration, Maternal and Child Health Bureau); Jane Martin (Health Resources and Services Administration, Bureau of Primary Health Care); William Harlan, (Disease Prevention, National Institutes of Health); Evelyn Kappeler (Office of Population Affairs); and Peter Cortese (Division of Adolescent and School Health, Program Development and Services Branch, Centers for Disease Control and Prevention); and from the U.S. Department of Education (Federal Interagency Coordinating Council, Office of the Undersecretary), Connie Gamer.

In conjunction, with its first meeting, a public workshop was convened to examine selected elements of a comprehensive school health program in depth. The committee extends its appreciation to the following workshop speakers: Tom O'Rourke, Ph.D., M.P.H. (Professor, Department of Community Health, University of Illinois) for his review of new directions in health education; Mary Jackson, B.S.N., M.Ed. (Nurse Consultant, Bureau of Women and Children, Texas Department of Health) for her analysis of the relationship of health education to the core curriculum; Eulalia Muschik, M.S., R.D. (Supervisor of Food Services, Carroll County [Maryland] Public Schools) for her examination of nutrition education and food services; Karla Shepard-Rubinger, M.S. (the Conservation Company) and John Santelli, M.D., M.P.H. (Medical Epidemiologist at the Baltimore City Health Department and Adjunct Assistant Professor, Maternal and Child Health, Johns Hopkins School of Hygiene and Public Health) for their presentations about school-affiliated clinics and service delivery; and Genie L. Wessel, R.N., M.S. (Project Director, Making the Grade Program, Maryland Governor's Office) for her presentation on approaches for integrating school health programs.

After the first meeting and workshop, the committee considered it important to develop this interim document for several reasons. First, committee members brought to the table a variety of backgrounds; we needed a common definition and understanding of what a comprehensive school health program is to serve as the foundation for our further study of these programs. Second, the committee realizes that a wide range of constituencies and disciplines are interested in these programs—teachers, administrators, health and social service professionals, parents, students, and community and political leaders. With this document, the committee hopes to inform these groups that the study has begun, generate discussion and possible informal feedback, and suggest a common language to facilitate interaction among these groups.

The committee would like to thank Valerie Setlow, Director of the Division of Health Sciences Policy, for her enthusiasm and guidance in

launching this study. Special thanks are also owed to Study Director Lois Nicholson and Research Associate Elaine Lawson for their efforts in collecting background information, organizing the first meeting and workshop, and assisting in drafting this interim statement. Sincere appreciation is also extended to Project Assistant Margo Cullen for her excellent administrative support in making meeting and committee travel arrangements, assisting in the review process and producing this interim statement. Finally, the co-chairs wish to thank all committee members for their extraordinary spirit of teamwork and commitment. It has been a special opportunity to work with such a distinguished and dedicated group, and we look forward to continuing to work together in the development and production of the committee's full report.

Diane Allensworth, *Co-chair*

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Committee on Comprehensive

School Health Programs in Grades K-12

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Summary

An Institute of Medicine (IOM) committee has begun a study of comprehensive school health programs in grades K-12. These programs propose to combine health education, health promotion and disease prevention, and access to health and social services, at the school site. While earlier generations of school health programs were predominantly concerned with stemming the threat of infectious disease, such problems have now to a large extent been superseded by the "new" morbidities-injuries, violence, substance abuse, risky sexual behaviors, psychological and emotional disorders, problems due to poverty-and by concerns about many students' lack of access to reliable health information and health care. Comprehensive school health programs may be a promising approach for addressing many of these health-related problems of today's children and young people.

The committee's charge is to examine the structure, operation, and possible outcomes of comprehensive school health programs and to consider their status and potential for wider implementation. At the conclusion of its study, the committee will produce a full report presenting its findings and recommendations, which **should** be of interest to educators, professionals in health-related fields, families, and policymakers-in short, to everyone concerned with the health, education, and quality of life of our nation's children and young people.

As a first step in the study, the committee has produced this interim statement setting forth its provisional definition of a comprehensive school

health program, to serve as the basis for further work. To provide a general context for this definition, the interim statement reviews briefly the history of school health programming and examples of previous definitions and models for these programs; these topics will be examined in depth in the full report. The interim statement also identifies additional questions and issues that emerged in the process of formulating the definition, which the committee intends to explore during the course of its study.

The provisional definition of a comprehensive school health program adopted by the IOM Committee on Comprehensive School Health Programs in Grades K-12 follows:

A comprehensive school health program is an *integrated* set of **planned, sequential, school-affiliated strategies, activities, and services** designed to promote the optimal physical, emotional, social, and educational **development** of students. The program *involves* and is **supportive of families** and is **determined** by the **local community** based on community **needs, resources, standards, and requirements**. It is **coordinated** by a **multidisciplinary team** and **accountable** to the community for program **quality and effectiveness**.

Each term in the definition is described in Chapter 3 of this document. This definition is intended to be compatible with various existing models and definitions, but allows the committee flexibility in pursuing its charge. This definition emphasizes what the committee believes are the unique features of a comprehensive school health program—family and community involvement, multiple interventions, integration of program elements, and collaboration across disciplines.

Introduction

PURPOSE OF THIS INTERIM STATEMENT

The Institute of Medicine has convened a committee to study the potentiality of comprehensive school health programs (CSHPs) in grades K-12. These programs propose to combine health education, health promotion and disease prevention, and access to health and social services, at the school site. While earlier generations of school health programs were predominantly concerned with stemming the threat of infectious disease, such problems have now to a large extent been superseded by the “new morbidities”—injuries, violence, substance abuse, risky sexual behaviors, psychological and emotional disorders, problems due to **poverty**—and by concerns about many students’ lack of access to reliable health information and health care (Dryfoos, 1994). Comprehensive school health programs may be a promising approach for addressing many of the health-related problems of today’s children and young people (Allensworth and Kolbe, 1987; Nader, 1990; Lavin et al., 1992; American Academy of Pediatrics, 1993, 1994a).

During the course its study, the committee will examine what constitutes a CSHP, how its components fit together, the desirable and feasible health and education outcomes of these programs, and program configurations to produce optimal outcomes. The committee will also assess the current status of CSHPs and, if appropriate, recommend strategies for their wider implementation. A full report will be produced at the end of the study presenting the committee’s findings and recommendations.

At the onset of the committee's work, it became evident that a broad range of constituencies has become *interested* and involved in **CSHPs**, and a variety of conceptions *exist* about 'what these programs are and do. The committee itself represents a diversity of backgrounds and **experiences**, and determined that it would be **useful** to establish its own working definition of the **term**, "comprehensive school health program." This interim statement sets forth the committee's definition; *it is* intended to serve as a guide for the rest of the *committee's work* and to stimulate discussion among those involved in the field.

WHY THE COMMITTEE NEEDED TO ESTABLISH ITS DEFINITION

The structure and operation of a comprehensive school health program have been contemplated, but few, if any, truly comprehensive programs have actually been **implemented** and institutionalized. The vision of what **constitutes** a comprehensive school health program continues *to evolve*, and several models and definitions for these *programs have* been proposed. Some definitions *are* conceptual and focus on the desired goals for these programs, others are operational and emphasize essential program processes or components. The committee acknowledges the contributions these *various* models and definitions have made and uses them as the starting point for its own definition. The committee believes that *its* definition-and the elaboration of key terms in its definition-will further **clarify** the nature and essential elements of these programs. Through this interim statement, the committee is also attempting to generate discussion *in* the education, health, and social services fields and to suggest a common language that might facilitate interactions across these fields.

THE CONTEMPORARY CONTEXT FOR THE DEFINITION

Interest in the education, health, and welfare of *our nation's children* and youth has reached a new **level** (National Commission on Children, 199 J). **Economically**, children are the poorest segment of our citizenry, and infant

¹ The term "health" is used throughout this interim report in a broad sense to include optimal physical, mental, social, and emotional function, not just the absence of disease.

² The following poverty rates existed in 1992: children under age 18, 21.9%; adults 18-64, 11.7%; adults 65 and older, 12.9% (National Research Council, 1995).

mortality rates in some parts of the country are as high as those in many developing countries.' The greatest threats to **child and adolescent** health-injuries, violence, substance abuse, risky sexual behavior, poor dietary and physical activity habits-can be attributed to conditions and behaviors that are preventable. In addition, the major causes of chronic disease and death among adults-cancer, heart disease, injury, stroke, liver and lung disease-can be influenced by health behaviors and lifestyles established during childhood and youth (US. Department of Health and Human Services, 1990). To improve the health of all age groups, the U.S. Public Health Service, in partnership with **practitioners** and private organizations, developed the **Healthy People 2000** initiative, a set of nearly 300 national health **promotion** and disease prevention objectives to be achieved by the year 2000. An examination shows that one-third of these objectives can be influenced **significantly** or achieved in or through the schools (McGinnis and DeGraw, 1991).

Concern about students' academic performance has led to a **national** education reform **movement** and national standards in core academic **subjects**. The *relationship* between academic achievement and student health status has been acknowledged by the National Education Goals, a bipartisan effort that began at a national governors' summit convened by President Bush in 1989. Among its directives, the National Education Goals call for (National Education Goals Panel, 1994):

1. Students to start school with the healthy minds, bodies, and mental alertness necessary for learning.
2. Safe, disciplined, alcohol- and drug-free school environments.
3. Access for **all** students to physical education and health education to ensure that students *are* healthy and **fit**.
4. Increased parental partnerships with schools in order to promote the social, emotional, and academic growth of children.

Although the prospects for future federal health care legislation are uncertain, the reform of the health care delivery system is a topic receiving intense **attention**. Many states are passing their own legislation to reform **health** care at the state level; this legislation will affect the quality and equity of **care** for children as access to care is *beginning to* differ **from** state to state. Increasingly greater numbers of individuals participate in managed health care arrangements, which emphasize prevention and early **detection** of health problems in order to maximize the effectiveness and contain the costs of care.

³For example, the infant mortality rate for U.S. blacks ranks 40th when compared with other countries' overall rates; countries ranking higher include Jamaica, Costa Rica, Malaysia, and Sri Lanka (Children's Defense Fund, 1994).

Against this backdrop of health and academic concerns, our nation's schools stand out as those community institutions that touch all children and families. The school may, in fact, be the public institution that is most familiar, convenient, and welcoming to families, especially families in disadvantaged communities who have the greatest needs and the most limited access to services. Comprehensive school health programs are intended to take advantage of the pivotal position of the school by making the school the location of a set of integrated programs and services to enhance the education, health, and welfare of children and their families. These programs may not only improve health and educational outcomes for students but also reduce overall health care costs by emphasizing prevention and early identification of health problems and by providing easy access to care.

CRITICAL ASSUMPTIONS

Given today's education and health care environment, the committee began its work with the following, fundamental assumptions:

1. The primary goal of schools is education.
2. Education and health are linked; academic performance is related to health status.⁴
3. Efforts to promote student health and prevent disease are an essential component of a school's education program.

With regard to the last assumption, the committee recognizes the many demands that have been placed upon *the* schools. Even before beginning its study, the committee agreed that although the school may be the site for programs to promote student health and prevent disease, these programs are not the sole responsibility of the schools *but of the entire community*,⁵ including the health care and social services sectors. In fact, to emphasize that the responsibility for these programs must be shared, some have suggested that the title "comprehensive school health program" be reworded or even that the

⁴The nature and extent of this linkage will be examined further in the committee's full report.

⁵The term "community" will be explained in Chapter 3 as part of the discussion of terms in the definition. However, since the term is frequently used prior to that section, a brief explanation here is in order. The term "community" refers to the wide range of stakeholders at the particular site where the program will be implemented, including parents, students, educators, health and social service personnel, insurers, and business and political leaders.

word "school" be eliminated, lest it be assumed that the burden lies only on the schools. That may not be practical, given the widespread use of the phrase and the fact that the schools *do* provide the focus and target site for these programs. However, it is likely to be useful in the committee's further work to distinguish the various levels of school responsibility and involvement as follows:

- Programs/services that schools have the responsibility to *deliver*, such as classroom instruction.
- Programs/services that schools have the responsibility to *arrange*, such as clinical services.
- Programs/services with which schools should *affiliate* to benefit students, such as family protective services or public safety campaigns.
- Programs/services that schools should *promote*, such as youth services and agencies or church-based programs.

In any event, the roles and responsibilities of others beyond the education sector will be *closely* examined during the rest of the committee's study.

ORGANIZATION OF THE REMAINDER OF THE INTERIM STATEMENT

Chapter 2 describes the historical background and evolution of health programming in the schools, proposes goals and optimal outcomes for comprehensive school health programs, and reviews previous definitions and models of school health programs. Chapter 3 gives the committee's provisional definition of a comprehensive school health program, with an explanation of terms. This definition may be subject to revision or expansion, based on findings from the committee's study. Chapter 4 sets forth a set of questions and issues that the committee intends to examine in its full report.

The Evolution of School Health Programs

HISTORICAL OVERVIEW OF SCHOOL HEALTH⁶

Numerous public health initiatives, reports, studies, organizations, and professional societies have promoted the development of school health since the colonial American era. In fact, Benjamin Franklin advocated a "healthful situation" and promoted physical exercise as one of the primary subjects in the schools that were developing during his time. However, prior to the mid-1800s, efforts to introduce health into the schools were isolated and sparse. It was not until 1840 that Rhode Island passed the first legislation to make health education mandatory, and other states soon adopted this concept.

In 1850, the Sanitary Commission of Massachusetts, headed by Lemuel Shattuck, produced a report that has *become* a classic in the field of public health and had a significant influence on school health. Shattuck served as a teacher in Detroit and member of the school committee in Concord, Massachusetts, where he helped reorganize the public school system of the town. This background led to school programs receiving major attention as a means to promote public health and prevent disease. The report states that

good health is the basis for wealth, happiness, and long life and that all children should be taught that preserving their health and the health of others is one of their most important duties. Knowledge leads to good health, while ignorance leads to poor health and disease,

Between the late 1800s and 1950, many social concerns and public health issues focused on the role of schools in promoting and maintaining health. In the 1890s, schools in Boston and Philadelphia were early pioneers in establishing cooperative programs with philanthropic organizations to provide school lunches to fight malnutrition. The era of "medical inspection" in schools started at the end of the nineteenth century in response to problems of urbanization and immigration. In 1894, 50 "medical visitors" were appointed in Boston to visit schools and examine children thought to be "ailing." By 1897, Chicago, Philadelphia, and New York had all started comparable programs, and most of the participating medical personnel provided their services without compensation. The success of these early programs developed into more formalized medical inspection. In 1899, Connecticut made examination of school children for visual defects compulsory. In 1902, New York City provided for the routine inspection of ail students to detect contagious eye and skin diseases and employed school nurses to help their families seek and follow through with treatment. In 1906, Massachusetts made medical inspection compulsory in all public schools and this ushered in broad-based programs of medical inspections in which school nurses and physicians participated. By 1911, there were 102 cities employing cadres of school nurses. In 1913, New York City alone had 176 school nurses. A great deal of the nurses' time was spent in home visits to families with children who had been excluded from school because of illness or infection, encouraging these families to have their children treated and returned to school. During this period the prevalence of tuberculosis in the United States also had a dramatic impact on school health with the development and spread of "open-air classrooms" in all major cities under the supervision of both medical and educational personnel.

One of the most influential groups in the development of school health was the Joint Committee on Health Problems and Education, which was jointly sponsored by the American Medical Association (AMA) and the National Education Association (NEA). Prior to 1920, the committee published the report *Minimum Health Requirements for Rural Schools*. Their 1927 paper *Health Supervision and Medical Inspection of Schools* strongly promoted the emerging concept of coordination among the medical services, the physical education, and the health education programs in schools.

Early in the 1920s, the AMA/NEA Joint Committee on Health Problems and Education reported the results of a nationwide survey on the status of health education in 341 city schools. The findings are particularly interesting

⁶ Much of the information in this synopsis has been excerpted from the book entitled, *Historical Perspectives on School Health*, by Richard Means, Ed.D. (Means, 1975). The reader is encouraged to refer to this source book for a more complete understanding of the history of school health in the United States prior to 1975.

in light of the current U.S. Public Health Service's *Healthy People 2000*, which calls for an "increase to at least 75 percent the proportion of the nation's elementary and secondary schools that provide planned and sequential kindergarten through grade 12 quality school health education" (U.S. Department of Health and Human Services, 1990). In the 1920s, over 73 percent of the surveyed schools taught health directly under the name of "health" or "hygiene." Correlating content in their health curriculum to other subjects such as language, civics, reading, physical education, general science, and art was reported by 108 cities. Daily inspection for health habits was reported by 69 percent of the 341 cities and nearly 30 percent reported having organized student health clubs for the promotion of health in the elementary schools.

School health became the focus of a variety of organizations during the 1930s. The May 1938 issue of the *Journal of Educational Sociology* was exclusively devoted to the subject under the theme "Health Education." At the end of the decade, the Educational Policies Commission of the NEA issued a report, *Social Services and the Schools*. The report dealt with administrative guidelines for health examination, medical attention, communicable disease control, mental health, health instruction, the healthful environment and regimen, and health supervision of teachers and employees:

The focus on school health continued throughout the next several decades. In 1940, the U.S. Public Health Service published a 100-page pamphlet titled *High Schools and Sex Education*. In 1940, the Eighteenth Yearbook of the American Association of School Administrators was titled *Safety Education*. In 1942, the Twentieth Yearbook was *Health in Schools*. When many World War II draftees were found to suffer from nutritional deficiencies, the school was considered the place to focus on a solution; the National School Lunch Act was passed in 1946 to provide federal funds and surplus agricultural commodities to assist local schools in providing a nutritious hot lunch to school children. In 1950, the Twenty-Ninth Yearbook of the Department of Elementary School Principals of the NEA was titled *Health in the Elementary School*. The February 1960 issue of *The National Elementary Principal* also featured elementary school health programs including health services, health instruction, and health administration. The AMA/NEA Joint Committee on Health Problems in Education issued three editions of a publication titled *Health Appraisal of School Children*. This booklet established "standards for determining the health status of school children, through the cooperation of parents, teachers, physicians, nurses, dentists, and others."

The most significant school health education initiative of the 1960s was the School Health Education Study (SHES). This study defined health as a dynamic, multidimensional entity and outlined 10 conceptual areas of focus that over the years have often been translated into 10 instructional content

areas. These conceptual areas include such themes as human growth and development, personal health practices, accidents and disease, food and nutrition, mood-altering substances, and the role of the family in fulfilling health needs. The primary publication from this initiative was titled *School Health Education Study: A Summary Report*, which provided the basis for most of the current legislation on school health education (Sliepevich, 1964). Numerous additional publications resulted from nearly 10 years of this activity, including curriculum designs and teacher-student resource guides addressing the 10 instructional content areas of health education across all grade levels.

Several important school health services initiatives also took place in the 1960s, including the U.S. Public Health Service's study of school health services and the Title I provision of the Elementary and Secondary Education Act, which tripled the number of school nurses. Another significant event was the development of the school nurse practitioner role in the late 1960s. At this time, issues of diagnosis and treatment in nontraditional health facilities surfaced, and the prevailing belief was that such activities were not permissible by any primary care provider, including physicians in the school. However, by 1972, a state-by-state survey sponsored by the Robert Wood Johnson Foundation failed to uncover any legislation that would prohibit the delivery of these services in schools, and working in close collaboration with physicians, the clinical functions of school nurses were expanded to include primary care services. The introduction of school nurse practitioners into schools resulted in reaching students in need of primary care, an increase in problem resolution rates, and greater accuracy in excluding students from school for illness and injury (Hilmar and McAtee, 1973; Kohn, 1979; Silver et al., 1976).

During the twentieth century, several White House conferences have been convened that relate directly to school health issues. One of the most important was the White House Conference on Children and Youth, which had a session in December 1970 on children under age 13 and a session in February 1971 on young people over age 13. Each of the landmark conferences resulted in specific recommendations and suggested programs related to school health services, health instruction, and a healthy school environment.

Many additional developments in school health have taken place in recent years. Examples include: the establishment and funding of school health initiatives through the Centers for Disease Control and Prevention; the creation of a Federal Interagency Committee on School Health, chaired by the assistant secretaries of health and of elementary and secondary education, and a National Coordinating Committee on School Health; and the Robert Wood Johnson Foundation school-based clinic initiative, which catalyzed the rapid proliferation of school-based clinics.

The committee will revisit some of these historical developments in its full report in order to understand the lessons learned and the bases for current programs. However, it is clear from this brief overview that for many decades, health and education professionals have joined together to establish, implement, and evaluate school health programs in response to societal needs. The history of these school health programs provides perspective and a valuable resource of information for understanding current programs and for designing and improving programs in the future.

THE COMPREHENSIVE SCHOOL HEALTH PROGRAM

Today, school health has evolved into what is termed a comprehensive school health program (CSHP). The committee believes that the general goal of a CSHP is to establish a system of home, school, and community support to assure that students are provided with a planned sequential program of study, appropriate services, and a nurturing environment that promotes the development of healthy, well-educated, productive citizens.

At this preliminary stage, the committee has proposed a set of optimal outcomes for CSHPs—a vision of what these programs ought to be and what they might be able to do. The feasibility of these outcomes and possible strategies for achieving them will be examined in the committee's full report. The optimal outcomes can be categorized into three general areas:

1. student outcomes,
2. programmatic and organizational outcomes, and
3. community outcomes.

Student Outcomes

Students will assume personal responsibility for avoiding social, emotional, and physical health-compromising behaviors and for engaging in health-promoting behaviors. Students' health needs—preventative, emergency, acute, and chronic—will be addressed to allow students to reach the highest possible level of educational achievement and personal health. Particular attention will be given to the health component of Individual Education Plans of students with special health care needs who require special education and related services.

Programmatic and Organizational Outcomes

The relationship between health status and educational achievement will be evident in the policies and programs of the school. The school's health emphasis will be integrated across all activities. Linkages among program components, disciplines, and participating agencies will be clearly defined and regularly evaluated. Individual and group health problems will be identified and managed with appropriate prevention, assessment, intervention or referral, and follow-up measures. Services will be organized to provide appropriate and timely responses to emergency, acute, and chronic health problems. The school's education and health programs will be continually reexamined and reformed as necessary to enhance student health, performance, and achievement.

Community Outcomes

The community will be actively involved in determining the design of a school health program and in supporting and reinforcing the goals of the program. This design will include assurance that schools are safe, with an environment conducive to learning and health promotion, and that policies and procedures are in place to enhance the use of schools as a community resource for health. All health-related programs delivered by the school and by community members through the schools will enhance the health status of the students and result in an improvement of the health and quality of life of the community.

PREVIOUS DEFINITIONS AND MODELS OF SCHOOL HEALTH PROGRAMS

The Three-Component Model

The three-component model is considered the traditional model of school health programs. Originating in the early 1900s and evolving through the 1980s, this model defines a school health program as consisting of the following three basic components:

1. *Health instruction* is accomplished through a comprehensive health education curriculum that focuses on increasing student understanding of health principles and modifying health-related behaviors.

2. **Health services** includes prevention and early identification and remediation of student health problems.

3. **A healthful environment** is concerned with the physical and the psychosocial setting and such issues as safety, nutrition, food service, and a positive learning atmosphere.

The Eight-Component Model

In the 1980s, the three-component model was expanded to include additional components (Kolbe, 1986; Allensworth and Kolbe, 1987). According to this model, a comprehensive school health program contains the following eight essential components:

1. **Health education** consists of a planned, sequential, K-12 curriculum that addresses the physical, mental, emotional, and social dimensions of health.

2. **Physical education** is a planned, sequential, K-12 curriculum promoting physical fitness and activities that all students could enjoy and pursue throughout their lives.

3. **Health services** focuses on prevention and early intervention, including the provision of emergency care, primary care, access and referral to community health services, and management of chronic health conditions. Services are provided to students as individuals and in groups.

4. **Nutrition services** provides access to a variety of nutritious and appealing meals, an environment that promotes healthful food choices, and support for nutrition instruction in the classroom and cafeteria.

5. **Health promotion for staff** provides health assessments, education, and fitness activities for faculty and staff, and encourages their greater commitment to promoting students' health by becoming positive role models.

6. **Counseling, psychological, and social services** include school-based interventions and referrals to community providers.

7. **Healthy school environment** addresses both the physical and psychosocial climate of the school.

8. **Parent and community involvement** engages a wide range of resources and support to enhance the health and well-being of students.

The Division of Adolescent and School Health of the Centers for Disease Control and Prevention has promoted the eight-component model, and it has received widespread attention and adoption by many states in recent years.

Joint Committee on Health Education Terminology

In 1990, the Association for the Advancement of Health Education convened a committee of delegates from the Coalition of National Health Organizations' and the American Academy of Pediatrics. The charge to this Joint Committee on Health Education Terminology was to review and update earlier terminology and to provide definitions for new terms currently used in the health education field. The Joint Committee defined a CSHP as follows (Joint Committee on Health Education Terminology, 1991):

A comprehensive school health program is an organized set of policies, procedures, and activities designed to protect and promote the health and well-being of students and staff which has traditionally included health services, healthful school environment, and health education. It should also include, but not be limited to, guidance and counseling, physical education, food service, social work, psychological services, and employee health promotion.

Related Models and Definitions

In recent years, additional models, definitions and descriptions have emerged that build upon previous models. Several examples are discussed below.

• Nader (1990) has proposed that the school is one locus of a broad range of health and educational activities, carried out by a diverse group of health and educational personnel based both in the community and in the school. The model emphasizes that the school, community, and family/friends are the three important systems supporting children's health status and educational achievement. Further, the media—including educational, electronic, and print media—play a prominent role as part of the community system in influencing health-related behaviors. According to this model, the first steps in developing a CSHP are to establish community linkages and carry out a community needs and resources assessment. These steps will then lead to the implementation and

*Members of the Coalition are: American Public Health Association, School Health Education and Services Section and the Public Health Education and Health Promotion Section; American College Health Association; American School Health Association; Association for the Advancement of Health Education; American Alliance for Health, Physical Education, Recreation and Dance; Association of State and Territorial Directors of Public Health Education; Society for Public Health Education, Inc.; and the Society of State Directors of Health, Physical Education and

expansion of school health services, school health education, and a healthful school environment.

- Allensworth (1993) has described a CSHP by what it does, rather than by listing what it contains. According to this model, a comprehensive school health program:

- Focuses on priority behaviors that interfere with learning and long-term well-being.
- Fosters the development of a supportive foundation of family, friends, and community.
- Coordinates multiple programs within the school and community.
- Uses interdisciplinary and interagency teams to coordinate the program.
- Uses multiple intervention strategies to attain programmatic goals.
- Promotes active student involvement.
- Solicits active family involvement.
- Provides staff development.
- Accomplishes health promotional goals via a program planning process.

The Illinois Department of Health has recently developed a model of a CSHP as part of their long-range plan for school health (Wallace et al., 1992). This model consists of six critical elements:

1. management,
2. health promotion and education,
3. school health services,
4. healthy and safe environment,
5. integration of school and community programs, and
6. specialized services for students with special needs.

The distinguishing characteristics of this model include the importance of the management role in coordinating and integrating the other critical elements, and the emphasis on students with special health care needs.

- International models often include the school health program as an element of a country's primary health care system (Wallace, et al., 1992). Although each country's approach to primary health care may vary, school programs throughout the world typically include components of preventive, promotive, curative, and rehabilitative services. Another prominent feature in many countries is the strong collaboration between the school nurse and physician, with both health professionals often available to the school, either on a full- or part-time basis.

Full-Service Schools

Previous definitions and models have culminated in the full-service schools model (Dryfoos, 1994). A full-service school is the center for collocating a wide range of health, mental health, social, and/or family services into a one-stop, seamless institution. The exact nature and configuration of services and resources offered will vary from place to place, but services should thoroughly address the unique needs of each particular school and community—hence the title “full-service schools.”

According to this model, a full-service school provides a quality education for students that includes individualized instruction, team teaching, cooperative learning, a healthy school climate, alternatives to tracking, parental involvement, and effective discipline. The school and/or community agencies provide comprehensive health education, health promotion, social skills training, and preparation for the world of work.

A distinguishing feature of this model is the broad spectrum of services to be provided at the school site by community agencies. Some examples of these various services include:

- Health services: health and dental screening, nutrition, and weight management.
- Mental health services: individual counseling, crisis intervention, and substance abuse treatment and follow-up.
- Family welfare and social services: family planning; child care; parent literacy; employment training; legal **services**; **basic** services for housing, food, and **clothing**; and recreation and **cultural** activities.

SUMMARY

The preceding discussion of definitions and models is not intended to be exhaustive. Other worthy definitions and models may exist, and any exclusion from this discussion is not intended to minimize their importance. Instead, the purpose of the preceding discussion is to illustrate the diversity of definitions that exist and to emphasize that as these models and definitions have evolved, they tend to become more complex and appear to demand more from the schools and community.

Committee's Definition and Explanation of Terms

The provisional definition of a comprehensive school health program (CSHP) adopted by the Committee on Comprehensive School Health Programs in Grades K-12 follows:

*A comprehensive school health program is an **integrated** set of **planned, sequential, school-affiliated strategies, activities, and services** designed to promote the optimal physical, emotional, social, and educational **development** of students. The program **involves** and is **supportive of families** and is **determined** by the local **community** based on community **needs, resources, standards, and requirements**. **It is coordinated by a multidisciplinary team and accountable to the community for program quality and effectiveness.***

The committee recognizes that many widely used definitions of CSHPs list a set of essential program components. The committee acknowledges that there are undoubtedly certain basic key components of these programs but decided not to define a CSHP in terms of these components at this initial stage of deliberation. During its study, the committee will examine **evidence** about the impact and interrelationship of various program components, and in its full report the committee will likely make recommendations about the importance and **necessity** of particular components. Since **communities** needs and resources vary, perhaps the components-or the relative emphasis on various **components**—may be different from one community to the next. Thus, the committee chose to adopt a **preliminary** definition that would be compatible

with existing definitions but not confine or constrain the committee's study. The committee's definition emphasizes the **unique** features of these programs—family and community involvement, multiple interventions, integration of program elements, and collaboration across disciplines. Each italicized term or phrase in the definition is explained in the following discussion.

COMPREHENSIVE

The term comprehensive means inclusive, covering completely and broadly, and refers to a broad range of health and education components. Thus CSHPs are a broad set of school-based and community-based components involving a wide range of professionals. Examples of components include health education, health services, physical education, counseling and psychological services, nutrition and food programs, a healthful and supportive school environment, work-site health promotion for **school** faculty and staff, and integration of school programs with a wide range of community health and social programs. These components provide educational, social, and health care interventions assisting students and families in preventing disease, promoting and protecting health, minimizing the complications of health problems, and managing chronic conditions.

While **comprehensive** implies broad and complete coverage, it should be emphasized that programs and services actually delivered **at** the school site may not provide complete coverage by themselves. Instead, school-site programs and services are intended to work with and complement the efforts of families, primary sources of health care, and other health and social service resources in the community to produce a continuous and complete system to promote and protect students' health.

INTEGRATED

Integrated means to form, coordinate, or blend into a -functioning or unified whole, to unite. When the various elements of CSHPs are integrated, they mutually reinforce and support each other, and produce a whole that is greater than the sum of its separate parts, in meeting the health needs of students and fostering student health literacy.

As an example, consider how the various elements of a CSHP might be integrated in the area of nutrition. Lessons on nutrition in the health education classroom can be supported by a school food service that serves healthful, well-balanced meals and labels the nutritional content of cafeteria selections.

Classroom lessons can also be strengthened by school policies requiring that foods available through vending machines and **fundraising** drives meet a high standard of nutrition. School nurses and counselors can promote awareness about weight management and eating disorders and provide assistance for students with problems in this area. Physical education instructors can help students understand the relationship between nutrition and physical stamina and performance, and nutrition-related topics can enhance instruction in other subject matter areas, such as science, mathematics, and social studies. Community-wide campaigns can promote nutrition awareness so that healthy eating habits acquired in school will be reinforced in the home.

A single standard process for achieving integration does not exist, for each situation is unique. In general, however, an *integrated* program is characterized by a community-based approach to identify the needs and resources in the educational, health care, and social services areas, and to develop a delivery system that may more effectively and efficiently meet these needs (American Academy of Pediatrics, 1994b).

PLANNED

The term *planned* implies a deliberate design, a detailed formulation of a program of action. Planning involves developing an orderly arrangement of *program* strategies, activities, and services, after careful consideration of needs and resources, in order to meet the needs of students and their families. Comprehensive school health programs should include a *planning* process that involves a broad range of people—providers and recipients of programs and a cross section of community members. The **planning** process should begin by conducting a local needs and resources assessment and establishing desired local goals and outcomes. A program to achieve the goals must then be designed and implemented, with **specific** timelines and **benchmarks**. An essential component of the planning process is ongoing process and outcomes evaluation.

SEQUENTIAL

The term *sequential* implies a deliberate ordering or succession of program **elements**, so that each successive event builds upon previous student experience and is compatible with a student's developmental status. Health beliefs, behaviors, and needs of children change with age and experience. As children grow to full size and maturity, different physical, cognitive, social, personal, and sexual characteristics must be addressed. Early case finding must

identify and promptly confront any **problems** that **would** interfere with this process. A sound understanding of child **development** principles—including physical, cognitive, social, and emotional development—is required to design an effective sequence or ordering of program activities.

SCHOOL-AFFILIATED

The term *school-affiliated* refers to activities that are school-based, **school-linked**, or have any other connection with the schools. *School-affiliated* activities generally represent a collaborative effort in which the school and community partners share in the planning and governance responsibilities. Examples include **health** services, environmental health and safety measures, counseling programs, and social services. *School-affiliated* activities may be provided on-site at the school (school-based) or off-site but coordinated with the school (school-linked). School-based services may be provided by school personnel or by community agency personnel working on-site at the school. Generally, school personnel do not provide services outside the school, although community outreach and home visits by school personnel are often utilized in school-linked programs.

STRATEGIES, ACTIVITIES, SERVICES

Strategies, *activities*, and services refer to approaches, methods, actions, and interventions for the purpose of accomplishing program goals and objectives. *Strategies* are the **overall** approach or network of related methods and processes, **carefully** designed to achieve desired goals. Examples include policy mandates, environmental change, media use, role modeling, and social support. *Activities* and services are those specific and concrete actions carried out as part of a strategy. **Examples** are classroom lessons in health education, fitness exercises in physical education, the provision of nutritious and appealing school meals, health screening, and psychological counseling. All strategies, activities, and services should be carried out *in* a culturally sensitive and competent manner. They should be designed to enhance student knowledge and skills, encourage desired behavior, promote appropriate use of professionals, and advance physical mental, and emotional health.

DEVELOPMENT

Development refers to the process of growth, advancement, and maturation. Comprehensive school health programs provide age-appropriate activities, programs, and services that take into account students' developmental needs and help students achieve developmental **milestones**. Optimal *development* implies setting children on a course of growth and maturation that will lead to a healthy adulthood. The most important risk factors responsible for chronic disease and premature death among adults can be attributed to unhealthy habits and lifestyles, and the foundations for these behaviors are established in childhood and adolescence (U.S. Department of Health and Human Services, 1990). During the formative developmental years, children and young people spend a significant proportion of their time in schools. Schools can be pivotal in promoting health-enhancing behaviors, detecting health-threatening conditions, and contributing to development of the next generation of productive healthy adults.

INVOLVES ... SUPPORTIVE OF FAMILIES

Involves means to engage as a participant, to include. *Supportive* implies help, assistance, advocacy-to hold up or serve as a foundation. *Family* is defined here in its broadest context. A *family* includes one or more children plus one or two parents, a legal guardian, or an adult acting as a care provider. In the absence of any of these arrangements, a designated adult or group residence may take responsibility for a child.

Family *involvement* implies that the family has knowledge of the **CSHP**— and participates in community deliberations to determine the needs and the activities, strategies, and services that are to be offered. Adult family members serve on the advisory committee for school-based health centers and work with teachers or school boards in the design and delivery of health education and health promotion curricula and services. Parental consent for services is based on laws specific to each state, and families are informed about the confidentiality policies that govern school-based health **programs**.

Comprehensive school health programs provide *support* to families in many different forms. Primary health services may be available on-site in the school or made more accessible through better linkages with community health care providers. Access to services for the entire family, including siblings and parents, may be facilitated. Family visiting, consultations, and counseling may be provided in conjunction with social and mental health services. Other school-affiliated activities and services of CSHPs that involve families may include: parenting education, nutrition education, provision of meals, physical

activity and aerobics programs, and community **use** of school facilities for sports.

If families are closely involved in the program and program developers are sensitive to community concerns, **CSHPs** will support, not supplant, the role of the family in developing the health of children and improving the quality of life in the community.

DETERMINED ... LOCAL COMMUNITY

Determined means to come to a decision by investigation, reasoning, or calculation, to settle or decide by choosing among alternatives or possibilities. The *local community* refers to the wide range of stakeholders—parents, students, educators, health and social service personnel, insurers, business and political leaders, and so forth—at the particular site where the program will be implemented. The form and structure of a CSHP should not be perceived as being imposed on the local community by some outside mandate but should be determined through a deliberative process by those who will be involved in and affected by the program.

Although local autonomy is important for community involvement, commitment and support, **it** is important to recognize in advance that tensions may arise. Conflicting views within a community will need to be resolved so that differences do not lead to gridlock. **Program** standards proposed by the community must satisfy the quality standards of those professions involved in school health in order to ensure program quality, safety, and effectiveness. **In** fact, professional standards can function as basic unifying forces from one school system to another.

NEEDS, RESOURCES, STANDARDS, REQUIREMENTS

The term *needs* refers to the lack of something desirable or useful and to conditions requiring relief or remediation. An important step for a community in establishing a CSHP is to conduct a comprehensive *needs assessment* to determine the health status of its children and young people, recognize health promotion and education opportunities, and identify existing conditions that require help and relief. *Resources* refer to the strengths and sources of relief or recovery within the community—the ability of the community *to* meet and handle the situation. The components of a CSHP should be based upon documented needs, fill gaps in education and services, -and draw from community strengths and available resources,

Standards and *requirements* refer both to professional and legal criteria and to community ethics, mores, and values. School health programs are currently influenced by state laws and regulations mandating certain procedures. These legal mandates influence to a great degree the distribution and nature of staff and services that can be provided. Certainly in designing a CSHP, a community must conduct a careful evaluation of existing statutory requirements. In addition, program design must consider and, be sensitive to the cultures, values, and moral standards of the community.

COORDINATED ... MULTIDISCIPLINARY TEAM

Coordinate means to bring into combined action, to cause separate elements to function in a smooth concerted manner. *Multidisciplinary teams* involve individuals with different backgrounds, skills, and knowledge working together. *Coordination* implies a formal relationship, mutual understanding of mission, planning and division of roles, and open communication channels; however, the coordinating partners can still retain their identity and affiliation to their profession.

In today's terminology, *coordination* and integration of services entail going beyond merely working together in a harmonious fashion; in newer models of integrated service programs, it is expected that the usual professional roles and responsibilities will be shared and less distinct. At the institutional level, it means more effective collaboration among agencies, joint funding, relaxation of bureaucratic barriers and regulations, simplification of procedures, involvement of both the public and private sector, and transfer of power and decision-making to the local community.

The use of the term *multidisciplinary team* reflects the committee's opinion that a distinguishing feature of a CSHP is the involvement of individuals with varied skills and knowledge. Even in a small or isolated school, it should be possible to find two or more individuals with different disciplinary backgrounds to coordinate the program, link it to the community, and see that the separate program elements function in a smooth concerted manner.

ACCOUNTABLE

Accountable means responsible, answerable. *Accountable* refers to the planners, coordinators, and implementers of a CSHP. These individuals are responsible to the community in which the program operates to assure that the program has a high degree of excellence and produces the desired results—that

there is a sustained partnership with the community, including ongoing interaction during the planning, implementation, and evaluation of the program. Accountability includes making process and outcome measurements, providing this information to allow for informed decision-making, and financial responsibility.

QUALITY ... EFFECTIVENESS

Quality refers to the degree of excellence; *effectiveness* has to do with producing the desired result. Judgements about *quality* contain subjective elements, while measures of *effectiveness* tend to be more objective. *Quality* and *effectiveness* are interrelated in CSHPs—the existence of one implies the presence of the other.

Quality reflects the degree to which the program is consistent with current professional knowledge and standards, is delivered by competent personnel in a manner that respects and protects the dignity of the recipients (students, families, communities), and is delivered within an accountable system in which resources are used efficiently with minimal waste and cost. *Effectiveness* is the degree to which the program improves desired outcomes—health, developmental, and educational. Effective programs carefully match needs with appropriate and necessary interventions. They ensure the proper use of and access to needed interventions and avoid unnecessary or inappropriate interventions that can waste resources and increase the risk of harmful side effects. An implicit component of a high-quality, effective program is the presence of an ongoing feedback system that monitors processes and outcomes, and continually adjusts processes to optimize outcomes.

Issues to Be Addressed in the Full Report

In the remainder of its study, the committee will examine the structure and functioning of comprehensive school health programs (CSHPs), consider evidence for the effectiveness of these programs and possible approaches for restructuring programs to increase effectiveness, and, if appropriate, recommend strategies for wider implementation of effective programs.

In order to carry out these tasks, the committee has identified, at this preliminary stage, some questions that are important to the further study of CSHPs. The committee recognizes that an extensive analysis has already been carried out on some of these questions by others, and in these cases the committee will review existing work. In other cases, no simple answers may exist. In some of those situations, the committee may propose an answer, based on a consensus reached through the knowledge and expertise of its members. In cases where insufficient evidence exists or no consensus can be reached, the committee will seek to point out the knowledge gaps and recommend how they might be addressed. The committee also recognizes that it may not be feasible to answer all of these questions, but they may provide the basis for future studies.

The committee has organized its preliminary questions into the following categories:

- fundamental understandings,
- program outcomes,
- comprehensive programming,
- health education,
- health-related services,

- research and evaluation,
- funding,
- local, state, and federal policy,
- personnel and training issues, and
- obstacles and opportunities.

FUNDAMENTAL UNDERSTANDINGS

In order to understand how comprehensive school health programs may possibly affect student health and education outcomes and future health literacy, the committee will examine the following questions:

- What are the basic health needs of children and young people? What are the role and responsibility of the school in meeting these needs?
- What lessons have been learned from the 150-year history of health programming in schools?
- What are appropriate measures of health status? Of educational achievement? What is known about the nature and extent of the linkage between health status and educational achievement?
- How, to what extent, and for what duration, might CSHPs influence health and education outcomes and future health literacy?

PROGRAM OUTCOMES

Some of the optimal outcomes of CSHPs described earlier may not be feasible to achieve or measure. Yet in order to establish criteria for determining the effectiveness of these programs, realistic and measurable program outcomes must be identified. Therefore, the committee will seek answers to these questions:

- What are the realistic and measurable student, teacher, parent, organizational, and community outcomes that can be expected from comprehensive school health programming?
- What are the similarities or differences in expected student outcomes, depending on developmental and grade level?
- Are changes in health knowledge and attitudes sufficient endpoints for measuring the effectiveness of CSHPs, or should programs be considered ineffective unless there is an impact on related health behavior and health problems are adequately and appropriately addressed?
- What changes in health status should be considered meaningful endpoints for CSHPs?

- What should be the evaluation standards in order to attribute improved health and education outcomes to CSHPs?
 - Can realistic and measurable outcomes be achieved at reasonable cost?

COMPREHENSIVE PROGRAMMING

The distinguishing feature of the committee's provisional definition of a comprehensive school health program is that many separate elements work in harmony in an "integrated" fashion. Questions about the specific nature of these programs and how schools and communities can provide such intensive programming are:

- To what extent have CSHPs been implemented and evaluated? What are the findings?
 - What role should the various program components (e.g. health education, physical education, health services, nutrition services, counseling and psychological services, social services, staff work-site health promotion, and healthy school environment) play in a CSHP?
 - What does "integration" of program components mean in practice? How can the impact of integration be measured? Are student outcomes enhanced when program components are integrated?
 - How does organization of the school affect the integration of the components of a CSHP?
 - What is considered the state-of-the-art CSHP? What factors appear to predict success (or lack of success) of a program?
 - What is the best process for establishing and implementing a CSHP?

HEALTH EDUCATION

Health education is considered an important component of CSHPs, yet the role and organization of health instruction within our education agenda is unclear. From this uncertainty arise obstacles in incorporating health education as a credible and critical part of a student's overall education. To address these issues, the committee will consider the following:

- Where in the school curriculum does health education best fit? How can health education best articulate with other subjects?
 - What are the nature and extent of the preparation of health education teachers? How do the quality and quantity of teacher preparation influence the effectiveness of health education?

- Should there be a standardized curriculum for school health? Should there be a national standardized assessment of student health knowledge?
 - Which health problems or health risk behaviors should be given priority in health instruction? How would this vary by grade level?
 - Are there advantages-or possible disadvantages-of incorporating health topics into other curricular areas? Of incorporating other curricular areas into health education?
 - Are there advantages-or possible disadvantages-of integrating health education into the delivery of health services to individuals and groups?
 - What evidence exists about the effectiveness of various health education modalities, such as skills training, fear messages, and peer interventions?
 - Is there sufficient evidence to recommend a minimum "dose" of health education, within and across developmental stages? Does an increased dose of health education produce more lasting effects?
 - Is there evidence of a synergistic effect between health education and the other components of a CSHP?
 - Which statistically significant health education outcomes have actual public health significance?

HEALTH-RELATED SERVICES

Communities are exploring new ways to provide equitable, efficient, and effective health care for children. Since schools are "where the children are," the school is receiving increased attention as the site for access to health-related services. To determine how best to provide these services, the committee will ask:

- What is the range of school-affiliated health-related services?
 - What health-related services are school districts currently mandated to provide? Are these mandates scientifically sound?
 - What are the principal sources of health services and health information for students? Are these sources adequate? If not, why not? How would the situation be different if school-affiliated services were more widely available?
 - What should be the role of educators and administrators in providing health-related services?
 - To what degree should school-based health and social services be integrated into the total school program?
 - What are the advantages- and possible disadvantages-of the schools, rather than other community institutions, serving as the site for primary health care?

- How might the range and types of needed school-affiliated services vary depending on community demographic and socioeconomic characteristics?
- What are the mechanisms to coordinate school health services with health services in the community?

RESEARCH AND EVALUATION

Comprehensive school health programs have not been implemented to a sufficient extent to provide a broad knowledge base about these programs. Research and evaluation of varying quality have been done in categorical areas, both in instruction and in services, but typically programs have not been studied comprehensively. The committee will make recommendations about conducting research on comprehensive school health programs and criteria for judging effectiveness by first examining:

- What kinds of research and evaluation studies have already been done? What research and evaluation studies are needed to measure the impact of CSHPs?
- What should be the criteria for declaring a program successful or effective?
- What existing databases can be utilized in research and evaluation of CSHPs?
 - How might the effects of programs delivered in "real-world" settings differ from those of programs delivered under experimental or research conditions?
 - Is a meta-analysis of CSHP evaluations useful and feasible? If so, what criteria should be used in selecting studies?
- What is the receptivity to the CSHP concept by teachers, administrators, school board members, families, and the community? What is the level of understanding of the CSHP concept of these groups? How does the level of understanding relate to receptivity?

FUNDING

For many years, free and appropriate public education has been a standard entitlement in this country. In these days of increasing needs, financial constraints make the provision of quality education problematic. The inclusion of school-affiliated health and social service delivery adds a new dimension to this tension, so the committee will ask:

- What is known about the costs and benefits of CSHPs, especially at particular grade and developmental levels?
- What is the current public perception about the importance and cost/benefits of CSHPs?
 - Are current priorities and investments in school health programming consistent with cost/benefit analyses?
 - What should be the role of federal, state, or local governments in providing financial support for CSHPs? The private sector?
 - What kinds of administrative and fiscal relationships at federal, state, and local levels appear to work best? Should the fiscal "lead agency" at the local level be the school system or some other community agency(ies)? How might the school-system's participation be influenced if it is not the lead agency?
 - Should health services be considered part of the guarantee of free and appropriate education?

LOCAL, STATE, AND FEDERAL POLICIES

Local control of education has been a tradition in this country. Furthermore, most experts believe that successful school health programs require the active involvement of the community in which the children live. However, with the diversity of mores, values, and needs in each community, stimulating and maintaining the community's participation in and support of the school health program is likely to be a challenge. While the local context is crucial, state and federal policies may also play an important role in fostering or inhibiting the success of these programs. To assess the impact of these factors, the committee will examine:

- What is the proper balance between prescriptive program standards and local autonomy?
- Who should take the lead at the community level? Is there an optimum model for governance and administration?
- How should a community's needs be assessed?
- How can disagreements and conflicting views be resolved?
- How might community institutions—such as businesses, institutions of higher education, and academic health centers—become involved in CSHPs?
- How might state and federal policies enhance or inhibit the success of local programs?
- What data are needed by various constituencies in order to make policy decisions?

PERSONNEL AND TRAINING ISSUES

Funding for schools and public health is constrained and many community agencies are undergoing restructuring; however, the scope of school health programs continues to broaden. As a result, new roles may emerge for personnel working in the area of school health, requiring new kinds of preservice and inservice training. Questions relating to training issues are:

- What kinds of educators and health care providers will be required in the future? How might the reorganization or blending of traditional roles produce new careers, and possibly new disciplines, in the field of child and adolescent health?
- Who should delineate the various roles of community and school personnel in the CSHP? Who should coordinate the efforts of consolidating and integrating the diverse components of a CSHP?
- What should be the qualifications of a classroom teacher of health education?
- What are the issues involved in delegation of health care from the primary care practitioner to school personnel?
- What changes might be required in preservice and inservice training to produce the personnel needed for CSHPs? How might training and personnel recommendations differ in primary and secondary grades?

OBSTACLES AND OPPORTUNITIES

Once a community is committed to establishing a comprehensive school health program, many barriers and obstacles still make implementation of such programs difficult at best. The committee will ask:

- What are the principal barriers and obstacles—are they legal, regulatory, political, territorial, technological, time demands, or labor intensiveness?
- What are the core changes that must be made to overcome or modify these barriers?

SUMMARY

As mentioned earlier, a review of the existing literature may provide concrete answers to some of these questions. In other cases, the committee may attempt to arrive at an answer through consensus based on the knowledge and expertise of members, or may simply point out those areas that require more research before an answer can be obtained.

The committee also realizes that it may not be feasible to address all of these questions in this study, but they may provide the basis for future studies. The committee has charted an ambitious course for its work but trusts that its full report will be of vital interest to families, educators, health service providers, and policymakers—in short, to everyone concerned with the health, education, and quality of life of our nation's children and young people.

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