A SURVEY OF SCHOOL HEALTH ADVISORY COUNCILS IN NORTH CAROLINA

by

Mary Franklyn Pratt

1 April 2006

A Master's paper submitted to the faculty of the University of North Carolina at Chapel Hill in partial fulfillment of the requirements for the degree of Master of Public Health in the School of Public Health, Public Health Leadership Program.

Approved by:

Nancy A. Langenfeld

Content Reader: Nancy Langenfeld, RN, MS

William Williamson

Second Reader: William Williamson, MPH

Abstract

Research as shown that healthy students are more successful academically; therefore, school systems have a stake in doing whatever is possible to increase their chances of having a healthy student population. Initially, school health programs were begun to stop the spread of communicable disease and to focus on health conditions brought on by poverty and malnutrition of immigrants. While these issues continue to be a part of school health programs, today the major threats to the health of school children are the result of lifestyle choices and high risk behaviors. Schools need to partner with parents, teachers, healthcare providers, community leaders, and the students themselves to create and maintain a healthy school community. Rather than fragmented, piecemeal solutions, efforts to improve the health of the school community need to be coordinated and include all relevant stakeholders. Recent federal and state legislation has mandated the development of School Health Advisory Councils (SHACs) to oversee Coordinated School Health Programs in each school district by the start of the 2006-2007 school year. A survey of school districts in North Carolina demonstrates that, although most have begun the process, there are significant disparities among existing School Health Advisory Councils. Areas of future study might include comparisons of SHAC development in urban vs. rural districts, poor vs. affluent districts, and the impact of the school nurse to student ratio on SHAC effectiveness.

School Health and Public Health

Research supports the premise that healthy students are more successful academically. Every school day, 52 million young people attend more than 110,000 schools across the nation. This represents an accessible, captive audience (NCHE, 2005). Therefore, since students spend a large portion of their days within the walls of a school building, the school community should be a place that provides an environment in which children can be healthy. Society has a stake in developing and maintaining healthy school communities because children are the future of society. The Institute of Medicine defines public health as "what we as a society do collectively to assure the conditions in which people can be healthy" (IOM, 2003, p.88). Schools have been identified by the Institute of Medicine as potential actors in the public health system; and as partners with other community organizations, schools can have an enormous impact on the health of students, school staff, and parents (IOM, 2003).

School systems are struggling to bring all students up to grade level, while at the same time students are "awash in a sea of toxic problems, especially in communities in which a high percentage of the children are poor, recent immigrants, unsupervised before and/or after school, lacking medical care, and exposed to mayhem in their neighborhoods" (Tyson, 1999, p.1).

School health programs have undergone substantial changes since Lina Rogers, the first school nurse, began her practice in the New York City Schools at the turn of the last century. Stanhope and Lancaster reported that in 1902, more than 20% of children could be absent from school on a single day due to communicable diseases, infections, lack of warm clothing, and malnutrition (Stanhope & Lancaster, 2004). Since communicable diseases such as measles, diphtheria, typhoid, and pertussis could sweep quickly through a school, the role of the school

nurse focused on keeping sick children at home and healthy children in school. In the 1900's, school nurses began health screening activities, including screenings for hearing and vision. In the 1950's, health counseling, first aid, and immunization programs were added to school health programs (Vesalik, 2001). Today, the threat of communicable disease is substantially lower thanks to comprehensive immunization programs and mandatory immunization requirements for school enrollment, but the role of the school nurse has continued to grow. With the enactment of the Individuals with Disabilities Education Act in 1975, children with special health care needs who formerly were educated at home or in institutions are now attending public schools, greatly increasing the demands on school health programs. Today, many of the features of the 1900's have returned, as we are again seeing a tidal wave of immigrants, urban and rural poverty, health disparities among races, and lack of access to medical care (Tyson, 1999).

As threats to public health have changed, so has the focus of school health programs. The current major threats to public health are related to risk behaviors rather than communicable disease. Kolbe states that high risk behaviors that are preventable become established during school age years and are associated with the major causes of death, disability, injury and illness, These include sexual activity, tobacco use, violence, self inflicted injuries, substance abuse, unhealthy diets, and lack of physical activity (Kolbe, 2005). These threats to our children are not limited to poor and immigrant neighborhoods. All children may be affected by the stresses of family instability, depression, and violence. One child in four is at risk of failure in school because of social, emotional, and health handicaps (Tyson, 1999). An unhealthy school environment not only affects the health of students, but their academic achievement as well. "No curriculum can compensate for deficiencies in student health status…A rich body of literature confirms a direct link between student health risk behavior and educational outcomes,

educational behaviors, and student attitudes about education" (Symms et al., 1997). Furthermore, of the National Educational Goals, three out of eight relate directly to student health:

- Every child come to school ready to learn.
- High school graduation rates increase to 90%.
- All schools are free of violence, drugs, and alcohol.

School systems have struggled to meet the challenges of the poor health of our children, but in a way that is fragmented, spotty, and many times ineffective. There are many examples of this:

While a Virginia teacher taught her students about the food pyramid, the cafeteria manager prepared a meal of pizza and French fries, the school business manager rejoiced in the revenues produced from candy and soft drink vending machines, and the school nurse counseled a group of obese girls (Tyson, 1999).

A depressed, pregnant, drug using teenager in Maryland saw three counselors in one week which included a suicide prevention counselor, a parenting counselor, and a drug abuse counselor. None of them talked to the others. The student missed so many classes due to counseling sessions that she flunked the semester and dropped out of school when the baby was born (Tyson, 1999).

In a Washington, DC school, a teacher discussed the importance of handwashing to prevent the spread of infections, while the faucets in the restrooms were broken, there were no paper towels, and no plumbing renovations were scheduled for another two years (Tyson, 1999).

Coordinated School Health Programs

As threats to a healthy school community have changed and become more complex, it has become clearer that more is needed to create the conditions in which the members of the school community can be healthy than an occasional visit by the school nurse.

In 1998, Congress recognized this and urged the Centers for Disease Control and Prevention, the CDC, to expand its support of Comprehensive, later changed to "Coordinated", School Health Programs in schools (Wyatt & Novak, 2000).

A Coordinated School Health Program consists of eight inter-related components that address the health needs of the school community and connects resources from the community, families, and the school itself. The components are:

Health Education. This includes programs and activities to address the physical, emotional, mental, and social aspects of health that are designed to help students improve their health, prevent illness, and reduce high risk behaviors.

School Health Services. These include services by the school nurse such as assessment of health status, emergency care, identification of students with chronic illnesses, development of individual health plans, case management, health screenings, referrals and follow up care, and other activities that are designed to prevent or minimize health related barriers to learning. They may also include dental services and school based/school linked health centers.

School Health Environment. This includes indoor air quality, tobacco, drug or alcohol use, violence prevention, and assessment of issues related to safety, and is intended to create a healthy, safe, and supportive environment for learning.

School Nutrition Services. This includes the provision of nutritious, affordable, and appealing meals and snacks, nutrition education, and an environment that promotes healthy eating and drinking.

School Counseling, Psychological and Social Services. These include individual and group assessments, interventions and referrals. They are designed to prevent mental health and social problems when possible, and to provide early intervention to minimize existing problems.

Physical Education. This includes a planned, sequential curriculum that is age appropriate from kindergarten through high school that promotes lifelong physical activity. Programs are designed so that students can learn, practice, and receive assessments on developmentally appropriate motor skills, social skills, and knowledge.

Staff Wellness. This includes health assessment, education and fitness activities to promote the health and well-being of staff, to enable them not only to maintain optimum health, but to serve as role models for students.

Family and Community Partnerships. This includes the School Health Advisory Council as well as other coalitions to build support for and advise about coordinated school health programs (CDC, 2003).

A Coordinated School Health Program includes programs and activities in all eight areas, and provides a framework for developing policies, procedures, and activities to improve both health and educational outcomes (Zimmerman, 2005).

Within an individual school system, a Coordinated School Health Program can best be developed through a School Health Advisory Council, or SHAC. A SHAC is a group of individuals who represent the eight components of coordinated school health, as well as segments of the community in which the school system resides. It provides advice to the school

district on all aspects of school health. Its members are appointed by the school system, and it in turn reports to the Superintendent. It is important to note that it is not a regulatory body and is not a part of the administrative structure of the school system, nor does it have any legal authority. SHACs provide opportunities to ensure that local school systems create and implement school health programs that respond to individual needs and the unique values of each community. They are one of the most effective vehicles for interacting with the local community on school health issues (ACS, 1999).

In 2003, the North Carolina State Board of Education adopted the Healthy Active Children Policy (HSP-S-000). It requires that each school system in the state establish and maintain a local School Health Advisory Council composed of school and community representatives from the eight components of a coordinated school health program. Furthermore, it recommends that elementary schools offer 150 minutes per week and middle schools offer 225 minutes per week of physical activity throughout the school year. In addition, the policy prohibits taking away physical activity as a form of punishment. The policy must be fully implemented by the 2006-2007 school year, and yearly reports detailing the activities of the school system with regard to the eight components will be required (NCSBE, 2003).

On the federal level, on June 30, 2004, President Bush signed the Child Nutrition and WIC Reauthorization Act (PL 108-265) into law. With rates of childhood obesity rapidly increasing to epidemic proportions, the law requires that a School Health Advisory Council be established in each school system by the 2006-2007 school year in order to receive federal funds for school lunch and breakfast programs. Another provision of the law is for each school system, utilizing its SHAC, to develop a Wellness Plan which also must be in place for the 2006-2007 school year. (Zimmerman, 2005)

Survey of North Carolina School Health Advisory Councils by Region

A survey of the School Health Advisory Councils in schools systems throughout the state was conducted to determine their effectiveness in utilizing the eight components in the development of coordinated school health programs. The results were obtained from reports submitted in 2004, the last year for which reports were available, and are summarized by geographic region. There are 100 counties in North Carolina and 115 school systems. In addition to county-wide school systems, there are also some systems that are city-wide. The SHAC reports were received from only each county rather than from each separate school system. Therefore, some reports may reflect the results from more than one school system.

In the table provided (Appendix), the results of the survey are shown for each geographical region. Included are the total number of counties in the region, the total number of counties with a functioning SHAC, the number of counties that include each of the eight components of coordinated school health in their plans, the total number of counties whose SHACs incorporate all eight components in their Wellness Plans, and the number of counties with tobacco free policies.

Mooresville Region

The Mooresville Region is comprised of school systems in thirteen counties, ranging from the largest system in North Carolina in Charlotte with 152 schools and 125,000 students to small rural districts. All thirteen counties reported that they had active School Health Advisory Councils, but there was a wide variety of the effectiveness of the Councils. Only 15% of the counties reported that they had SHACs in which all eight components were represented in their plans. 85% of the counties reported that they had the Physical Education component in their Wellness Plans, the most widely reported component. Parent/Community Involvement was the

least reported component, with less than a third (31%) of the counties having it in their Wellness Plan. One county, although it reported having an active SHAC, stated, "They are just beginning a Health Program and are getting a group together to see if a Health Advisory Team is needed" (Mooresville Region SHAC Report, 2004).

Raleigh Region

The Raleigh Region is home to Wake County, which has the second largest school system in the state with numbers of schools and students that are close to the numbers in Charlotte. It also has within its borders three major universities, North Carolina State University, University of North Carolina at Chapel Hill and Duke University, as well as Research Triangle Park. The Region also has its share of poorer counties as well, due to the loss of manufacturing jobs in the region.

The SHACs in this region had the most comprehensive Wellness Plans, with the components included ranging from 41% to 71%. In addition, the region had the highest percentage (24%) of SHACs that included all eight components. Among the counties in the region, 15 reported having an active SHAC, while two reported they were in the process of developing one. In contrast to the Mooresville Region, Parent/Community Involvement was the component most often included (71%) in plans, while only 41% of SHACs reported having a Health Education component in their Wellness Plans (Raleigh Region SHAC Report, 2004).

Greenville Region

The Greenville Region is in the more economically disadvantaged eastern part of the state. It is made up of many small counties with school systems of less than a dozen schools. Of the nineteen counties in the region all but three have active SHACs, while three are in the process of setting them up. The inclusion of the components in Wellness Plans ranged from 32%

including Counseling/ Social Work/Psychological Services to almost three quarters (74%) that included Physical Education. Only 11%, however, included all eight components in their plans (Greenville Region SHAC Report, 2004).

Asheville Region

The Asheville Region is in the most western part of the state in the mountains and foothills, and includes the Cherokee Indian Reservation. Of the nineteen counties in the region, all but one have active SHACs. The highest reported component included in Wellness Plans was Child Nutrition (74%), while Parent/Community Involvement was the lowest reported component (32%). At only 5%, this region also had the lowest percentage of counties whose Wellness Plans included all eight components (Asheville Region SHAC Report, 2004).

Winston-Salem Region

The Winston-Salem Region is in the central part of the state. Its economic base consists primarily of agriculture and furniture manufacturing, and comprises fourteen counties. Of those, all have active SHACs with one in the process of development. The percentage of components included ranged from 43% (Healthy Environment and Health Education) to 71% (Child Nutrition and Parent/Community Involvement), and 7% of the counties included all eight components in their Wellness Plans (Winston-Salem Region SHAC Report, 2004).

Fayetteville Region

The Fayetteville Region contains a large military base as well as many small coastal communities, and the city of Wilmington, the largest seaport in the state. All of its 17 counties with one exception have active SHACs. The remaining county is in the process of developing its

SHAC. The components included in Wellness Plans ranged from a low of 29% (Health Services and Staff Wellness) to a high of 76% (Physical Education). With only 6% of its SHACs including all eight components in their Wellness Plans, this was the second lowest percentage of the regions (Fayetteville Region SHAC Report, 2004).

In summary, 92% of counties reported that they have active SHACs in various stages of development, well ahead of the requirement by both federal legislation and North Carolina mandates to have them in place by the 2006-2007 school year. However, there clearly is much work to do since only one in ten SHACs (11%) has a Wellness Plan that includes all eight components of coordinated school health.

There is no clear pattern of association between components included or not included and the various regions. However, the two components most likely included were Physical Education (53% to 85%) and Child Nutrition (47% to 74%). This may reflect the fact that schools have traditionally had child nutrition and physical education programs in place for many years. However, they may not have been coordinated along with other components to form a comprehensive school health or wellness plan.

Whether or not the county has a Tobacco Free Policy on school campuses (no tobacco products allowed on campus at any time, including sports events) is an important indicator of the effectiveness of the SHACs. The majority of school systems adopting Tobacco Free Policies did so after the establishment of SHACs in their counties. The counties with Tobacco Free Policies in place range from 14% in the Winston-Salem Region to 84% in the Fayetteville Region, with an average of 44% statewide in 2004. That number has increased to 64% in 2006 (Tobacco Free

Schools, 2006). The majority of counties that have not established Tobacco Free Policies are tobacco growing counties which may face considerable local pressure to maintain the status quo.

The literature reports significant barriers to forming a School Health Advisory Council on the road to developing a Coordinated School Health Program. Symms and colleagues state, "Many administrators, parents, and concerned citizens remain unconvinced that an investment for improving learner health status will pay dividends in enhanced performance on proficiency tests and overall academic achievement" (Symms et al., 1997, p.223). The lack of administrative support was listed as the most significant barrier. Administrators face pressures to produce positive academic outcomes, and tend to put resources where they will have the most immediate impact on student test scores. In addition, many administrators believe that health should be the responsibility of parents and guardians rather than the school community.

Among local obstacles are time limitations and severe budgetary constraints. School Health is perceived as consuming valuable time and resources that could be better spent on academics. Furthermore, there is limited government support. Despite the recent legislation on both the state and federal levels, there are few state and federal mandates to reduce health risks.

Conventional patterns of funding and research constitute an additional barrier. Education and health promotion funding and research have focused on specifically identified concerns within discrete disciplines. This has limited an interdisciplinary body of knowledge that addresses the relationship between health and academic outcomes. Although research shows an association between health and academic outcomes, studies lack the empirical evidence with well designed evaluations that demonstrate a direct link between the two (Symms et al., 1997).

Some of these barriers are mirrored in the experiences of the SHACs in North Carolina. Lack of administrative support was mentioned by two Regional School Nurse Consultants (RSNCs), Muriel Overman from the Fayetteville Region and Frances Tutterow from the Mooresville Region, as a major barrier. Tutterow stated that some SHACs were not empowered by school administration. Several of the RSNCs reported that time constraints were a major barrier for the effective functioning of the SHACs in their regions. They reported that Council membership represented a major time commitment and that it was an enormous amount of work. There were also difficulties in finding meeting times that suited all Council members. In addition, they reported a wide variety in the frequency of SHAC meetings, ranging from every other month up to once per year, and at least one reported that it was difficult to maintain momentum when Councils meet so infrequently.

RSNCs also reported financial limitations as a significant barrier. One stated that there were no financial resources allocated for Council activities. Additional barriers reported were that a few people end up doing all the work, and communication problems between the SHAC and school administrators.

Martha Guttu, RSNC for the Greenville Region, reported that a significant barrier was a lack of understanding of the basic elements of the coordinated school health program model, despite training sessions by program experts from both the NC Department of Public Instruction and the NC Department of Health and Human Services. An example of this is one SHAC report in which it was stated under Staff Wellness, that there was a plan to develop an abstinence program (Cumberland County SHAC Report, 2004). In another case, under Physical Activity, the report stated the plan was to use it as a punishment for poor behavior (Mooresville Region SHAC Report, 2004). Council members did not seem to understand that physical activity should

be a pleasurable experience that is continued over a lifetime, not something to avoided because it is assigned as punishment.

In spite of the many barriers, there are many success stories contributed to the establishment of SHACs and subsequently the development of coordinated school health programs. Examples in the literature are plentiful.

With the focus on the growing problem of obesity, and the support of the local SHAC, a school nurse began a weight management plan for middle school students and their parents. In a different middle school, students were arriving early to school and either waited for the building to open, or wandered through the adjacent neighborhood unsupervised. The SHAC responded to this by starting a pre-homeroom program that allowed students to use the gym for exercise, or the library for early morning tutoring. In another case, a physical education teacher started a walking program for school staff. Not only did it improve their health, but it built relationships between teachers who previously had not worked together (Tyson, 1999).

In the H.E. Corley Elementary School in Irmo, South Carolina, some of the healthy school activities include a bicycle safety program, healthy food choices, comprehensive health education, and walking and jogging club for students, and the Corley Care Buddies, a mentoring program staffed by community volunteers (Saunders, 1999).

An excellent example of an effective Coordinated School Health Program is that of the McComb Separate School District in McComb, Mississippi. Superintendent Patrick Cooper joined the district in 1997, and faced a host of community-wide problems including high unemployment rates, high teen birth rates, high dropout rates, low student test scores, and a student population who received their medical care in the local emergency room. He began the

transformation by calling together community members at a meeting at which 350 people attended. They included the mayor, judges, other government leaders, fire and police officers, the director of Head Start representatives from the medical community, business and community leaders, and parents. Together, this group formed the SHAC and developed study teams, each representing a different component of a Coordinated School Health Program. The program was implemented gradually over a period of five years, with one or two components as the focus each year. Initially, the SHAC was concerned about safety, funding, and test scores. Creative funding allowed the use of federal sources such as Goals 2000 (Educate America Act), Title I (Education for the Disadvantaged), Title II (School Improvement), Title IV (Safe and Drug Free Schools), No Child Left Behind funds, and Special Education funds. Local, state, and private sources such as Medicaid, hospital and private partnerships and interagency agreements were also tapped. Funding allowed for a school health clinic and school nurse in every school (Cooper, 2004). The results have been slow but steady. In the area of safety, the district saw a drop in suspension rates, disciplinary hearing numbers, assignments to alternative school, and the juvenile violent crime arrest rates. Funding has increased as success has increased. Test scores are improving, graduation rates are up from 74% to 91%, and dropout rates have dropped from thirty percent to less than five percent (Cooper, 2003).

Among the school systems in North Carolina, there are similar success stories in which SHACs have assessed the unique situations in their communities and come up with creative solutions. In the Mooresville Region, the Regional School Nurse Consultant Frances Tutterow reported that the SHACs have been instrumental in developing school health policies, addressing the need for more school nurses, establishing Wellness Plans for the school community and developing a suicide prevention program. Mecklenburg County has developed a School Health

Newsletter in both English and Spanish that is available on the school system website, and is sent to all parents in the system to keep the lines of communication open on school health issues (CMS, 2006). Tutterow reported that another has implemented a Family Fitness Night, and another offers on-site vaccinations for kindergarteners. One county SHAC worked with community partners to put on an Obesity Summit, and ensured that all school staff received training on the signs and symptoms of depression.

In the Raleigh Region, one SHAC focused on reducing the incidences of bullying to address the Healthy Environment component by developing an annual survey and following up on the results. Another SHAC has established a "Home-School Compact" that addresses healthy meals and physical activity at home and school, and another is developing anger management programs to address the Counselor/Social Worker/Psychologist component. Another is installing outdoor lighting at high schools to address safety as a part of the Healthy Environment component. One SHAC has partnered with a local YMCA for staff wellness opportunities and started walking programs in all elementary schools (Raleigh Region SHAC Report, 2004).

In the Greenville Region, RSNC Martha Guttu reported that one community identified a problem with teen pregnancy, and the SHAC chose to focus on this by creating educational programs for pregnant teens and their parents. Another SHAC had created a three year project focusing on obesity. In Beaufort County, the SHAC noticed few options for dental care for children without insurance and looked for ways to increase access to care for those children (Beaufort County SHAC Report, 2004). In Hyde County, the SHAC is creating a Wellness Library and walking club for school staff (Hyde County SHAC Report, 2004).

In the Asheville Region, the Caldwell County SHAC chose to focus on the Healthy Environment component by providing a district wide initiative called *Respecting Diversity* to all staff and students (Caldwell County SHAC Report, 2004). Graham County offered before and after school programs to take advantage of available time for students who are dropped off early or picked up late. The before school program is called *Walk and Talk,* while the after school program centers around the *Healthy Me Club.* They have also established a *Fruit Friday* program (Graham County SHAC Report, 2004). In Transylvania County, the SHAC is helping to implement a drug abuse prevention program for high school students, which focuses on students making positive choices. Under the Healthy Environment component, they are offering CPR training for all 9th grade students (Transylvania County SHAC Report, 2004). In McDowell County, the SHAC is exploring the feasibility of providing on-site mental health services for students (McDowell County, 2004). In Macon County, the schools struggled with no consistent medication administration policy. Working together with SHAC members, the policy is now in place. They have also created a Counseling Services subcommittee to identify gaps in services (Macon County SHAC Report, 2004). In Swain County, the SHAC plans to train half of all school staff, including bus drivers, in CPR/First Aid. Under the Parent/Community Involvement component, SHAC members are exploring partnering with the local Community Substance Abuse Task Force (Swain County SHAC Report, 2004). Yancey County has established walking trails, and Cherokee County offers mammograms and prostate screening at their School Staff Health Fair (Yancey County, Cherokee County SHAC Reports, 2004).

In the Winston Salem Region, the Forsyth County SHAC chose to focus on nutrition and completed a pilot project in which the competitive foods at seven schools were changed to include only healthy items. Sales were tracked and the findings were analyzed by SHAC

members. In addition, the SHAC promotes community involvement by partnering with the Hispanic League and Que Pasa, a Spanish Language media group, to assist newcomers to the community (Forsyth County SHAC Report, 2004). In Davidson County, the SHAC has started a Diabetes Support Group for students. They also arranged for the local YMCA to offer memberships to school staff at a discounted rate, have established communication with local pediatricians to discuss existing health needs, and are looking at ways to reduce the local teen pregnancy rate (Davidson County SHAC Report, 2004). In Stokes County, the SHAC is exploring staffing options in order to free up extra time for students to meet with counselors, and offering suicide prevention training to school staff (Stokes County SHAC Report, 2004).

In the Fayetteville Region, the Bertie County SHAC has appointed a Family Coordinator who conducts monthly workshops for parents (Bertie County SHAC Report, 2004). In Carteret County, the SHAC works with the County Mobile Dental Lab to provide dental services to needy children (Carteret County SHAC Report, 2004). The Cumberland County SHAC has arranged for physical activity classes such as yoga, kickboxing, and dance after school three nights per week (Cumberland County SHAC Report, 2004). In Onslow County, the SHAC has 55 school, student, parent and community representatives participating. They are collaborating with each school to develop and provide all student families with a comprehensive list of community resources (Onslow County SHAC Report, 2004).

In addition, there are some initiatives that are seen in many of the Wellness Plans developed by SHACs across the state. In the area of nutrition, many SHACs are utilizing the *Winner's Circle* in their lunchroom offerings. These consist of menu items identified with the Winner's Circle logo as foods of a high nutritional value. SHACs are also investigating vending machine items that may be healthier choices for students and school staff. In the area of physical

activity, many programs are being offered such as *Girls on the Run,* an after school program staffed by volunteers, *Take Ten*, a program of ten minute activity lessons for classroom use, and outside activities such as *Hoops for Heart* and *Jump Rope for Health.* Many SHACs are working on violence prevention and safety programs at their schools. In addition, each SHAC is working toward developing a School Health Team in each of its schools. The team can assist in carrying out initiatives developed by the SHAC, tailoring them to the unique situation in each school.

There is a great deal of difference in the effectiveness of SHACs across the state. Some have been functioning effectively for several years, while others are still in the formative stage. Most are somewhere in between, celebrating some successes, while recognizing how much more needs to be done. Each SHAC is developing a Wellness Plan that is tailored to the unique characteristics of its individual school system.

The Next Step

For those school systems with fully functioning SHACs, they should continue to build on past successes, incorporating all eight components of a Coordinated School Health Program into their Wellness Plans as new challenges present themselves. For those school systems whose SHACs are just getting started or lack all eight components, there are some strategies that they can utilize to increase their effectiveness. Some of these are:

- Meet with key school personnel and community representatives and enlist their support.
- Identify existing school and community groups that address health issues and invite them to join in the effort.

- Find a chair for the SHAC who is concerned about the health of children and youth, who understands the school organization and is willing to make the necessary commitment of time and energy (NCSBE, 2004)

There is no one right way to accomplish the effective functioning of a SHAC. However, some important elements for success are:

- Create a customized plan based on the needs and strengths of the school and community.
- Foster teamwork and collaboration at all levels among community and school members.
- Involve youth, families, and other community members in planning and decision making.
- Commit to continuing school health improvement (NCSBE, 2004).

North Carolina Regional School Nurse Consultants are convinced that a fully functioning SHAC can have a significant positive effect on the health of the school community.

Amy Quesinberry from the Winston-Salem Region, stated that SHACs provide community leaders with an opportunity to come together to discuss issues affecting school children. Furthermore, they keep members of the community informed of the students' needs and allow for input from professionals from various fields to share their expertise. She stated, "County Commissioners almost always implement our suggestions."

Martha Guttu stated that educators are recognizing the link between health and education and are beginning to understand that students must be healthy in order to learn. "Getting all the different people around the table has brought out some issues that are now being addressed, i.e. realizing that water can be a beverage choice for lunch!" Frances Tutterow

stated, "It is absolutely the most effective way (to promote a healthy school community). It is well worth the time and effort."

Muriel Overman was equally enthusiastic when she stated,

> It brings awareness of issues to the forefront so that services are improved, and encourages the adults to be positive role models. It also gets the entire community involved so that students see positive benefits and school, at home, and in the larger community resulting in true life-style changes.

Eileen Benson from the Asheville Region stated, "I am happy it (establishing a SHAC in each school district) became mandatory because, like so many other initiatives, just talking about it does not create plans."

There will always be health issues confronting students, and there will always be well meaning school administrators, parents, school nurses, and community members working to solve the problems of student health and academic achievement. Coordinated School Health Programs developed by School Health Advisory Teams may be one of the best ways to develop effective solutions to these problems. Pat Cooper stated,

> I believe that most administrators feel than in education we have tried most everything commercial and professional during the last thirty years of education reform. Some have worked for some students, but most have failed for many. Administrators are looking for something that really works for all children, and help the profession as a whole. Coordinated School Health will do that (Cooper, 2004).

Without the support of representatives of all components that determine the health of the school community, achieving the goal of meeting the health needs of all students is an illusion. School Health Advisory Councils are an essential element in achieving that goal.

References

American Cancer Society. (1999). *Improving school health: A guide to school health councils.*

CDC (2003) *Stories from the field: Lessons learned about building coordinated school health programs.* Washington: US Dept. of Health & Human Services.

Charlotte Mecklenburg School System (November, 2005). *School Health News* (Newsletter).

Cooper, P. B. (January, 2003). Our journey to good health. *The School Administrator.*

Cooper, P. B. (2004). Coordinated school health and education reform: What administrators need to see. *The RMC Health Educator,* 5 (1).

Costante, C. C., (January, 2002). Healthy learners—the link between health and student achievement. *American School Board Journal*, 31-33.

Institute of Medicine (2003). *The future of the public's health in the 21st century.* Washington: National Academy of Sciences.

Kolbe, L. J. (2005). A framework for school health programs in the 21st century. *Journal of School Health*. 75(6) 226-228.

National Center For Health Education (2005). Growing healthy: Coordinated school health education.www.nche.org/growinghealthy_coordinatedschoolhealth.htm

NC County SHAC Reports (2004). www.nchealthyschools.org.

NC State Board of Education, Dept. of Public Instruction, and the Dept. of Health and Human Services (March, 2004). *Effective school health advisory councils: Moving from policy to action.*

NC State Board of Education Policy Manual. Healthy active children policy, www.nchealthyschools.org

O'Rourke, T. W. (2005). Promoting school health—an expanded paradigm. *Journal of School Health*, 75(3) 112-114.

Saunders, R. P., Fee, R. M., & Gottlieb, N. H. (January, 1999). Higher education and the health of America's children: Collaborating for coordinated school health. *The Kappan,* Phi Delta Kappa International.

Stanhope, M., & Lancaster, J. (2004). *Community and public health nursing* (6th ed.). St. Louis: Mosby, pp 29-30.

Symms, C., Cinelli, B., James, T., & Groff, P. (1997). Bridging student health risks and academic achievement through comprehensive school health programs. *Journal of School Health,* 67(6) 220-226.

Tobacco Free Schools, www.tobaccofreekids.org

Tyson, H. (January, 1999). A load off the teachers' backs: coordinated school health programs. *The Kappan,* Phi Delta Kappa International.

Veselak, K. E. (2001). Historical steps in the development of modern school health programs. *Journal of School Health,* 71(8) 369.

Wyatt, T. H. & Novak, J. C. (2000). Collaborative partnerships: A critical element in school health programs. *Family and Community Health*, 23(2) 1-11.

Zimmerman, B. (November, 2005). What do all of these have in common? Linking the coordinated school health program, school health council, and the Child Nutrition and WIC Reauthorization Act of 2004-PL 108-265. *National Association of School Nurses* (Newsletter), 22-24.

Appendix

SCHOOL HEALTH ADVISORY COUNCILS IN NORTH CAROLINA

BY REGION, 2004

Region	**Mooresville**	**Raleigh**	**Greenville**	**Asheville**	**Winston-Salem**	**Fayetteville**
Counties	**13**	**17**	**19**	**19**	**14**	**17**
Counties with SHAC	**13**	**15**-2 in process	**16**-3 in process	**18**	**13**-1 in process	**16**-1 in process
Health Education	**7** *54%*	**7** *41%*	**8** *42%*	**9** *47%*	**6** *43%*	**11** *65%*
Physical Education	**11** *85%*	**9** *53%*	**14** *74%*	**13** *68%*	**9** *64%*	**13** *76%*
Healthy Environ.	**6** *46%*	**10** *59%*	**11** *58%*	**12** *63%*	**6** *43%*	**9** *53%*
Health Services	**5** *38%*	**9** *53%*	**9** *47%*	**7** *37%*	**8** *57%*	**5** *29%*
Staff Wellness	**5** *38%*	**10** *59%*	**10** *53%*	**9** *47%*	**7** *50%*	**5** *29%*
Child Nutrition	**8** *62%*	**11** *65%*	**13** *68%*	**14** *74%*	**10** *71%*	**8** *47%*
Couns., SW, Psych.	**6** *46%*	**11** *65%*	**6** *32%*	**9** *47%*	**9** *64%*	**6** *35%*
Parent/Com Involvement	**4** *31%*	**12** *71%*	**9** *47%*	**6** *32%*	**10** *71%*	**9** *53%*
All eight components	**2** *15%*	**4** *24%*	**2** *11%*	**1** *5%*	**1** *7%*	**1** *6%*
Tobacco free policy	**7** *54%*	**6** *35%*	**9** *47%*	**6** *32%*	**2** *14%*	**8** *84%*