



Continuing Education

AAHE Scholar Address

Promoting Adolescent and School Health: Perspectives and Future Directions

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The process and privilege of becoming an AAHE Scholar does not develop in a vacuum; the influences are pluralistic. Consider my faculty at the State University of New York, College at Brockport in the late 1970s: Bill Zimmerli, Bob Gold, Mary Sutherland, Dave Duncan, Dave Bedworth, and Jim Eddy, among other excellent health educators. Venturing to the University of Illinois sight-unseen, I studied with seasoned veterans: Bill Creswell, Don Stone, Tom O'Rourke, and Dave Macrina, in addition to classmates Fred Peterson and Mike Hoadley, who challenged my thinking. Completion of a postdoctoral fellowship with Richard Windsor at the UAB-Medical Center, School of Public Health was another excellent experience. Influential colleagues at the University of South Carolina include Murray Vincent, Roger Sargent, J. Wanzer Drane, and Scott Huebner, in addition to graduate students Silas Pearman, Ashley Aull, Scott Winnail, John Oeltmann, and Keith Zullig, who challenged me as often as I challenged them. In retrospect, my high

school coaches were correct in stating that, "luck is what happens when preparation meets opportunity." I have been most fortunate to have studied under some of the best and worked with a number of other outstanding health educators.

Suffice to say, I am humbled by this recognition and have experienced a certain level of anxiety in regard to addressing an audience of my peers. After exploring and discarding various topics, I did what most health education scholars would do by conducting a focus group ($n=1$) with a fellow health educator. In turn, Sandy Kammermann Valois provided guidance and direction. Her conclusion: "It's simple; you have to talk about what you *know* and what you *love*." In turn, the "piece de resistance" of what I have come to *know* and *love* over the past 23 years involves the promotion of adolescent and school health.

EARLY INFLUENCES: MY VILLAGE

Elmira, NY, was a thriving blue-collar, gray-steel town, surrounded by hills and

dairy farms (pop. 35–40,000) in the 1950s, '60s, and most of the '70s. The post-WWII economy enabled supporting most families with one income. Major employers included American La France; Kennedy Valve; Thatcher Glass; Remington Rand; American Bridge; Bendix Brakes; the Pennsylvania Railroad; Ann Page (A&P) Foods; two hospitals; four high schools; Elmira College; and the Elmira Reformatory. The baby boom was in full swing, and most families had both parents present and functioning effectively. Exceptions were accidental and premature deaths, with divorce somewhat uncommon. Corner grocery stores and neighborhood taverns often had ethnic identities, and places of worship represented

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most denominations. Our schools were small, public and private, with curriculums moving at a manageable academic pace, accompanied by reasonable standardized testing and extracurricular activities. We usually walked to school or rode our bicycles, weather permitting. My experience involved surviving 12 years of Catholic school and living to tell the stories (regarding nuns, priests, altar boy duties, CYO sports, et al.). The "Southside" of Elmira was flavored by railroads, small steel foundries, and middle class families of mostly Irish, Italian, and Polish decent. Home systems managers (aka stay-at-home moms) kept a close watch on the neighborhoods during the week and used (low-tech) rotary dial telephones for communication and child surveillance reporting purposes. Almost everyone knew your name, and more than likely, they knew your parents or one of your siblings. With four sisters and one brother, mine was a robust experience. It was not uncommon to be rewarded or reprimanded by a parent, not necessarily yours, and sometimes in the presence of others. In turn, parents thanked each other for the supervision and discipline (lawsuits being nonexistent). Teachers, parents, neighbors, friends, coaches, scout leaders, and clergy, among others, supported each other in the development of each villager. Risk behaviors were low in prevalence, and developmental assets were abundant. My father was an industrial arts instructor and Reception Center evaluator for the New York State Department of Corrections, while my mother worked (at various times of family development) as a registered nurse at St. Joseph's (a teaching) Hospital. Reflecting here, I can say without hesitation that both personally and professionally I was raised by good folks in a safe and supporting village. Elmira, NY, like many towns in the U.S.A. during the 1950s–1970s, was a modern day Camelot, with a high level of connectedness among neighborhoods, schools, and families.

IT TAKES A WHOLE VILLAGE ...

The old African proverb "it takes a whole

village to raise a child" offers a timeless reminder that children and adolescents thrive only if their families, neighborhoods, schools, and society care enough to provide for them. The sage who first offered this proverb would undoubtedly be bewildered by what constitutes the modern day village.

Not so long ago the "village" meant an actual geographical place where individuals and families lived, worked, worshiped and relaxed. To many of us the word village still conjures up a road sign that might read "My Town, U.S.A., population 12,344," followed by emblems of the local civic organizations and places of worship. Or in my case, "Welcome to Elmira, New York, home of Eileen Collins, Ernie Davis, Tommy Hilfiger, Olivia Langdon, Thomas Beecher, and Hal Roach, among other famous folks. Visit the National Soaring Museum, the Quarry Farm, Mark Twain's study, Elmira College, Woodlawn National Cemetery, and the former Civil War Prison Camp site. Visit in the fall, the colors are gorgeous!"

For most of us, though, the village doesn't visualize like that anymore. It is becoming more difficult to paint a picture of the modern day village, as our culture becomes more frantic and fragmented. Extended families rarely live in the same town, let alone the same house. In many communities, crime and fear keep people behind locked doors. Where we used to chat with neighbors on stoops and porches, we now watch videos, work, and play on computers. Instead of strolling down Main Street and shopping in stores, we now spend hours in automobiles and at anonymous shopping malls. Robert Putnam, in his national best-selling book, *Bowling Alone*, depicts how we have become increasingly disconnected from one another and how social structures, whether they be the PTA, church/synagogue, union, civic organizations, or political parties, have disintegrated, thus privatizing life experiences. Putnam also deftly diagnoses the harm that these broken bonds have wreaked on our physical and civic health and exalts the fundamental power of these bonds in creating a society that is happy, well-educated, healthy,

and safe (Putnam, 2000). This is a provocative argument to explain what Putnam observes as the loss of "social capital," the storehouse of civic energy to tackle community and social ills. Whether one agrees with Putnam's (1995) conclusions, he unearths a good question: Are we more or less involved with our fellow citizens than we used to be?

The horizons of the contemporary village extend well beyond the town line. Children and adolescents, as well as adults, are influenced by many human and nonhuman components of a massive sociocultural matrix. Technology connects us to the impersonal "global village" we have created, which is often dehumanizing and inhospitable. Some of us yearn for the good old days as a refuge from our rapidly changing world and its hectic pace. However, by turning away we blind ourselves to the critical importance of how we live together. The village is no longer a place on a map or a list of people or organizations. Its essence, its core, however, remains the same: the network of values, shared goals, and relationships that support and affect our lives. The American village has evolved. A brief review of these changes as they relate to children and adolescents is discussed in the following sections.

THE VILLAGE HAS CHANGED

From an observational perspective our current generation of adolescents could be described as a "hurried-up, instant gratification, premature entitlement cohort." Technological advances and the speed at which Americans can receive goods or services foster an instant gratification mentality and lifestyle. Working with adolescents and young adults suggests that many feel a sense of entitlement that, in my opinion, is premature. Ringo Starr said it best: "You've got to pay your dues, if you wanna sing the blues, and ya know it don't come easy." However, too many young people today are looking for the "big easy," and the consequences can be costly.

American society at the end of the 20th century is a good-news bad-news scenario.



The decade of the nineties has witnessed progress in some key social indicators: reductions in welfare, violent crime, AIDS, divorce, and suicide; upswings in SAT scores and charitable giving. A closer look suggests some significant gains. For example, since 1994 there has been a 46.5% decrease in the welfare rolls. The murder rate is at its lowest point since 1967. Alcohol-related traffic fatalities are at their lowest level since the government began keeping such statistics. Since 1993 the reported number of AIDS cases has decreased by more than 50%. There has been a 16-point increase in SAT scores and a 38% increase in charitable giving (in inflation-adjusted dollars, pre-9/11). However, during the same 1990s we experienced some serious social regression. The percentage of births to unwed mothers, already at the alarmingly high level of 28% in 1990, was even higher in 2000 at 32.4%. The United States still has the highest divorce rate among Western nations, and the highest incidence of single-parent families of any industrialized nation. Our rates of sexually transmitted disease far exceed those of every other developed country. In 1998, 5.6% of high school seniors reported using marijuana on a daily basis, a 180% increase from 1991. In math achievement American 12th graders ranked 19th out of 21 nations (Bennett, 1999). From 1985 to 1993, homicide arrests of young people aged 10 to 17 rose by 154%, from 5.7 to 14.5 per 100,000. Similarly, the violent victimization rate has also experienced an overall increase since 1980. By 1997 this upward trend had reversed, and the arrest rate declined to 8.2 (Snyder & Sickmund, 1999). However, the United States still experiences more homicides than the next 10 developed nations combined. Depending on perspective, these trends could be considered by some as upbeat, or by others with despair. Nonetheless, the trends are deeply troubling and afflict, in particular, the American family and especially the American adolescent.

ADOLESCENT VILLAGERS: CHANGES AND CONCERNS

Significant past and ongoing changes in

our society's norms and social structure suggest that many adolescents are being raised in an environment differing significantly from that which was traditional during the late 20th century. Social and environmental context play an important role in adolescent development.

Population

The size, mean age, and racial and ethnic composition of the adolescent population changed significantly during the 1990s, and the prediction is continued change throughout the next several decades. From 1990 to 2000 the population of adolescents aged 10 to 19 grew by almost 3 million, or 7.7%, and will grow by more than 2 million over the next decade, from 39.9 million in 2000 to 41.7 million in 2010. This change represents a 4.6% increase, far smaller than the projected 8.6% increase for the total U.S. population. The projected adolescent population in 2020 will be 42.4 million, and by 2050 a record 53.2 million. Meanwhile, the number of young adults aged 20 to 24 is projected to grow at a much faster rate, increasing by 2.7 million, or 12.4%, over the next 20 years (U.S. Census Bureau, 2001a, 2001b).

Disparate growth rates among different age groups within the U.S. population will result in the percentage of adolescents decreasing as a proportion of the total population, falling from 14.5% in 2000 to 13.9% in 2010. This trend is expected to continue through 2020, when adolescents are projected to comprise 13% of the population. As the baby-boom generation ages and the elderly population swells, the proportion of adolescents will shrink even as their numbers grow (more than likely diverting resources to the older population).

Race/Ethnicity

In the coming decades the racial and ethnic makeup of the U.S. adolescent population will become increasingly heterogeneous. We can expect a decrease in White adolescents as a proportion of the population, with a concurrent increase in other racial/ethnic groups, a shift from Black to Hispanic as the most populous minority group, and an adolescent population signifi-

cantly more diverse than the population as a whole (U.S. Census Bureau, 2001a-d). This can increase intergenerational tensions, with the mostly White elderly vying with non-European American adolescents for resources and political clout. It also increases the likelihood of poor communication and understanding of one another's needs and interests. However, diversity will remain localized, with many parts of the United States remaining homogenous, especially in states with smaller populations.

Socioeconomic Status

Due to the dramatic shift in the structure of the American family, more adolescents are being raised in single-parent families, usually headed by a female, and likely to be poor. Socioeconomic status often predicts adolescent well-being vis-à-vis access to education, health care, and housing, as well as exposure to violence, delinquency, and adverse emotional health (Annie E. Casey Foundation, 2001). Poor children are twice as likely as nonpoor children to report being in fair or poor health (Brooks-Gunn & Duncan, 1997). Although poverty levels have fallen in recent years, approximately one in six Americans aged less than 18 lives at or below the poverty line (\$17,029 for a family of four in 2002; Dalaker & Proctor, 2000). Longer periods of time spent in poverty have been linked to serious deleterious health effects (Brooks-Gunn & Duncan, 1997; Duncan, Brooks-Gunn, & Klebanov, 1994).

Family Structure

The percentage of children and adolescents living in two-parent households has fallen sharply over the past 20 years. This change has potential negative health implications for youth, given that the number of parents present is associated with the amount of resources available, both human and economic (U.S. Census Bureau, 2001c). In 1999 an alarming 42% of children aged less than 18 who lived in households headed by females lived in poverty, versus only 8% of children in households with both parents present (Federal Interagency Forum of Child and Family Statistics, 1997). Race and ethnicity play a key role in predicting the



likelihood of a single-parent family structure as well as the socioeconomic status within these single-parent family households (Corcoran & Chaudry, 1997).

Selected Health Risk Behaviors

Cigarette Smoking. Smoking among adolescents as a whole peaked in the late 1970s and declined in the 1980s and early 1990s. These trends changed by 1994, and smoking among teens rose until 1997. Since then it appears to have stabilized (Grunbaum, Kann, & Kinchen, 2002).

Alcohol. Use of alcohol remains very high among U.S. adolescents and has gradually increased over the past decade, with a minor increase (0.7%) in 30-day prevalence of reports of "having been drunk" among both 8th graders (from 7.6% in 1991 to 8.3% in 2000) and 12th graders (from 32.6% to 32.3%). Binge drinking experienced a gradual increase in the 1990s with 26.2% of 10th graders and 30% of 12th graders reporting that they binge drink (Johnston, O'Malley, & Bachman, 2001).

Marijuana Use. After 6 years of steady increases (from 6.2% in 1991), annual marijuana use among 8th graders peaked in 1996 at 18.3% and has fallen since, to 15.6% in 2000. Among 10th and 12th graders similar increases were observed, with 36.5% of 12th graders reporting current (past 30 days) marijuana use in 2000 compared with 23.9% in 1991 (Johnston et al., 2001).

Sexual Risk-Taking. In 2001, 45.6% of high school students reported having had sexual intercourse at some time, down from 53% in 1993.

Violent Behavior. From 1985 to 1993, homicide arrests of young people aged 10 to 17 rose by 154%, from 5.7 to 14.5 per 100,000. Similarly, the violent victimization rate also has experienced an overall increase since 1980. By 1997 this upward trend had reversed, and the arrest rate declined to 8.2 (Snyder & Sickmund, 1999).

Suicide. Suicide rates have seen the most dramatic increase (39%) within the 10- to 14-year-old age range during the past 20 years (Centers for Disease Control and Prevention [CDC], 2001). Studies have shown that adolescent risk behaviors tend to clus-

ter or overlap (Donovan & Jessor, 1985; Dryfoos, 1990; Osgood, Johnston, & O'Malley, 1988), particularly in the areas of substance use, sexual risk-taking, and violence (Garrison, McKeown, Valois, & Vincent, 1993; Valois, MacDonald, Bretous, & Fischer, 2002; Valois, Oeltmann, Hussey, & Waller, 1999), and more than likely, youth developmental assets (Reininger et al., 2003). Teenagers today reach puberty two or three years earlier than in 1900, and young people have vastly increased access to improved transportation and communication technologies. These two factors make it easier for adolescents to become more knowledgeable and worldly at an earlier age, often before they are ready to handle the consequences of their actions (National Association of School Boards, 1999). It should be noted here that most adolescents are in the process of developing five basic life skills that can greatly enhance the quality of their daily lives and their satisfaction with life: decision making, problem solving, goal setting, stress management, and communication (Valois, Vincent, McKeown, Garrison, & Kirby, 1993).

School Dropout. High school dropouts have lower earnings, experience more unemployment, are more likely to receive welfare, and are more likely to be incarcerated than peers who complete high school or college (Kaufman, Kwon, Klein, & Chapman, 2000). Students from low-income households are much more likely to drop out of school than middle- and upper-income students. High school dropouts are approximately three times more likely to become impoverished than their counterparts who complete high school (Annie E. Casey Foundation, 2001). Data from 1999 indicate that among working adults aged 25 to 34, the median personal income of those with a high school degree (\$28,143) is about 32% higher than for high school dropouts (\$21,400). The mean income of 25- to 34-year-olds with a bachelor's degree (\$45,078) is more than twice that of high school dropouts (U.S. Census Bureau, 2000). Females who drop out of high school are more likely to become pregnant and give

birth at an early age and are more likely to be single parents (Annie E. Casey Foundation, 2001). Dropout rates have decreased for all racial and ethnic groups: from 9.9% in the 1980–1982 cohort to 5.6% in the 1990–1992 cohort. By 1999 the overall dropout rate for high school students was 5.0% (Kaufman et al., 2000). Native American, Hispanic, and Black youths have disproportionately high dropout rates. In the 1990–1992 cohort of 10th to 12th graders, 18.2% of Native American, 10.9% of Hispanic, and 7.6% of Black youths were dropouts (Kaufman et al., 2000). With economic changes favoring more highly skilled workers, the wage gap between high school dropouts with fewer skills and technical knowledge and their educated counterparts will likely grow. The Bureau of Labor Statistics predicts that computer and data processing services will be the industry with the fastest employment growth in the next decade (Bureau of Labor Statistics, 1997), emphasizing the need for higher reasoning skills.

Computer Use. Computer availability and use among adolescents has increased dramatically over the past decade, both at home and in school. The rapid growth of the Internet has contributed to making computers indispensable educational tools. Resources are not evenly distributed, with children and adolescents from poorer homes and schools having significantly less access to computer technology (Irwin, Burg, & Uhler-Cart, 2002). In 1983, America's schools had, on average, one computer for every 125 students. By 1998 there was one computer for every 6 students. By 1999 Internet access had made its way into 95% of schools, up from 35% in 1994. Recently, computers have entered the classroom as an important teaching and learning tool. In 1994 only 3% of instructional classrooms had Internet connections; by 1999 that number had risen to 63%. Schools in lower income areas with a high rate of free or reduced-price lunches (71% or greater) have less access, with 90% of such schools and 39% of classrooms having Internet access (Snyder & Hoffman, 2001).

Use of Visual Media. In 1999, youths aged



8 to 18 watched an average of more than 3 hours of television per day, whereas 28% of 11- to 13-year-olds and 18% of 14- to 18-year-olds reported watching more than 5 hours of television per day. This does not include other video media, such as video games, videocassettes, and DVDs. If these are included, children and adolescents, on average, are spending more than 6.5 hours with these visual media each day (Roberts, Foehr, & Rideout, 1999). A recent report by the American Academy of Pediatrics (2001) suggests that such high levels of media exposure may have negative effects, both for physical and behavioral health. However, prevalent, excessive television use has declined in recent years across all races and income groups. In addition to watching television, youths are spending a great deal of time with other visual media. In 1999, youths aged 8 to 18 spent an average of 45 minutes per day watching videotapes and 27 minutes playing video games. This compares to just over 1 hour spent listening to CDs and tapes, 48 minutes for radio, 44 minutes with print media, and 31 minutes for computer use (Roberts et al., 1999).

Schools and Educational Status. Significant changes in school environment include a decrease in the total number of schools, an increase in the size of schools, and the rapid growth in the number of middle schools. The decline in the total number of schools is the result of the consolidation of smaller schools into larger schools. In 1930 there were more than 262,000 public schools, compared with 88,548 today. More recently, this downward trend has reversed for middle schools serving grades four, five, and six, or six, seven, and eight. Over the last 30 years the number of middle schools has multiplied fivefold, from 2,080 in 1970 to 15,407 in 1999. Meanwhile, the number of junior high schools has decreased, while the number of high schools and elementary schools has remained the same (Snyder & Hoffman, 2001). Public school enrollment declined significantly during the late 1970s and early 1980s, reaching a low of 39.2 million in 1984. Since that time enrollment has steadily increased, reaching 46.5 million in

1998, its highest level to date. However, increased enrollment has not been matched with sufficient funding, resulting in the deterioration of many public schools' buildings. In 1998, 39% of public schools were using temporary buildings, and one in five public school buildings were in less-than-adequate condition (Snyder & Hoffman, 2001). Average class size in public schools has increased from a low of 23 in 1981 to 31 in 1996, resulting in less student-teacher interaction. Private schools continued to have lower pupil-to-teacher ratios: 16.6 for elementary schools and 11.6 for high schools (Snyder & Hoffman, 2001). These changes in school structure are not healthy for adolescents. As our youth is forced into larger, more impersonal academic environments in middle childhood and early adolescence, the school environment is losing its claim as the "arena of comfort" that K-8 schools once provided for developing adolescents (Simmons, 1987).

Expectations for Student Achievement

Proficiency Scores. A recent Educational Testing Service Study of 25,000 students showed that although student proficiency has increased in some subjects and for some age groups, significant gaps continue to exist between racial and ethnic subgroups and between male and female students (Snyder & Hoffman, 2001).

Reading. Between 1980 and 1999 there was an increase of less than 1% in reading proficiency test scores for both 13- and 17-year-olds. Black and Hispanics were somewhat higher at 2 to 3%, slightly narrowing the performance gap between White and minority youth. White test scores remained 10 to 12% higher than their Black and Hispanic peers, with Hispanics scoring slightly higher than Blacks. Gender gaps favoring female students in reading achievement widened slightly, with females outperforming males by approximately 5% (Snyder & Hoffman, 2001).

Writing. Among 8th and 11th graders, writing achievement fell slightly between 1984 and 1996. Female students continued to outperform males, with 6 to 10% higher assessment scores. Declines in performance

across racial lines were fairly uniform, with White students continuing to score from 8 to 11% higher than Blacks and Hispanics, and Hispanics slightly outperforming Blacks (Snyder & Hoffman, 2001).

Mathematics. Between 1982 and 1999, math test scores increased slightly (2 to 3%) for both 13- and 17-year-old students. For 13-year-olds an upward trend from the previous decade was continued, whereas a downward trend was reversed among 17-year-olds. Among 13-year-olds, males overtook females with slightly higher test scores in 1999, whereas the male advantage among 17-year-olds narrowed slightly. Although the gap between Whites and minorities had narrowed, Whites continued to outscore their Black and Hispanic peers by 10 to 12%, with Hispanics performing slightly better than Blacks (Snyder & Hoffman, 2001).

Science. After declining in the 1970s, science proficiency scores increased among both 13- and 17-year-olds from 1982 to 1999: scores for 13-year-olds in 1999 were the same as 1970 levels, whereas 1999 scores for 17-year-olds were below 1970 levels. Males continued to score higher than females, with the difference narrowing slightly for 17-year-olds, while remaining constant among 13-year-olds. Again, Black and Hispanic proficiency scores increased faster than those of Whites; however, the racial/ethnic disparity in science remained the highest of all disciplines, with Whites scoring roughly 14% higher than Hispanics and 18% higher than Blacks in 1996 (Snyder & Hoffman, 2001). Review of these social contextual factors suggests that the village and young villages have changed. However, healthy adolescent development and academic success remain as important objectives for American adolescents.

Health and Academics

Given the ever-evolving village contextual factors, changes in the adolescent villagers and the limited success in student achievement, perhaps we, as a society, have the "proverbial cart before the horse." Perhaps we are out of balance in our approach to long-term academic success. Current improvement efforts in public schools



focus on the “Leave No Child Behind Act,” which includes requirements in student testing, report cards on school progress, teacher quality standards, and strict consequences for poor-performing schools.

If statewide high-stakes testing policies actually improve student learning, we should observe that improvement reflected in a state’s own test scores and also in independent measures (Amrein & Berliner, 2003). Amrein and Berliner examined 18 states that require exit examinations for high school graduation. Specifically, they looked at how student achievement—as measured by the SAT, ACT, Advanced Placement tests, and the National Assessment of Educational Progress—related to implementation of the graduation exams. These researchers found no evidence that, in states using their own tests, student achievement increased on those other measures. In addition, dropout rates increased, retention rates (students being held back a grade) increased, and the number of students obtaining alternative high school diplomas increased. These findings suggest that high-stakes testing pushed low-achieving students out of school rather than helping them succeed.

Dr. Allan Cross stated in his address to the American School Health Association, “Health and Academics: The Price of High Stakes Testing,” that accountability is needed. However, when everything is focused on testing, we lose site of the full purpose of school. We erroneously narrow our efforts in ways that actually reduce test scores and sacrifice the health, development, and well-being of students and staff (Cross, 2002). This focus on standardized testing causes stress among teachers and administrators, narrows the mission of schools, contributes to teacher burnout, and creates added stress for the students.

This, in turn, is not good for overall learning and does not hold a school accountable for its comprehensive mission (Cross, 2002). This becomes a lose-lose situation. The goals of public education in a general sense include (1) teaching a sequence of knowledge and skills in language,

math, social studies, history, and science; (2) creating an environment where kids learn to be responsible, productive, and happy adults (quality of life/life satisfaction); and (3) making school a place where kids learn how to get along with others, take responsibility, learn from mistakes, are rewarded for success, and are respected as they learn to respect others.

The pursuit of high-stakes testing is an example of the “Law of Unintended Consequences.” Students most in need of physical activity, nutrition, tobacco prevention education, and extracurricular activities are usually those with lower academic success. Eliminating physical education, health education, and extracurricular activities (usually first on the chopping block) often projects these challenged kids into deeper academic despair. In turn, high-stakes testing becomes “an unintended consequence,” disrupting the balance needed between academic success and promoting child and adolescent health.

Economic changes that have occurred in our education and health care systems post-9/11 cannot be ignored. Schools and health care facilities will have to “do more with less” until our economy can stabilize. For the first time in our nation’s history we have entered war preemptively. War in the Middle East and the effects of 9/11 will influence the future of today’s adolescents. Ignoring these effects is like ignoring the “elephant in the living room.”

However, our educational system appears caught in a great dilemma. Many child and adolescent problems that used to be solved at home or in the neighborhood, now walk, or more often ride, to school every day. Ignoring a student’s physical and emotional needs risks lowering his or her academic achievement, thus impeding schools in their primary task of education. As more and more teachers and school administrators come to appreciate, there is an inextricable link between students’ health and their ability to learn (WHO, 1996). If schools do not deal with children’s health by design, they deal with it by default (Marx & Wooley, 1998). It would be “penny wise and pound

foolish” to ignore the health challenges that interfere with academic success of adolescents, our adults of the future.

INVESTING IN ADOLESCENTS: PAY NOW OR PAY LATER

Because adolescents suffer from few life-threatening conditions, they are often ignored by public health investments. Adolescence is a time period of great plasticity, when the formation of harmful habits can have long-term effects that will eventually exact a heavy toll on society, but when positive health habits may have the opposite effect and will lead to the health of the county. Burt (2002) suggests that a focus on the quality of life for adolescents and the rest of the community, rather than merely on morbidity and mortality, is a more effective strategy for convincing policy makers of the need to invest in adolescents. Policy makers need to understand the value of investing in the future health and productivity of adolescents and the need for holistic rather than problem-focused programming for youth. Efforts to help adolescents become contributing members of society rather than “resource absorbers” have the potential to foster economic productivity. Holistic programs for youth need positive development opportunities that are appropriate to adolescents’ age and experience, families and environments, and the overall context in which their behavior occurs.

Policy makers also need to know what strategies work for adolescents. Dr. Brian Flay, in his research laureate address to the American Academy of Health Behavior, eloquently outlined and explained why positive youth development requires comprehensive health promotion programming for health and academic achievement (Flay, 2002). This paper provides evidence of comprehensive programs, effective in multiple domains, that address multiple behaviors (health and academic) and involve families and community (Flay, 2002).

Consider the consequences of not making investments in adolescents. In the United States, \$260 billion is lost in earnings and forgone taxes for each year’s cohort of



high school dropouts, and \$20 billion is spent annually in payments for income maintenance, health care, and nutrition to support families begun by teenagers (Carnegie Council on Adolescent Development, 1983). Burt (2002) maintains that because decision makers value these potential costs differently, such justifications for investments in adolescents must take into account the personal and societal outcomes that are most valued by the people who are being asked to invest.

Thomas Hine (1999) in his book, *The Rise and Fall of the American Teenager*, suggests that although most observers of “at-risk” youth point to the same complex of bad behaviors, causes and solutions depend largely on the politics of the observer. Those on the right fear nihilism and anarchy and blame parental values and fatherless households that are encouraged by federal welfare policies. A more comprehensive perspective finds a steady disinvestment in the young during the last two decades, as spending on schools and children’s health has suffered, and only law enforcement and incarceration have been able to build a political consensus. Those on the left see many of the same problems of poor educational achievement, suicide, drug use, STDs, and violence, but cite underfunded institutions and programs, not bad morals.

This diametric opposition creates a difficult landscape for fighting the good fight in the political area. However, for adolescent health and academic achievement, the challenge still comes back to “pay now or pay later.”

THE COORDINATED SCHOOL HEALTH PROGRAM: PANACEA OR POTENTIAL?

The Coordinated School Health Program (CSHP) offers a solution to schools’ responsibilities for both the health and academic success of children and adolescents (Allensworth & Kolbe, 1987; Marx & Wooley, 1998; Kolbe, 2002). The 2000 Joint Committee on Health Education and Promotion Terminology defined the CHSP as “an organized set of policies, procedures,

and activities designed to protect, promote, and improve the health and well-being of student and staff, thus improving the student’s ability to learn.” The CHSP includes, but is not limited to (1) family & community involvement in school health; (2) comprehensive school health education; (3) physical education; (4) school health services; (5) school nutrition services; (6) school counseling, psychological, and social services; (7) healthy school environment; and (8) school-site health promotion for staff (Joint Committee on Health Education and Promotion Terminology, 2000, p.5). The CHSP model recognizes that the focus of the school should be on the whole child, with academic achievement as its *raison d’être*. Schools with such a program provide basic health programs and services to meet the routine physical and mental health needs of children and adolescents, as a support, essential so that students can learn, which is central to the educational mission of the institution.

In addition, such schools provide a referral system for services the school does not provide, building partnerships with other community service agencies that can respond to family needs that are most acute. To achieve their mission, schools should provide physical and mental health care for problems that interfere with students’ ability to learn, and focus on prevention for the student body as a whole. The goal is to teach youth to respect and care for their minds and bodies and create a cycle of enlightenment about good health that enhances the life satisfaction and quality of life for adolescents (Huebner et al., in press; Valois, Zullig, Huebner, & Drane, 2001; Valois, Zullig, Huebner, Kammermann, & Drane, 2002; Zullig, Valois, Huebner, Oeltmann, & Drane, 2001). In our fast-paced, hard-nosed competitive society, development of a community-wide infrastructure and commitment to child and adolescent health and academic achievement may seem quixotic. Our sense of neighborhood and village (although it reemerged strongly post-9/11, temporarily) has faded, and the very notion of community seems almost inapplicable to

contemporary American life. Absent larger loyalties, we often settle for smaller loyalties that diminish our national or state unity and widen social separation. There seems to be a growing pessimism in American, a feeling that the social pathologies we confront on a daily basis may be too deep to be dealt with in some communities.

However, as the popular ESPN host Lee Corso would say, “Not so fast my friend!” Drive, determination, perseverance, and good will run deep in America. Throughout our history, citizens have demonstrated their ability to come together and organize energetically in times of crisis. Americans have dedicated themselves to great causes with vigor and an outpouring of concern and subsequent action. With a balanced blend of commitment, imagination, and enthusiasm, communities in America can realize that their future is with the next generations and rally once again, on behalf of school-aged children and adolescents.

Effectiveness of CSHP Components: Evidence is Emerging

Alone, or in some combination, the components of a CSHP are effective in positively affecting the health behaviors and academic achievement of children and adolescents (Association of State and Territorial Health Officers and Society of State Directors of Health, Physical Education, and Recreation, 2002). A quick review of the research reveals the following.

Family and Community Involvement in School Health. Students whose parents are actively involved in their education have demonstrated significantly greater achievement gains in math and reading (achievement and comprehension), improved attendance, and consistency of completed homework compared with students with uninvolved parents (Henderson, 1987; Shaver & Walls, 1998). Nettles (1991) and Allen et al. (1997) found that community activities that connect to the classroom reduced school suspension rates, improved school-related behaviors, and positively impacted academic achievement.

Comprehensive School Health Education. From the School Health Education Evalu-



ation study, students who participated in health education classes using proven effective curricula increased their health knowledge and attitudes and improved their health promoting skills and behaviors (Connell, Turner, & Mason, 1985). Constancy of these effects is established for all three learning domains with 40–50 classroom hours of instruction. Dent and colleagues (1995) found that through a social influences model curriculum (Project Towards No Tobacco), smokeless tobacco and cigarette use increases can be attenuated by various approaches, and these effects were stable for junior high adolescents at 2 years postprogram and with the transition to high school. Botvin, Griffin, Diaz, and Ifill-Williams (2001) found similar results for the reduction of binge drinking in early adolescents. Protective effects from a school-based program were present at the 1-year (8th grade) and 2-year (9th grade) follow-up assessments. Elias, Gara, Schuyler, Branden-Muller, and Sayette (1991) found that students who had received an intensive 2-year social decision-making and problem-solving program in elementary school showed more prosocial behavior and less antisocial and self-destructive behavior when followed up in high school 4 to 6 years postprogram.

Physical Education. Physical activity among adolescents is consistently associated with higher levels of self-esteem, lower levels of anxiety and stress (Calfas & Taylor, 1994), and higher levels of perceived life satisfaction (Valois, Zullig, Huebner, & Drane, manuscript submitted). Physical activity is positively associated with academic performance for children and adolescents (Dwyer, Blizzard, & Dean, 1996; Sallis et al., 1999; Shepard, 1996).

School Health Services. Early childhood and school-aged, school-based intervention programs that provide parental support and health services are associated with improved school performance and academic achievement (Reynolds, Temple, Robertson, & Mann, 2001). The Chicago Child-Parent Center Program also found that early intervention improved high school comple-

tion rates and lowered juvenile crime (Reynolds et al., 2001) for students up to 20 years of age. McCord, Klein, Foy, & Fothergill (1993) and Walters (1996) found that schools with school-based health centers increased school attendance, decreased school drop-outs and suspensions, and had higher graduation rates.

School Counseling, Psychological, and Social Services. Hawkins, Catalano, Kosterman, Abbott, and Hill (1999) through use of the social development model found that a comprehensive intervention combining teacher training, parent education, and social competency training for children had long-term effects including greater commitment and attachment to school, reductions in violent behavior, heavy drinking and sexual intercourse by age 18 (6-year follow-up), less school misbehavior, and better academic performance for multiethnic urban children. Eggert, Thompson, Herting, Nicholas, and Dicker (1994), through the use of an intensive school-based social network development program targeted at high-risk youth in grades 9–12, found increases in grade point averages (all grades), school bonding, and self esteem and modest success in stemming the progression of substance use. Bowen (1999), using school social workers and school-family partnerships, found improved academic performance for children who participated in a social service intervention focused on improving parent-child and parent-teacher communication. Resnick and colleagues (1997) found from the National Longitudinal Study on Adolescent Health that parent-family connectedness and perceived school connectedness were protective against every health risk behavior (with the exception of history of pregnancy), and parental expectations for school achievement were associated with lower levels of health risk behaviors.

School Nutrition Services. From an analysis of data from the NHANES III, Alaimo, Olson, and Frongillo (2001) found that teenagers who were “food-insufficient” were more likely to have repeated a grade, visited a psychologist, been suspended from

school, and had difficulty getting along with other children. From a study of public school students in Philadelphia and Baltimore, Murphy et al. (1998) found that school breakfast programs increased learning (especially math) and academic achievement, improved student attention to academic tasks, decreased visits to the school nurse, and decreased psychosocial problems (days absent and days tardy). Meyers, Sampson, Weitzman, Rogers, and Kayne (1989) in their Massachusetts study found that school breakfast programs positively impacted academic performance and reduced absenteeism and tardiness among low-income elementary school students.

Healthy School Environment: Physical. From a study in the District of Columbia, Berner (1993) found that the size of a school’s PTA budget is positively related to the school building’s condition. In turn, the physical condition of a school is statistically related to student achievement. This study found an improvement in the school’s physical condition by one category, poor to fair, was associated with a 5.5 improvement in average achievement scores. Allan Cross (2002) suggests taking a closer look at pesticide (neurotoxins for insects) use around and in a school. Safe levels are determined by extrapolating from adult and rat studies, and currently we do not know the harm these toxins may cause in children. Integrated pest management for schools has been suggested (Cross, 2002). Asthma is the leading cause of school absenteeism due to chronic illness, and indoor air quality (IAQ) is a key factor in asthma exacerbations. Half the schools in the United States have poor IAQ (USEPA, 2003). A greater push for indoor air quality is needed (Cross 2002).

Healthy School Environment: Psychosocial. The feeling of belonging to and being cared for at school has been referred to as school connectedness (McNeeley, 2002). Intervention research suggests that the relationship between feeling connected to school and good health may be causal. For example, a classroom management program that gave middle school students responsibility for setting classroom rules



and managing the classroom increased school connectedness and promoted self-discipline. After 1 year, between 30 and 100% fewer students were sent to the principal's office for acting out in class and fighting, or assault (Freiberg, 1989). Although school connectedness cannot in and of itself improve student learning, it is one important ingredient (Lehr & Christenson, 2000). When students feel they are part of their school and are cared for, they are more receptive to the high expectations of academically rigorous programs. In turn, school administrators do not have to choose between competing social and academic agendas. Efforts to promote connectedness can reinforce efforts to increase academic achievement (Bosworth, 2000) and reduce misconduct at school (Simons-Morton, Crump, Haynie, & Saylor, 1999). School connectedness can be modified via intervention. Evaluation of the Yale Child Study Center School Development Program found that if a program is well-implemented, sensitivity, caring, respect, and trust increase in the school, and this change is responsible, in part, for improved student academic performance (Comer, Hayes, & Hamilton-Lee, 1989). Improving school connectedness requires a focus on positive development rather than simply preventing bad outcomes. Two key developmental needs are caring support from adults and acceptance by peers. When these needs are met, young people learn to self-regulate and avoid risky behaviors and develop competencies necessary for adulthood (Eccles, Midgefield, & Wigfield, 1993; Masten & Coatsworth, 1998).

School-Site Health Promotion for Staff. Blair and colleagues (1984) found that teachers in Texas who participated in a 10-week health promotion program emphasizing exercise, stress management, and nutrition reported increased participation in exercise, improved physical fitness, lost weight, lowered blood pressure, higher levels of general well-being, and better ability to handle job stress. A study in Michigan found a staff wellness program responsible for a significant drop in teacher absences

and a subsequent savings of approximately \$8,000 related to substitute teachers (Falck & Kilcoyne, 1984). Allegrante and Michela (1990) evaluated a New York City school district health enhancement program and found that teachers who participated viewed their school environment more positively and reported higher morale than nonparticipants.

In summary, the CSHP model has potential for improving students' academic performance and increasing healthy behaviors as well as preparing school-aged children and adolescents for their future of "making a living, and leading a healthy life" (Valois, Ory, & Stone, 1989).

IF YOU BUILD IT, THEY WILL COME

Schools can implement a CSHP, but it takes time and commitment. The keystones that support a village are the family and home; the interreligious community; the workplace; and the educational system. Currently in the United States, however, the family and home are in serious need of assistance. Influence from the interreligious community continues to diminish and the economy and workplace can be, for some Americans, unstable at best. Our educational system thus has become the strongest base holding up our "village" until the other supports become stronger. A CSHP can strengthen not only the educational system, but also the other keystones, and as the other keystones become stronger, they contribute to a stronger school health program.

Borrowing from the movie *Field of Dreams*, it is possible to build a CSHP and people will come. They will come to know and embrace the program model and its potential for improving child, adolescent, and school health. However, building a CSHP takes time, commitment, patience, and success in some critical program elements. In results from the Mariner Project, a coordinated school health pilot project in South Carolina, Valois and Hoyle (2000) found that after a 3-year developmental period the foundation for program development and maintenance was a combination of four critical performance elements:

(1) administrative support/buy-in; (2) effective coordination by a school-based health promotion team; (3) an effective program champion/liaison/facilitator; and (4) an effective staff wellness coordinator. A recent report from CSHP efforts in Florida suggests that program strength and stability depend on long-term resources, qualified personnel, and administrative support (Weiler, Pigg, & McDermott, 2003).

From extensive fieldwork, Eva Marx, with support from the Centers for Disease Control and Prevention's Division of Adolescent and School Health (CDC-DASH) shares a wealth of information in *Stories from the Field: Lessons Learned About Building Coordinated School Health Programs* (CDC-DASH, 2002). Most of these lessons are not new, but they do reinforce most of what educators already know about building a CSHP. The most important lesson is that those involved in building and sustaining a CSHP must have the "drive and determination" to make CSHP a reality and a success. The 10 major lessons learned outlined in these stories are (1) Support of district and building-level leadership (superintendents, principals, school board members) is essential; (2) policies reinforce district and school commitment (mission statements) to positive student academic and health outcomes; (3) resources from outside the school are needed (change agents, partners, and advocates); (4) parents, families, and caretakers are essential partners (expertise and collective wisdom); (5) students are significant contributors to the success of programs, as well as program beneficiaries; (6) CSHP is a clear, practical approach (framework, common language); (7) successful CSHPs need to offer opportunities for participants to interact with other colleagues (enthusiasm, support, and recognition); (8) professional development engages staff and sustains their participation (enjoyable continuing education); (9) changing a system takes time (turf issues, "reluctance conversion," culture of schools); and (10) data make the case for a CSHP and systems change (documentation of ongoing needs, support,



monitoring, communication, process, impact, and assistance).

Thus, the evidence to date suggests that CSHP components, working alone and in combination, have the ability to improve academic achievement while reducing risk behaviors for children and adolescents. CSHPs can be developed and implemented. What the future holds for CSHPs depends on a variety of factors. The "holy trinity," so to speak, for health promotion program and evaluation success depends largely on the quality and appropriate quantity of people, time, and money (social and financial capital).

PERSPECTIVES FROM THE TIPPING POINT

Financial capital for promoting adolescent and school health will remain a challenge post-9/11 and postwar in Iraq. Therefore, effective use of social capital will be imperative for sustaining our efforts. It is valuable to consider here some of the more important concepts that Malcom Gladwell (2000) shares in *The Tipping Point: How Little Things Can Make a Big Difference*. He discusses word-of-mouth or "Social (positive) Epidemics," and three rules of the "tipping point": "the law of the few," "the stickiness factor," and "the power of context." These concepts have implications for promoting adolescent and school health, and the success of CSHPs.

In the law of the few, Gladwell (2000) introduces particular personality types who are natural pollinators of new ideas, people who create phenomenon by word of mouth (the most important form of human communication). "Connectors" know lots of people and have a truly extraordinary knack of making friends, acquaintances, and social connections. Connectors often function on impulse, they are accessible, and they function well in different subcultures and niches. Some combination of curiosity, self-confidence, sociability, and energy and the ability to bring people together (especially from the different subcultures and niches) is indicative of a connector. Connectors are not arrogant, possess a natural curiosity

about people, and tend to find things in people that they do not find in themselves. Connectors are "people specialists." "Mavens" are information specialists. They gather information and understand it in great detail. They are not passive collectors of information, but are, rather, information brokers, sharing and trading what they know. They are socially motivated and often want to solve other people's problems by solving their own and vice versa. Mavens want to help because they like to help. However, mavens are not persuaders. For a social epidemic to start, though, some people are naturally going to have to be persuaded to do something. Mavens are data banks; they provide the message. Connectors are social glue; they spread the message. "Salesmen" (or "salespersons") are folks who have the skills to persuade and are as critical to the tipping of the word-of-mouth (positive social) epidemics, as mavens and connectors. Salesmen have energy, enthusiasm, charm, likability, and they are very optimistic. They are great communicators, verbally and nonverbally. Salesmen are masters of micromovements, "interactional synchrony," conversational rhythms, and motor mimicry (seducing people into rhythms and emotions). Salesmen can be charismatic.

Gladwell (2000) suggests that in social epidemics, the "stickiness factor" is important. The stickiness factor asks, "Is the message memorable, in that it can create change, that it can spur someone to action?" The stickiness factor suggests that there is a simple way to package information and that, under the right circumstances, it can make the message irresistible and promote change. We need to develop and utilize our stickiness factor for promoting adolescent and school health at the national, state, and local levels.

Gladwell also suggests the importance of the "power of context" in making a difference. First, social epidemics are sensitive to the conditions and circumstances of the times and places in which they occur. For adolescents those places are schools, homes, families, neighborhoods, and communities.

Second, small, close-knit groups have the power to magnify a social epidemic and the potential of an idea or a message. The power of context suggests that the key to getting people to change their behavior sometimes lies with the smallest details of their immediate situation.

To illustrate of how these "tipping point" dynamics apply to the promotion of adolescent and school health, let me share an experience from my colleague Dr. Bill Zimmerli. In 1983 Bill was executive director of the New York State Federation of Professional Health Educators (NYSFPHE). Funding for district-level school health coordinators in New York state was in serious jeopardy. Knowing that the governor's wife, Matilda Cuomo, was the champion of school nutrition education curriculum efforts, Bill arranged a meeting with Mrs. Cuomo. The subsequent half-day meeting included a tour of the governor's mansion, refreshments, and a serious conversation on the status of school health. The NYSFPHE president and associate executive director conversed with Mrs. Cuomo for approximately an hour. At closure, she noted that Bill was relatively quiet during the discussion and asked for his input. In turn, Bill was parsimonious, but powerful in his message to Matilda. He simply stated that this request for funding was "very important for the children." It was not about jobs and not about politics. Bill asked Mrs. Cuomo to simply whisper in the governor's ear, as they retire for the evening, that this funding is "very important for the children." Working as a connector, with his maven and salesman, Bill had a simple message with a good stickiness factor that was sensitive to the current conditions and circumstances (context; i.e., it's for the children). A few weeks later, during his state-of-the-state address, Governor Cuomo allocated \$3 million dollars for district-level school health coordinators.

Health promotion/education is a human dynamic field. I continually remind my students that success in health promotion and education is often focused on developing and sustaining relationships. Identifying



and effectively utilizing health and education professionals with connector, maven, and salesmen personalities and skills, as well as understanding the stickiness factor and the power of context, are imperative in the planning, implementation, evaluation, and institutionalization of CSHPs, along with what we have gleaned from reported results to date.

PROMOTING ADOLESCENT AND SCHOOL HEALTH: QUO VADIS?

In 1902 Tommy Leach of the Pittsburgh Pirates led the National League with 6 home runs, all inside the park, and added 22 triples. In 1998 St. Louis's Mark McGuire led the major leagues with 70 homers; all cleared the fence, some by 200 feet or more. McGuire also extended his major league record for most consecutive at-bats without a triple to 4,272. The differences between Leach and McGuire illustrate how baseball has evolved in the past 100 years. With major changes in equipment and technology and somewhat radical changes in playing and training philosophies, the game as we enter a new century bears little resemblance to the game that began this one (Kurkjian, 2000).

As secretary of the Board of Education in the state of Massachusetts, Horace Mann's annual reports (1837–1843) called for mandatory health classes. In 1872 the Elmira, NY, Board of Education hired the first medical inspector to deal with a smallpox crisis. The state of Massachusetts in 1890 instituted the Medical Inspection Program in which physicians, nurses, and dentists visited schools conducting examinations to enhance health, introducing school health services and the concept of a healthy school environment. In the year 2003 we have somewhat radical changes in our philosophies with the CSHP model, full-service schools, school-based health clinics, proven-effective skills based curriculums, and connections with the human service and business communities. Major changes in our equipment include CDC's Division of Adolescent and School Health; the Youth Risk Behavior Surveillance System; the

School Health Education Profile Project; the School Health Index; numerous proven effective curricula and programs for adolescent health; the National Institute of Health's components on child and adolescent health; and an amazing array of technology, in particular the personal computer, the Internet, and other communication technologies. In turn, school health as we enter this century bears little resemblance to the one we knew at the beginning of the previous one.

What the future holds for adolescent and school health promotion is difficult to predict. It is reasonable to suggest that the CSHP, full-service schools, and other modern approaches will move forward, as schools, school districts and communities realize the benefits of working smarter versus harder for enhancing the health and academic achievement of students. However, gleaned from experience and the desire for future success, there are a number of directions that need to be seriously considered and pursued. The best way for health educators and health promoters to predict the future is to create it.

FUTURE DIRECTIONS: MICRO LEVEL

To sustain our current and previous efforts in child, adolescent, and school health, professionally we need to pursue a number of imperatives at the micro level. These include the following.

- There should be adequate time for staff development in health promoting procedures as compared to reading and mathematics.
- School health promotion needs to receive a fair share of staff development dollars and justify this funding via training for systemswide procedures such as school discipline and warning signs for health risk and problem behaviors.
- School health coordinators need to perceive themselves and behave as important and valuable "players" in planning and implementation for health and academic success at school district level—not operating out of a scarcity mentality, but positioning health as a requisite.

- Reward school and community people for working in a CSHP. This is a process (not an event) that takes time and perseverance. In turn, people need to be rewarded appropriately for sustained efforts.

- It is necessary to utilize research-documented, proven effective interventions aligned with objectives for improved health and academic performance.

- Eliminate disorganized, "one-shot" and "vampire type" programs that give health education and health promotion a bad reputation.

- It is necessary to do a better job of finding the niche for school health in the context of school reform, treating school health and CSHPs as systems change, rather than a program "add on."

- Our training for school health personnel needs to parallel systems change over time by building the capacity to move the system to higher levels over time (e.g., ACS Leadership Institute—has 3 years of training with annual institute training and 6 month boosters)

- We need ongoing training, consultation, and technical assistance in CSHP at the local level.

- It is imperative that we focus on the "whole child/adolescent" and begin convincing policy and decision makers to begin a movement away from high-stakes testing.

- We need to build coalitions of support, comprised of people who adequately represent "community" and the components of the CSHP model.

- To be successful in the future, we will need to build bridges to the education leadership community with a clear understanding that superintendents and principals are the gatekeepers of the local education system.

- We need to acculturate educational leaders into the value of CSHP and secure their support for the shared goals of success in academics and child/adolescent health promotion.

- Interdisciplinary state teams that represent the components of the CSHP need to be developed, sustained, and connected with local efforts for support and technical



assistance.

- Relationships need to be established and sustained with the business community with the shared understanding that a healthy and academically successful child/adolescent has more value to a community than those who are not.

- We need to pursue funding from various sources in the community, stagger our funding to eliminate gaps in financial support, and avoid brokered situations.

- We should solicit support from civic organizations regarding our common mission of connectedness among school and community organizations, for healthy kids becoming responsible and engaged citizens.

- Health educators need to get involved in the political arena. This begins with service on local school boards, PTOs, PTAs, and school improvement councils. If possible, serving on city and village councils or, by developing a sustained communication with these policy makers as to the value of supporting CSHPs. The squeaky wheel gets the grease, and there should be no barriers to health educators in "getting off the porch and running with the big dogs" in the political arena (Valois, 1994) for enhancing adolescent and school health.

- When fighting for support in school health, modesty will get us nowhere. Our success stories need to be shared. In turn, we need to improve recognition for and communication about our successes in CSHPs using both print and electronic channels of communication.

- The media should be challenged at the state, national, and local levels for more positive coverage on health-related topics associated with children and adolescents and successful school/community health education programs.

- Our pursuits at the local level need to be as relentless as the abstinence-only sex education people. Our connectors, mavens, and salesmen need to promote CSHPs as integral parts of each community's shared vision and a political "no brainer."

- Health educators need to get off the

"treadmill of life" at appropriate intervals, celebrate our successes, and socialize away from the workplace. It is imperative that we recharge our batteries, nourish our souls, and foster professional and personal connectedness and "esprit de corps."

FUTURE DIRECTIONS: MACRO LEVEL

To build on our previous success in promoting the health and well-being of children and adolescents through school and community health efforts, we as a profession need to push for a number of efforts at the macro level. These include the following.

- There should be sustained, noncategorical funding from a coalition of national funding sources both public and private.

- There should be a number of long-range studies, involving CSHPs from small, medium, and large school/communities with comparison groups from non-CSHP school/communities. These studies would begin with elementary schools and follow cohorts of students beyond high school, either through college or the workforce. Planning and implementation would be of the highest caliber. Evaluation would be qualitative and quantitative, include academic, clinical, and psychosocial measures, especially measures on quality of life and life satisfaction (Huebner et al., in press).

- CSHPs of the future will need to utilize the latest technology for their efforts, such as geographical information systems and global positioning systems for mapping their communities for selected variables of interest; CSHP training via two-way audio/video communication; local access cable television for community programming; the Internet for resource development and continuing education; and for various uses of pagers, cell phones, palm pilots, and handheld computers for success in the new "global village."

- Advocacy for CSHP at the national level should be a major initiative for the Coalition of National Health Education Organizations.

- Professional development programs are needed to prepare students for their respec-

tive roles in CSHPs. Students entering public health; medicine; social work; nursing; pharmacy; educational leadership; elementary and secondary teaching; school psychology; and other related disciplines need course work and practica associated with all aspects of CSHPs to gradually influence the culture of education, school health, and professional preparation for those responsible for advancing the health status and academic achievement of school-aged children and adolescents.

- Employers need to recognize and value the time and skills required of professionals working to develop, implement, and sustain CSHPs. This would include factoring such work into institutional rewards such as promotion, tenure, merit pay, and career advancement.

- We need to create and sustain at least two major stickiness factor messages at the national, state, and local levels, one dealing with the obvious child and adolescent obesity, overweight, and lack of physical activity problem, and the not-so-obvious problems with adolescent anxiety, stress, depression, and suicide. Adolescent and school health connectors, mavens, and salesmen need to utilize their skills in promoting child/adolescent health and academic success.

CONCLUSION

The village has changed, and professionally, we need to change to effectively help child and adolescent villagers of the future. The best way to predict the future is to create it. Imperative for future generations is the combination of healthy kids and academic success, and investments need to be made in children and adolescents. It could be argued that the school is our most important community cornerstone, and that CSHPs can help us meet our future goals while strengthening other community cornerstones. It is essential to consistently work toward tipping social and financial capital in the direction of CSHPs at the national, state, and local levels. Promoting child, adolescent, and school health is the right thing to do, and we need to do it right, because it takes a whole village to raise a healthy and



academically successful child.

"We must adjust to changing times while holding to unchanging principles."

Julia Coleman

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