CONGRESSIONAL TESTIMONY OUTLINE

UNITED STATES SENATE
COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY
March 31, 2009

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NEED FOR FEDERAL INTERVENTION AND REGULATION IN THE HEALTH OF OUR CHILDREN INCLUDING SCHOOL NUTRITION STANDARDS…IT CAN BE A "WIN-WIN" FOR STUDENTS, TEACHERS, COMMUNITY, BUSINESSES, PARENT ORGANIZATIONS

I. OBVIOUS ISSUES THAT ARE TALKED ABOUT INCLUDING POVERTY CONDITIONS THAT DENY MANY CHILDREN ACCESS TO NUTRITIOUS MEALS SOMEWHERE IN THEIR LIVES AND THE VERY REAL BUT "MEDIA FRENZY" ISSUE OF OBESITY

II. NOT SO OBVIOUS , IN A LARGER CONTEXT, IS THE ISSUE THAT RELATES TO A LOCAL SCHOOL SUPERINTENDENT BEING ABLE TO PROVIDE ACCESS TO A QUALITY EDUCATION EXPERIENCE FOR EVERY CHILD…THE REAL "NO CHILD LEFT BEHIND" ISSUE.

I will approach this issue today as a lifelong educator who, as a local school superintendent, has successfully embraced health and wellness of children and staff as my education reform cornerstone.

a. GIVENS
   i. If the public education systems don't work, then the other public systems will be overloaded and not work as efficiently as they should…public health, mental health, corrections
   ii. Public education systems are charged with serving every child in the best possible manner so that every child can emerge from high school with opportunities…college, military, job, public service.
   iii. We have to strive to provide opportunities for all children which are the same as those you provide for yours and I do for mine. The resiliency research says we don't have to be perfect in that but just approximate that care.

iv. We can provide those opportunities by using Maslow's Hierarchy of Needs…physical health, safety, sense of being loved and cared for, positive self-esteem, opportunity achieving potential.
v. We make Maslow possible in schools by instituting the Centers for Disease Control (CDC) model of Coordinated School Health…which is anchored in the provision of quality food and nutritious meals.

b. REALITIES
   i. In general, serious issues in academic performance, discipline, attendance
   ii. In particular, serious issues in students not participating fully in breakfast and lunch programs, general availability of junk foods to take place of healthy alternatives that were available, presentation of food from cafeteria lines that were not in themselves healthy or enticing to students, time restraints for eating meals, complaints and missed class time as result of stomach aches, headaches, and other obesity or malnourishment related ills.

c. APPROACH
   i. Approached the community and school staffs with the local and national data that linked poor school achievement, poor school behavior, and poor attendance with unhealthy behaviors and enabling policies.
   ii. Approached community and schools staffs with the broader linkages between failure of the public school system with failure of the other public systems and the economy (i.e., increase in healthcare costs, linkage to dropouts and corrections numbers)
   iii. Introduce utilization of the CDC Coordinated School Health program as the implementation reform model. It philosophically embraced Maslow's Hierarchy of Needs… in our schools it would give equity and equal opportunity to students so they could achieve success… whether they were rich, poor, black, white.
   iv. And the very first part of that implementation was addressing Maslow's Hierarchy of Needs "physical health" mandate by repairing our food and nutrition programs.

d. SOLUTIONS
    i. Looked at what data and research already told us.
    ii. Looked at our present policies and procedures and defined barriers and obstacles.
    iii. Changed procedures and policies to create a more healthy learning and living school environment.
        1. More time for meals
        2. Improved food nutrition (baking instead of frying, etc.)
        3. Policies on junk food sale
        4. Policies on availability of snack food brought from home
        5. Vending policies
        6. Staff wellness policies
        7. Classroom rewards policies
        8. Fund-raising policies
        9. More and higher quality health education
        10. More and higher quality physical education and activity
        11. Policies on concessions stands

e. OUTCOMES
    i. Higher breakfast and lunch participation
    ii. Gain in Revenue for principals and vendors
    iii. Lower BMI's
    iv. Higher attendance
    v. Lowered suspensions and expulsions
    vi. Higher academic achievement
    vii. Culture of health and wellness started

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Life After Tests … And Before
A district's coordinated health approach for the whole child's full range of needs

BY PAT COOPER

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

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

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

The trap comes into the picture because all of this achievement must be attained *in spite of* whatever emotional, physical and mental shape children come to us in each day. This achievement must be made regardless of the education level of the parents. This achievement must occur alongside family turmoil and neglect, disease and misfortune, apathy and abuse. And, oh by the way, you can't allow any student dropouts.

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

The high expectations for exemplary test scores and monumental pressures for overall excellence are ever-present f or school administrators. Unfortunately, the imperfect societal conditions are ominously just as present. The administrators and teachers are caught in the middle…trapped without the needed interventions being put in place. Needless to say, this trapped feeling can cause one's state of health and morale to deteriorate.

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

The Direction

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

First, school leadership met with community members to look at three questions: what we didn't like about our present school district status, what we wanted our schools to be and how we could get there. As one can imagine, the answer to the first question was wide-ranging, and generally included the same demons: lack of caring, lack of instruction, lack of leadership, little parental involvement, discipline and safety problems, dirty and outdated facilities, etc. While exasperating at times, overall it was a good exercise and very cathartic.

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

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

We replaced the old slogan, "It takes the entire village to raise a child," with something we heard at the North Carolina Closing the Achievement Gap conference: "We have to change the way we do business in the village." The change in the way we conducted the business of educating children in McComb, with physical and mental health at the core, had dramatic implications for our school operations, but this *coordinated school health approach* seemed promising.

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

The Fix

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

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

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

The overriding premise was this: Even when we work our hardest to maximize learning for children, we sometimes fail. We fail many times because the basic physical and emotional ingredients of success are not present. Most us know to feed our children the right foods, to take them to the dentist, we make sure they go to bed at a proper time, we monitor their activities to try to keep bad influences away from them, we listen and talk and counsel with them, and we help them find their niche in life and support them. We provide for their safety and we make sure they know we love them. This is second nature for most of us in middle class America, but not so for many of the parents of children we serve every day of the school year. The chance for success in life for these deprived children is greatly reduced without efforts to enhance their physical and emotional well-being. They will surely be the ones left behind.

Range of Needs

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

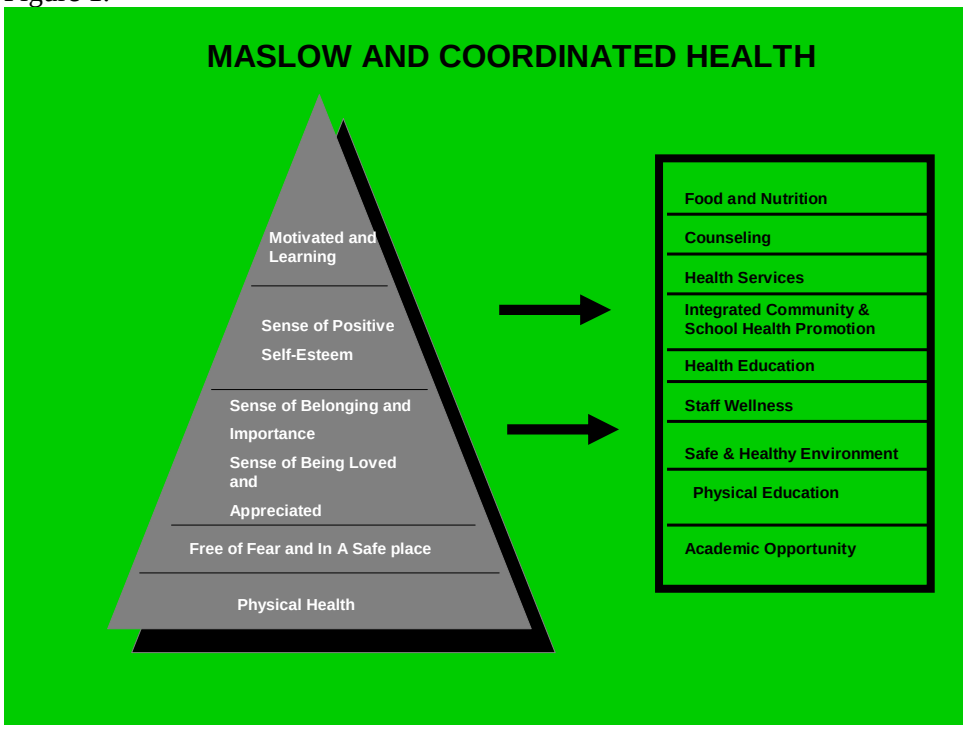
First, we had to supply a roadmap or pattern for our restructuring of schools. Maslow's Hierarchy of Needs seemed to represent the goals we held for all of our children. And besides, this concept really wasn't new. Many of us in our pre-service training had been exposed to

Maslow in at least one of our educational psychology courses. Maslow supplies us with a direction and set of goals for every child.

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

We tried to simply the model so everyone in the community could understand our approach. (See Figure 1, page xx).

Figure 1.



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

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

School and community safety go hand in hand as responsibilities shared with the city. We added nurses and mental health therapists and phys-ed teachers at each school. We have teen parenting support groups at the junior high and the high school. A district-run preschool program and day care for teen parents has been established. Teachers and staff emphasize health

education and nutrition with our students. Staff wellness is always promoted. Formal and informal interagency agreements with various entities interested in the welfare of children—ranging from a formal agreement with the juvenile justice system to provide assistance with parents who commit educational neglect to an informal agreement with the local Junior League to provide school uniforms. We don't do it alone.

Sources of Support

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

The first action we took as a district was to call all the caretakers of funding (any person who was responsible for a budget) together. I asked them to put their money on the table (figuratively) and then announced "It is not your money anymore, it is our children's money, it is our teachers' money." The point was that we had to first use existing dollars to our best advantage before looking somewhere else.

The other point made was that we needed to concentrate on buying people, not stuff. Real, live, caring human beings were going to make the difference with our children and families, not the latest computer software or reading kits. Nurturing professionals were needed to implement coordinated school health, not distribute red ribbons.

So we made the decision that each principal and the school's Core Committee of key teachers (selected by their peers and the principal) would come to the budget meeting with all of the caretakers of funds. Jointly, they would be responsible for putting in place at least one of the components every year until all nine components of our coordinated school health program were intact in every school for every child and every teacher.

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

Medicaid Backing

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

Some of the personnel needed to initiate each component were given to us, loaned to us or leased to us by the local hospital, local mental health agency, public health agency or university medical school. We just had to open ourselves up to them.

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

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

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

Three funding streams to Medicaid exist in the schools. One is for special education needs, another is for those children who qualify for Medicaid and who are not eligible for special education, and the third funding stream is called administrative claiming. The latter covers those staff in the district who oversee the health programs. Their salaries are reimbursed based on the

hours they spend in direct health services supervision as well as the percentage of Medicaid-eligible children attending the schools.

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

Positive Signs

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

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

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

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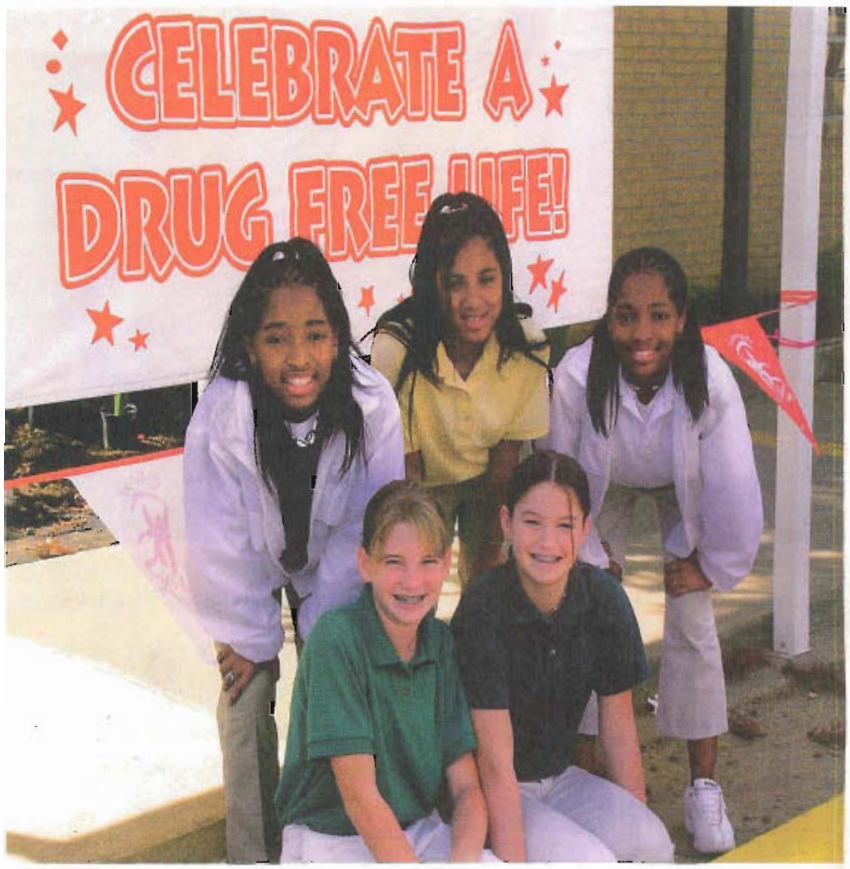
McComb School District in Mississippi supports the fundamental needs of all students—with outstanding results.

A Coordinated

Pat Cooper

In September 1997, the McComb School District in Mississippi hired me as the new superintendent of schools and gave me a mandate to improve academic performance, working within a framework of caring and inclusion. McComb is a small city of about 13,300 residents located in rural southwest Mississippi. Of the 3,000 students who attended the community's seven public schools, approximately 85 percent were eligible for free or reduced-price lunch, and more than 30 percent were living below the federal poverty line.

The school system had become fractious in terms of race relations, the "have and have not" syndrome, and private school competition. Public support was waning. In a community whose population was 50 percent white, McComb School District had a white student enrollment of only 15 percent.



PHOTOS BY CHRISTY KERN

Students at McComb's Denman Junior High School participate in Red Ribbon Week, a week of activities promoting a drug-free lifestyle.

A Community Comes Together

In undertaking the challenge of turning around this struggling school system, McComb's district leaders identified three questions that we needed to answer:

- What do community constituents not like about the school district?
- What do they want their school district to be like?
- How do they want us to get there?

To address those questions, we turned to the community. At the beginning of the 1997–1998 school year, we sent out notices to clubs, organizations, and churches, and we published invitations in the local newspaper encouraging people to take part in restructuring the school district. Respected and knowledgeable citizens and education leaders jointly facilitated the meetings. The 350 participants were divided into five groups according to their interests: health and wellness, facilities, technology, public relations, and academic opportunity. Each group met once or twice each month from September through May, and all groups participated in several joint meetings toward the end of the process to put the pieces together.

The meetings created unanimity in purpose and direction. Community members and district personnel reached agreement that excellence is not about test scores, but rather about enabling every child to excel in all of his or her abilities, whether that involves learning algebra, playing the trombone, shooting a basketball, or being of service to others. We developed a vision statement that revolves around the whole child:

> The McComb School District is a committed and nurturing community

School Health Plan

taking responsibility every day for positively impacting the physical, social, and academic well-being of every child and challenging him to become an extraordinary individual empowered to change the world.

A Plan of Action

Once the McComb community made its commitment, district personnel realized that we needed to translate the vision into an unwavering mission. As the first step to creating a school system that would address the needs of the whole child, we looked at the answers to our three questions.

What did community constituents not like about the school district? At the meetings, most participants focused on failures to meet our students' needs. A high proportion of their comments related to students' mental and physical health.

For example, the local hospital administrator complained that the only time doctors saw most of our students was in the emergency room—a practice that resulted in ineffective and costly health care. Most of our students did not receive regular Medicaid screenings because the doctors could not get their parents to bring them to the clinics. Even children with regular private insurance often received inadequate preventive care. School personnel identified cavities and gum disease as a major problem among students.

Businesspeople observed that our students were not ready for work when they graduated. Chamber of commerce personnel pointed out that the schools didn't appear physically inviting. Residents complained that there were too many kids hanging out on the streets as truants or dropouts.

Parents focused on the high number of students lagging behind in reading skills and being placed in special education. Some argued for tighter discipline strategies; others saw the district as too punitive.

Our job was to do for all children what we did for our own—no excuses.

Principals and teachers complained about poor attendance that was often the result of such medical conditions as asthma, lice, diabetes, and obesity. Secretaries and administrators worried about having to make medical decisions at school. Teachers said that poor physical facilities inhibited teaching and learning. Food-service directors said that they had a hard time financing the food services because students were skipping the school-provided meals in favor of junk food.

Recreation advocates complained about the lack of formal physical education in the schools, poor facilities, and too little opportunity for students to participate in less-competitive intramural and individual sports after school. Districtwide organized health education for students, they said, was almost nonexistent except as a rainy-day activity. Students had neither the knowledge of health that they needed nor opportunities to put that knowledge into action to make healthy choices.

Mental health advocates cited the prevalence among students of depression, eating disorders, thoughts of suicide, and violent behavior because of families' failure to find and use quality mental health services. Gangs and community violence were creeping into the middle and elementary schools, along with such problems as illegal drugs and alcohol, child abuse, and homelessness. According to the local Youth Court judge, the juvenile violent crime rate for McComb students was escalating. Law enforcement personnel complained about too many suspensions, which left kids roaming the streets unattended. And on and on and on . . .

Thank goodness we finally came to the next question!

What did they want their school district to be like? Community members and district personnel grappled with what the schools should be doing. We approached this question with a consensus that we had to do more for the students than provide traditional academics. At first, however, we disagreed about where the responsibility for our children's well-being should reside.

The well-being of youth in our community has improved.

Community members asserted that schools should play a major part in teaching students how to be healthy and in preventing social and emotional problems that kept them out of school. Teachers and principals countered that with so much emphasis on test scores, they found it hard to spend time on programs that didn't directly connect to academics.

A watershed moment occurred. We all agreed that having the best test scores doesn't make you the best school, especially if the dropout rate is high. We came to an agreement: McComb School District should strive to not only be the best *in* the state and country but also be the best *for* the state and country. If we focused on keeping all of our students in school through graduation instead of on the streets, our test score averages might never be the highest—but we would be serving the needs of our students and our community.

Community members and district personnel agreed not to blame parents, students, or circumstances. Our job was to do for all children what we did for our own—no excuses. We decided to measure our success not just according to the usual criteria of test scores, absenteeism, teacher retention, dropout rates, and graduation rates, but also according to outcomes that were crucial to the community as a whole—recreation opportunities, juvenile Medicaid service rates, juvenile arrest rates, and rates of teenage pregnancy, teen suicide and attempted suicide, drug abuse, and child abuse.

In short, to ensure the future of our society, we joined with parents and community partners in taking responsibility for the whole child. We believed that academic achievement would come for all children only when we addressed their basic needs. This approach would mean truly leaving no child behind!

How did the community want us to get there? Everyone was fired up and excited about the vision—at least until we faced the question, How do we get there? Then the magnitude of our commitment sank in. But the answer was there all along; we just had to rediscover it.

A breakthrough took place when one of our parents, a blue-collar laborer, proposed that we think of our children in school as having the same needs that adults do in their jobs. After all, school is children's job. This analogy led to the question, How do adults accomplish their best work, and what conditions need to be considered in the workplace? Then it was easy to recognize where we needed to look: Maslow's Hierarchy of Needs.

Abraham Maslow asserted that people must satisfy their lower-level needs—physiological well-being, safety, love and belonging, and a sense of competence and recognition—before they can concentrate on the needs involved in meaningful learning, including the cognitive drive to know and explore; the aesthetic drive to appreciate symmetry, order, and beauty; and the self-actualization drive to find self-fulfillment (Maslow & Lowry, 1998). Most educators read Maslow in their college sophomore psychology course. The problem was that we hadn't taken what we learned in that course and applied it to educating our students.

To translate Maslow's concepts into programs our system could implement, we turned to the coordinated school health model developed by the Centers for Disease Control and Prevention (2005). The model provided a framework for school reform based on programs in eight areas: (1) health education, (2) physical education, (3) health services, (4) nutrition services, (5) counseling and psychological services, (6) healthy school environment, (7) health promotion for staff, and (8) family and community involvement. To bring the circle back to teaching and learning, we added a ninth component: academic opportunity.

We had our restructuring plan in place. Our McComb School District vision statement kept us centered on serving the whole child. Maslow's Hierarchy of Needs provided the framework to accomplish that vision by defining what all our students needed. And our McComb nine-component coordinated school health model created the mechanism to meet the needs of all students, regardless of the circumstances.

Implementation of the Plan

During the next five years, every McComb school put into place programs that promoted the nine components of school health. The district mandated that each school tackle at least one component of its choice each year. Some schools worked on two or three components at a time, depending on their needs and available resources. For logistical reasons, the district central office took responsibility for the components of academic opportunity, nutrition services, and family and community involvement. "School Programs to Support the Whole Child" shows a sampling of programs that addressed the nine components.

The funding mechanisms for our districtwide initiative were incremental and evolved over time. First, we made more creative use of our existing funds from local, state, and federal sources. We worked from a zero-based budgeting model, finding funds for the health programs every year before funding anything else. We began to prioritize—for example, by devoting funds to hiring necessary staff before buying "stuff."

Next, we created interagency agreements that gave us access to the services of nurses, therapists, police officers, recreation personnel, and other staff working for the city government, hospitals, service clubs, and other local

School Programs to Support the Whole Child

Health Education

- Formal nine-week sequential K–8 health education classes for all students every year.
- 1/2 Carnegie Unit health education requirement for high school graduation.
- Data collection efforts to identify problem areas and progress of all programs.

Physical Education

- Certified physical education teachers in every elementary and middle school to provide an average of 30 minutes a day of organized P.E. or health for every student.
- Intramural sports leagues.
- Joint city- and school-sponsored summer recreation programs.

Health Services

- One nurse for every 450 students in a school.
- Health and wellness clinics with Medicaid services in each school, open to both students and staff.
- Follow-up referrals and contact with primary-care physicians and dentists.

Nutrition Services

- Redesigned menus that provide more attractive, healthful choices for our students.
- Policies that restrict school fund-raisers to nonfood or healthful food items.
- Policy that limits school site vending machines to selling water, 100 percent juice, or milk.
- Policy allowing drinks in the classroom to keep brains hydrated.

Counseling and Psychological Services

- One mental health therapist and one guidance counselor for every 450 students in a school to provide individual, group, and family counseling.
- An interagency health and wellness team in each school, which meets once a week to staff and case-manage troubled students.
- Drug and alcohol counseling services.

Safe and Healthy School Environment

- Annual districtwide safety checks by state department of education staff.
- Modernized and clean school physical plants.
- Security cameras in schools and on buses.
- A toll-free phone number for confidential reporting to law enforcement agencies.

Health Promotion for Staff

- Annual free health check-ups and screenings for all staff.
- School-provided aerobics and fitness classes.
- School nurse case management for staff with chronic illnesses.
- Extended school year beginning August 1, with four nine-week sessions and a nine-day break in between each session for stress relief.

Family and Community Involvement

- Joint community-school health fairs and screenings.
- Parenting classes and conflict resolution classes open to the community.
- Faith-based partnerships for mentoring.

Academic Opportunity

- District family nurturing center and day care for teen mothers and fathers and their babies for prenatal, postnatal, and child care classes and full-time day care while in school.
- Off-site tutoring centers at housing projects and churches in the community.
- Districtwide early childhood coalition (with private day-care providers and Head Start centers) to serve all 3- and 4-year-olds who will enter the McComb School District as kindergartners.

Source: McComb School District

Aims of Education

What then is the education to be? Perhaps we could hardly find a better than that which the experience of the past has already discovered, which consists, I believe, in gymnastic, for the body, and music for the mind.

—Plato

organizations. This win-win strategy gave the agencies much better access to the children and youth in our community. We also got increased funding by turning all our school clinics into Medicaid-eligible facilities so that we could collect reimbursement dollars for any services provided to Medicaid-eligible students. And, most important for the sustainability of our programs, we began to receive more state funding because our average daily attendance went up and dropout rates went down.

Improved Results

Good feelings from staff and community are positive indicators of success, but in the end, results are what matter. The problems that our community identified in 1997–1998 needed to show improvement in 2004–2005. And they did. The positive results of the coordinated school health approach for our schools and community have shown up in both expected and unexpected ways.

Some results reflect improved student discipline. We hoped that attendance would rise from 93 to 94 percent; in fact, it has stabilized at approximately 96 percent. Out-of-class suspension days have decreased by more than 40 percent. Disciplinary hearings for major infractions have decreased by more than half, from an average of 24 each year to 11.

Academic data are also encouraging. In the two years since the inception of our collaboration with private day-care providers and Head Start facilities, the academic functioning of children entering kindergarten has dramatically improved; the percentage performing below their age level has dropped from 57 percent to 45 percent. Student achievement has risen: For example, a representative sample of students tracked from 3rd through 6th grade showed improved Terra Nova scores in reading (from 32 percent to 46 percent of students exceeding the national norm); language (from 34 percent to 47 percent); and math (from 28 percent to 48 percent). Overall, state accountability levels for our schools have gone from Levels 2 (needs improvement) and 3 (successful) to Levels 3 and 4 (exemplary). Spring 2004 testing found that all but one school in McComb made adequate yearly progress in every category; the school that was the sole exception narrowly missed in special education.

In addition, we are keeping our students in school. Graduation rates rose from 77 percent in 1997 to 92 percent in 2004. Dropout rates in grades 7–12 were below 2 percent in 2004, compared with a national figure of more than 30 percent (Orfield, Losen, Wald, & Swanson, 2004).

The well-being of youth in our community has also improved. For example, the juvenile crime arrest rate in McComb has dropped by 60 percent (from 331 arrests in 1997–1998 to 131 in 2003–2004). The rate of teenagers having second babies—a significant indicator of teen mother dropout rates—has stood at 3 percent in McComb during the last six years, compared with a national average of 21 percent (Mississippi Department of Public Health, 2004).

Perhaps the most telling indicator is that the community is coming back to the public schools. White enrollment has risen to 25 percent, parental complaints to the superintendent's office have decreased by 75 percent (from 110 complaints in 1998 to 28 in 2004), and public funding for school facilities and programs has gained new support.

Overcoming the Odds

McComb School District's success started with the understanding that we had to address the needs of the whole child and then work toward systemwide change for our schools and community. We wanted to enable students to excel in spite of poverty, illiteracy, unhealthy environments, and the violence all around them. Eight years later, it seems to be happening.

Today, we have the same housing projects, the same one-parent households, the same poverty, the same teachers, the same reading program—but we see different results for our students. The common denominators for our success have been a focus on common human needs, a coordinated school health program, and a believing community. EL

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