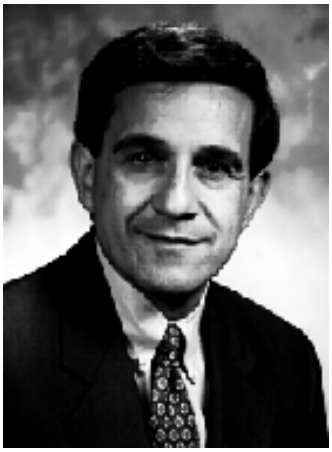
Commissioner's Update Archive



Commissioner's Update

February 27, 1998

Dear Superintendents and Charter School Leaders:

This is my final day on the job as Commissioner, and of course I have a final coordinated mailing for your review.

Under separate cover, you will be receiving two important documents. These are the FY 1999 preliminary estimates of net school spending, and the MCAS Guide to the English Language Arts. All superintendents and principals will receive several copies of the English Language Arts guide.

In this mailing, you will find the following documents:

1. Board-in-Brief summary of February 25 special meeting
2. FY 1996 per pupil expenditure summary by district
   [No Longer Available]
3. Memorandum on upcoming curriculum framework review process
4. Informational brochure indicating the Spring English Language Arts and History/Social Science content institutes
5. Executive summary of state evaluation of the use of the Health Protection Fund
6. Announcement of the appointment of Frank Haydu III as Interim Commissioner

In our last mailing, we included the Department's videotape and Q and A guide on the testing program. This clearly has met a need, because we have received requests for tens of thousands of additional copies of the guide. These will be available to you on a continuing basis by calling 781-338-3000. Also, please note that the video will be aired throughout the state on PBS in March and shown every day on the statewide educational satellite network, MCET, for schools to view or tape. The dates and times are: PBS - WGBY Channel 57 in Springfield and WGBH Channel 44 in Boston: March 17, 5:34 a.m.; March 24, 11:45 a.m.; and MCET - every weekday morning in March at 8:15 a.m.

It has been my privilege to work with you. You will be in good hands with Frank Haydu, the Interim Commissioner and Dave Driscoll, the Deputy Commissioner. Keep up the energy and commitment to children, and you will continue to have much success.

All the best, and

Sincerely,

Robert V. Antonucci
Commissioner of Education

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Board in Brief

Thursday, February, 26, 1998

This is "Board in Brief," issued at the request of Commissioner Bob Antonucci, to bring you up to date on Massachusetts Board of Education matters. The following is a report on the special meeting of the Board of Education held on Wednesday, February 25, here at the Massachusetts Department of Education in Malden.

Report of the Chairman

Chairman John Silber welcomed the opportunity to introduce Frank Haydu, who will become the interim Commissioner of Education on March 1, 1998. Dr. Silber expressed confidence that Mr. Haydu would provide distinguished leadership as interim Commissioner, and commented that he was honored that Mr. Haydu would accept the position on such a short notice as it represented a considerable sacrifice on his part.

Dr. Silber also welcomed the opportunity to publicly express the Board's appreciation of the leadership that the Board received from Commissioner Antonucci.

YouthBuild Charter School Charter Dissolved

Commissioner Antonucci reported that he had reached an agreement with the YouthBuild Boston Academy Charter School whereby YouthBuild Boston Academy would ask to have its charter dissolved rather than revoked, as the Board was prepared to do at this meeting. The Commissioner noted that the Department of Education had been working with the Boston-based Charter School for a year and a half in an attempt to correct serious problems in meeting the terms of the school's charter.

The "separation agreement," which was approved unanimously by the Board, will allow for the possibility of granting a charter to another applicant to replace the one granted to YouthBuild.

Awarding of Public School Charters

The Board voted unanimously to grant eight new charters to Commonwealth Charter Schools, and four charters to new Horace Mann Schools. The Board also voted to provide a further opportunity for consideration of the 19 Commonwealth charter and five Horace Mann charter applications that were not recommended for approval, and to vote no later than April 9 whether or not to grant any additional charters. Interim Commissioner Frank Haydu, Associate Commissioner Scott Hamilton, and Commissioner Antonucci, who will act as a consultant, were asked to work together to prepare for the Board's decision.

The eight new Commonwealth Charters are in Boston, Malden, Plymouth, Foxboro, Barnstable and Worcester. The four Horace Mann Schools are in Boston, Springfield and Barnstable. Of the eight Commonwealth Charters, six will open in September serving 2,150 students in their first year. Of the four Horace Mann Schools, three will open in September serving 445 students.

Frank Haydu Addresses the Board

Newly appointed Interim Commissioner Frank Haydu provided the Board with an update with what is going on during the transition period. "David Driscoll and I will be running this agency in a very strong way," said Mr. Haydu. "I think in a business sense it's clear I will be the C.E.O. but it's also clear that David as a professional educator will be the C.O.O. (Chief Operating Officer)."

Mr. Haydu said that he had met with Commissioner Antonucci and Dr. Silber earlier in the week "to make sure that there was an intersection of the policies and priorities that we would be trying to focus on over the next three to six months because I think it is incredibly important that we have clear focus and that we continue to move education reform forward." He identified the following priorities for the agency while he is Interim Commissioner:

1. recruit a top flight Commissioner
2. focus on Teacher Certification Exams
3. finish the framework revisions on Foreign Languages, Health and the Arts by June 1st and make the minor revisions on Math and Science that perhaps need to be made
4. focus on the third grade literacy exam and the MCAS tests in grades 4, 8 and 10
5. focus on an audit mechanism to track what is going on in the classrooms to determine which schools are moving forward in education reform

Mr. Haydu concluded by commenting that he was excited by this opportunity in public service. He urged the Board to continue the cooperative spirit in evidence at today's meeting. "I am very proud of where this Board has gone. I think while at times it has had difficult discussions at the table it has continued to move public policy forward. And it is important that we do not lose that momentum but it's also important that we have trust in the field, because you don't get public policy (to have an impact on) performance in classrooms unless the people in the field believe that what you are doing is right and makes sense."

Next Meeting

The next meeting of the Board of Education will be held on Tuesday, March 10, at 9:00 a.m. in Malden.

"Board in Brief" and other MA DOE documents are available for review at the Department of Education's web site: www.doe.mass.edu

Commissioner's Update Archive

Upcoming Review of the Massachusetts Curriculum Frameworks

Memorandum

To: Superintendents of Schools, School Principals, Other Interested Parties

From: Robert V. Antonucci, Commissioner of Education

Re: Upcoming Review of the Massachusetts Curriculum Frameworks

Date: February 27, 1998

As you may recall, Chapter 69, Section 1E of the Education Reform Act of 1993 directs the Board of Education to develop procedures for updating, improving, or refining the state's seven curriculum frameworks. The purpose for having these procedures is to ensure that the state's curriculum frameworks remain current, are responsive to the Commonwealth's commitment to high academic standards for all students, and continue to provide educators with the pedagogical approaches and strategies for assisting students in the development of the skills, competencies and knowledge called for by these standards.

The Board will initiate the curriculum framework review process this Spring with the following five frameworks that had been accepted and endorsed by the prior Board in December 1995:

- The Massachusetts Arts Curriculum Framework, *The Practice of Creating;*
- The Massachusetts World Languages Curriculum Framework, *Making Connections Through World Languages;*
- The Massachusetts Comprehensive Health Curriculum Framework, *Building Resilience Through Comprehensive Health;*
- The Massachusetts Science and Technology Curriculum Framework, *Owning the Questions Through Science and Technology;* and
- The Massachusetts Mathematics Curriculum Framework, *Achieving Mathematical Power.*

The review work for the Mathematics and Science/Technology frameworks will commence in late Summer or early Fall in order to be guided by the results of the Spring 1998 administration of the Massachusetts Comprehensive Assessment System (MCAS) in these two subject areas.

Review Panels, consisting of approximately 8-12 members, will be appointed soon. The Panels will be assisted in their work by Department program and assessment staff members. The Panels' work will be guided by the following expectations:

- Review Panels will work from existing frameworks, aligning them where appropriate with components from the other Massachusetts frameworks.
- The work of the Review Panel will be informed by current research in the field, the results from MCAS, work occurring in the discipline in other parts of the country and throughout the world, and recommendations from practitioners and experts in the content area.
- Review Panels will take into consideration MCAS assessment expectations and performance standards in use at the time of the revision.
- Each review process will include opportunities for public input so that educators, parents, and other

interested parties are engaged in the work of the Panel.

- The review/dissemination process will be streamlined in order to be completed in a timely manner.

Further information on the curriculum frameworks review process will be shared with you in the upcoming months by the Department.

I sincerely thank you for your ongoing support and efforts during my six year tenure as Commissioner of Education. I know that you will provide Interim Commissioner Haydu and Deputy Commissioner Driscoll with the same support.

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Spring Content Institute Descriptions

February 1998

The Massachusetts Department of Education is sponsoring four spring content institutes. There is one institute in English Language Arts and three in History & Social Science. Institutes are held outside of traditional school day hours, allowing classroom teachers to attend without being absent from the classroom. Stipends are available for participants.

The Department reviewed proposals from many providers and selected the following four institutes for funding through a competitive process. This announcement of the four institutes is informational in nature, as sponsors are marketing their institutes directly.

History and Social Science Institutes

1. Where We Live: Exploring National Historical Trends through Local History

Provider: University of Massachusetts - Amherst, History Department
Time Periods: Saturdays: March 7, April 4, May 2 and 16
Grade span: 5-12
Stipend: $100
Graduate Credit: one credit available through UMass Amherst, Continuing Education
Registration Information:

Lisa Middents
History Institute
University of Massachusetts
Amherst, MA 01003
Ph. 413-545-1330
Email: history@history.umass.edu

An institute focusing on the Massachusetts History and Social Science framework, particularly U.S. history. Features include:

- presentations by experts on frameworks and on three aspects of the history of western Massachusetts: Shay's Rebellion (18th c.), wealth and poverty (19th c.), the Cold War (20 c.);
- site visits to Wistariahurst Museum (Holyoke), Easthampton Lodging House, the Strategic Air Command bunker (East Coast headquarters, Amherst); and
- training in surfing the Internet for materials relating to local history.

2. Making the History and Social Science Curriculum Framework Work: Ancient Civilizations for Pre-K through Grade 4 Educators

Provider: Massachusetts Global Education Consortium at Framingham State College
Time Periods: Saturdays, 9am - 1pm, May 2, May 9, May 16, May 23
Grade Span: PreK-4

Stipend: $125
Graduate Credit: one credit available through Framingham State College, Continuing Education
Registration information:

Susan Dargan
Framingham State College Center for Global Education
100 State Street
Framingham, MA 01701
Ph. 508-626-4037
Email:sdargan@frc.mass.edu

Educators will learn strategies for teaching elementary school students about ancient civilizations in Europe, Asia the Americas, and Africa. They will:

- receive and review age-appropriate teaching materials on archaeology, geography, everyday life, the role of cities;
- learn about resources in local museums and on the Internet for studying ancient civilizations; and
- develop units based on these materials and the Learning Standards in the History and Social Science Curriculum Framework.

3. People of the Coast

Provider: SEA Connections Collaboration: Lloyd Center for Environmental Studies, Hankin Environmental and Educational Services, University of Massachusetts - Dartmouth
Time Periods:
A: March 21, April 11, May 16;
B: March 28, May 2, May 30;
C: April 4, May 9, June 6
Grade Span: 5-8
Stipend: $125
Graduate Credit: University of Massachusetts Dartmouth
Registration Information:

Alan Lee Hankin
Hankin Environmental and Educational Services>
1365 Tucker Road
North Dartmouth, MA 02747
Ph. 508-993-4176
Email: alhankin@aol.com

This institute is designed to increase teacher knowledge and ability to instruct about Native American and early colonial uses of the coastal environments in Massachusetts during the period from 1000 to 1700 A.D. Participants will learn about:

- the similarities and differences in how the Wampanoag people and European settlers used resources;
- field and laboratory research methods used by historians, archaeologists, and environmental scientists to gain evidence about cultures, economies, and resources;
- how to relate the environmental and cultural changes of the 17th and 18th centuries to changes in the world today; and how to use this material and the History and Social Science Curriculum Framework to develop projects and assessments.

English Language Arts

4. Linking the English Language Arts Framework to Instructional Practice for Diverse Learners

Provider: Center for Social Development and Education & Department of Continuing Education, University of Massachusetts - Boston
Time Periods: (37 Hours)
Fri., 3/20, 4-7pm Sat., 3/21, 8:30-3
Fri., 4/3, 4-8pm Sat., 4/4, 8:30-3

Fri., 5/1, 4-8pm Sat., 5/2, 8:30-3
Sat., 5/16, 8:30-3
Grade Span: 9-12
Stipend:
Graduate Credit: three credits
Registration Information:

Janice Magno
100 Morrissey Boulevard
Boston, MA 02125
Ph. 617-287-7250
Email:CSDE@umbsky.cc.umb.edu

This institute is designed to provide teaching strategies in English language arts to high school teachers, especially those working with students with mild to moderate special needs in substantially separate or alternative education programs. Some of the topics to be addressed are:

- strategies to increase students' comprehension of literary texts and research materials and their capacity to communicate orally and in writing;
- collaboration among regular and special education teachers on adaptations of curriculum in all subject areas;
- curriculum adaptations for block scheduling and flexible groupings of students;
- teaching practices that will provide opportunities for more students to meet the high standards of the English Language Arts Curriculum Framework.

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1998 Health Protection Fund Year IV Evaluation Status Report

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Acknowledgments

Dale McManis, Ph.D. is the Health Protection Fund Evaluator for the Department of Education and was the principal investigator and author of this report.

The Massachusetts Department of Education extends its appreciation to the health educators who participated in this research.

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1998 Report on the Health Protection Fund

February 27, 1998

Dear Educators and Interested Readers,

In Massachusetts, comprehensive school health education programs are made possible through the Health Protection Fund which dispenses state tobacco tax revenue to the Department of Education. This funding has been available for four years. In this time period, schools have worked to strengthen comprehensive health programs for students. Although it is still early in the process to evaluate the effect of this fund on risk behaviors of students, the Department has prepared a status report which contains information useful for consideration at the local, state, and national levels.

This status report contains the following information:

- Allocation of state funds in the major budget categories of grants to school districts.
- Relational trends between comprehensive school health education programs and reduced student risk behaviors. These relationships are discussed both for tobacco prevention education and reduced student tobacco use and for other types of prevention education and reduced risk behavior.
- A plan of action for 1998 for both tobacco prevention education and cessation and for prevention education in general.

It is important to recognize that these findings suggest relationships between factors and should not be interpreted as statements of cause and effect. The findings are informative and will guide our future research. We need to be sure that the state funds are being used effectively by schools to reduce student use of tobacco, drugs, alcohol, and other risk behaviors, but understand that affecting behavior is a slow process that must be sustained in order to succeed. The Department of Education will continue to study comprehensive school health education, with specific attention to tobacco prevention education and cessation, in order to provide a fuller understanding of the relationships between health education program practices and their impact on student behavior.

Sincerely,

Robert V. Antonucci
Commissioner of Education

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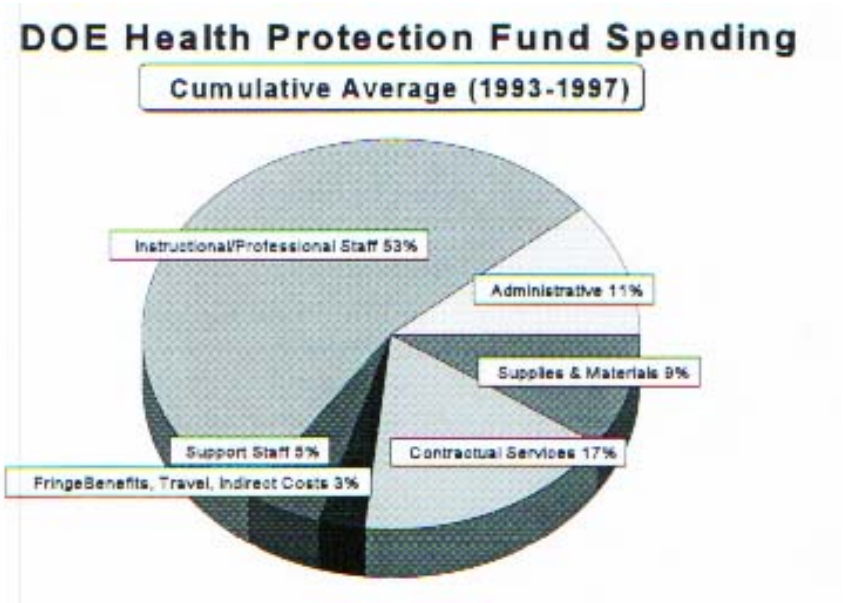
Report On The Health Protection Fund February 1998

Adolescent Behavior and School Performance
Schools have a vested interest in preventing risk behaviors that negatively impact on health. This is founded on the link between risk behavior and impaired cognitive functioning 1 and the link between good health and better school performance.2 Resilient factors derive from individual characteristics, family, community, and the school. The findings in this report focus on school-related health education program practices described in the Massachusetts Health Curriculum Framework, **Building Resilience** that are associated with the ability to "maintain a positive attitude and healthy body."3

Health Protection Fund
The Health Protection Fund (HPF) was created by a 1992 state legislative referendum that directs tax revenue on tobacco products to the Department of Education. These funds are used for tobacco prevention education and cessation in the context of comprehensive school health education. Comprehensive health education meets the complex and extensive needs of today's youth through a broad-based approach that includes school, family, and community, and consists of many related health components in order to create effective programs, services, and education. An average of 24 million dollars a year of Health Protection Fund monies has been distributed through grants to Massachusetts school districts over the last four years, totaling approximately $96,000,000.

Budget Allocations and Health Education Programs and Services
As shown in the figure below, the majority of the Health Protection Fund monies have been used for personnel. Instructional and professional staff account for the largest portion of the spending, followed by contractual services (e.g., consultants to do training, stipends paid to regular staff for duties outside their regular contract).



75% of the health coordinators' duties are in the area of facilitating health programs and activities for students, as well as parents, and the community; trainings for other health educators to provide services; and teaching health courses.

80% of health education teachers are currently certified to teach health education in the grade they now teach, a significant increase from 1994.

- 65% of high schools report a graduation requirement for health.

- Students in middle school (6th - 8th grade) receive approximately 30 hours per year of health education. A sharp decrease occurs at eleventh grade with just 10 hours of health education and less than 10 hours per year of health education for seniors.

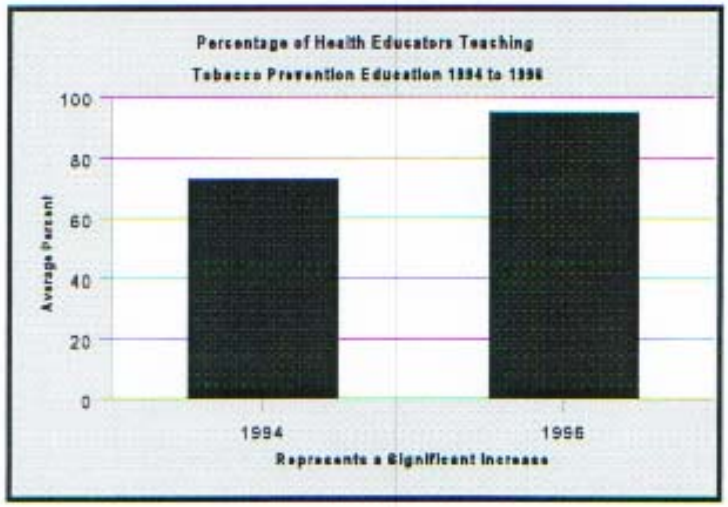
Tobacco Prevention Education and Cessation

Findings

- 100% of Massachusetts districts have Tobacco-Free School Policies.

- The greatest amount of tobacco prevention education is received by middle school students.

- Students who have more hours per year of required middle school health education (including tobacco prevention education) appear less likely to use tobacco compared to students who have fewer hours per year of required middle school health education (including tobacco prevention education).



- There has been a significant increase from 1994 to 1996 in the percentage of health educators teaching tobacco use prevention, from 73% to 95%.

- Students appear less likely to use tobacco in districts where health education professionals perceive support from district and non-health staff for implementing the health curriculum framework, **Building Resilience**.

- 56% of districts provide tobacco education to parents.

- Students appear less likely to use tobacco in districts that sent educational materials (including tobacco) to parents to involve them in health education.

- 75% of districts' tobacco control programs (including prevention education and cessation) are linked to community programs.

- Students appear less likely to use tobacco in districts that include community-based organizations on the school health advisory council.

1998 Action Plan

- A tobacco specialist will be assigned in DOE to oversee and facilitate the school-based tobacco control programs.

Districts will provide tobacco prevention education and cessation activities to all students

In the 1998-99 HPF grant application, districts will be required to submit:

- tobacco-free school written policies and enforcement procedures for students and staff, including number of violations and consequences.
- a description of the current curriculum and activities for tobacco prevention education.
- the name of a representative from the American Cancer Society who serves on the community health advisory council.

The Department of Education and the American Cancer Society are preparing narratives about successful school-based tobacco control programs.

The Department will collect and report specific information from districts around funding of tobacco education prevention and cessation; the amount of tobacco prevention education students receive; and the number of students, staff, parents, and community reached by cessation programs.

General Prevention Education

Findings

Students have more required health education per year in middle school (average 31 hours) than in high school (average 22 hours).

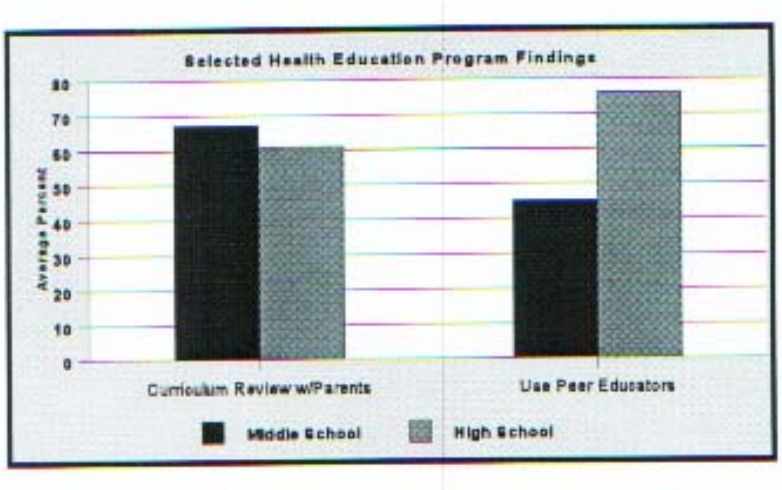
Compared to students with fewer hours of required middle school health education per year, students who have more hours per year of required middle school health education appear less likely to use alcohol and other drugs, and less likely to engage in violence.

45% of middle schools and 76% of high schools use trained peer educators. Peer educators are used to teach about health in the following ways:

- discussion or support groups in 67% of middle schools and 84% of high schools.
- conflict resolution and mediation sessions in 72% of middle schools and 83% of high schools.
- assembly programs in 49% of middle schools and 66% of high schools.

Students appear less likely to engage in violence and to use alcohol in districts that use trained peer educators to teach about health in group settings.

67% of middle schools and 61% of high schools had parents participate in the health education curriculum development and review.



- Students appear less likely to engage in violence in districts in which parents are involved in planning health education.

- In 65% of middle and 66% of high schools, health education teachers plan and coordinate health-related projects or activities with school counseling and psychological services.

- Students appear less likely to engage in violence in districts in which the health education teacher works with school- based mental health services.

Action Plan 1998

- In the 1998-99 HPF grant application, districts will agree to do the following:

  - provide opportunities for all students to develop positive relationships with peers and adults, as well as for strong guidance and counseling programs and the coordination of health and mental health services.
  - be guided by data from a student behavior needs assessment in planning the goals and timelines of their health education activities.

- In the 1998-99 HPF grant application, districts will be required to submit:

  - description of the integration of local health curriculum with the health framework, **Building Resilience**. Districts must show how this work supports the implementation of Prek-12 health school-based tobacco control programs.
  - results of a student behavior needs assessment.
  - formal evaluation plan assessing the accomplishment of established goals and timelines.

- The Department will identify model programs that exhibit effective comprehensive school health education program practices and reductions in student risk behaviors, especially around tobacco.

Endnote

The data sources for this report are the 1997 Self-Evaluation Tool for School-Based Tobacco Control Programs (SETT), the 1996 Massachusetts School Health Education Profile (SHEP), and the 1997 Health Education Telephone Interview Project (TIP). The findings discussed in this report are supported by research on effective comprehensive school health education programs that include classroom-based learning as well as peer participation, parent involvement, and community representation.4

The Department of Education has worked with many agencies to extend the knowledge of effective comprehensive school health education programs. These agencies are the Department of Public Health, the American Cancer Society, the Tobacco Oversight Council, the Division of Adolescent School Health at the Centers for Disease Control, and the Council of Chief State School Officers.

The entire report can be viewed on the Department of Education web site, www.doe.mass.edu

References

1. Squire, L. R. (1987). *Memory and Brain*. New York, NY: Oxford University Press.

2. Council of Chief State School Officers. (1989). A Concern About... Meeting the Health Needs of Children and Youth, Particularly Those at Risk for School Failure. *Concerns,* Issue XXVII, October.

3. Massachusetts Department of Education. (1996). *TheMassachusetts Comprehensive Health Curriculum Framework: Building Resilience Through Comprehensive Health*. Publication No. 17811-51-5M-4/96-ESIS W/S.

4. Davis, R., Gonser, H., Kirkpatrick, M., Lavery, S., & Owen, S. (1985). Comprehensive School Health Education: A Practical Definition. *Journal of School Health*, 55, 335-339

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1998 Report on the Health Protection Fund

Introduction

Adolescent Behavior
While recent national and local studies have found that an increasing number of adolescents have engaged in most risk behaviors, these same studies have also shown that the majority of young people do not engage in these unhealthy behaviors and that adolescent participation in some behaviors has leveled off or slightly decreased.1, 2, 3 While these instances of decreases in behavior often receive less attention, they may likely be the more important findings as they document that there are adolescents who are *not* engaging in unhealthy behaviors.

Adolescent Behavior and School Performance
In general, schools have the opportunity to reach young people based on the amount of time students spend in the school setting. Schools have a vested interest in preventing risk behaviors that negatively impact on health founded on the link between risk behavior and impaired cognitive functioning4, 5, 6, 7and on the link between good health and better school performance.8, 9

Health Protection Fund
The Health Protection Fund (HPF) was created by a 1992 state legislative referendum that directs tax revenue on tobacco products to the Department of Education for tobacco prevention education and cessation in the context of comprehensive school health education. Comprehensive health education meets the complex and extensive needs of today's youth through a broad-based approach that includes school, family, and community, and consists of many related health components in order to create effective programs, services, and education. An average of 24 million dollars a year of Health Protection Fund monies has been distributed through grants to Massachusetts school districts over the last four years totalling approximately $96,000,000.

Purpose of the Evaluation
The purpose of this HPF evaluation is to better understand what contributes to risk behavior decreases in Massachusetts students. The majority of the public supports health education.10 , 11 The evaluation addresses the call for evidence that these programs have an impact on Massachusetts youth, particularly in the area of tobacco use.12

Methodology

Design and Analysis
Data on comprehensive school health education programs from randomly selected middle and high school lead health teachers and principals were correlated with data reported by district health coordinators on the change in each of the student risk behaviors of tobacco use, alcohol use, drug use, and violence after four years of Health Protection Fund programs. The extent to which districts were implementing elements of the local comprehensive school health education program was compared for districts that decreased and districts that increased in each of the four risk behavior areas. The data were checked for relationships with type of community as a marker for geographic and socioeconomic attributes, and with funding of HPF and other health-related grant monies. There was a relationship in a limited number of cases between a very few program practices and type of community on tobacco change groups only. To control for this, analyses in these instances were done *within* urban and suburban/rural districts. About half of these few relationships held in urban but not suburban/rural and about half of these few held in suburban/rural, but not urban. The majority of the relationships, however, were not influenced by type of community. Therefore, there are not major differences on how health education programs are implemented in different types of communities. There was no relationship between the amount of Health Protection Funding or other health-related grant monies per district and health education program practices nor with changes in student behavior.

Instruments
The **Telephone Interview Project (TIP)** was developed in 1997 by the Department of Education to record information from the district health coordinator on the change group status of "decreased", "stayed the same", or "increased" on middle and high school student risk behaviors of tobacco use, alcohol use, drug use, and violence after four years of Health Protection Fund. This data was based on the districts' yearly needs assessments required by the HPF grant application. Information about comprehensive school health education programs was also available from the TIP. **1996 School Health Education Profile (SHEP)** is a nationally administered instrument developed by the Centers for Disease Control (CDC) Division of Adolescent and School Health in collaboration with state and local education agencies. The SHEP yields information about middle and high school comprehensive school health education programs and is completed by randomly selected lead health teachers and principals.

Findings

Massachusetts comprehensive school health education programs are still relatively new. As the first time the HPF evaluation has studied the relationships between program implementation practices and student impact, replication of these findings on a larger sample and more in-depth study of health education program practices will be important. What is presented here is available information that can be thought of as markers, supported by literature, about health education program practices that appear to be effective in relation to decreased student engagement in risk behavior. The findings section will first present the percentage of funds in the designated budget categories for each year of the Health Protection Fund as well as averaged across the four years. The findings section will next report on and discuss health education program practices and their relationship with lowered student risk behavior. It is important to note that these are associations which cannot be seen as cause and effect statements, but rather as informative findings which can guide future research.

Funding--How Health Protection Fund Monies are Spent

Figures 1-4 below show for Year I (1993-94), Year II (1994-95), Year III (1995-96) and Year IV (1996-97) the percent of the total yearly budget devoted to each of the major budget categories. Figure 5 shows the same breakdown cumulatively averaged across Years I through IV. The majority of funding has been dedicated to teaching.

Figure 1

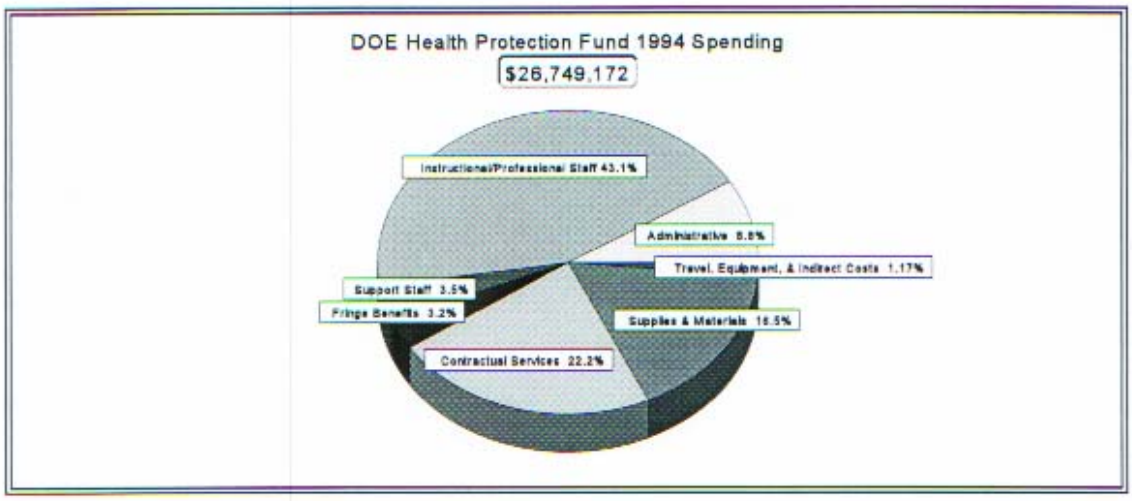


Figure 2

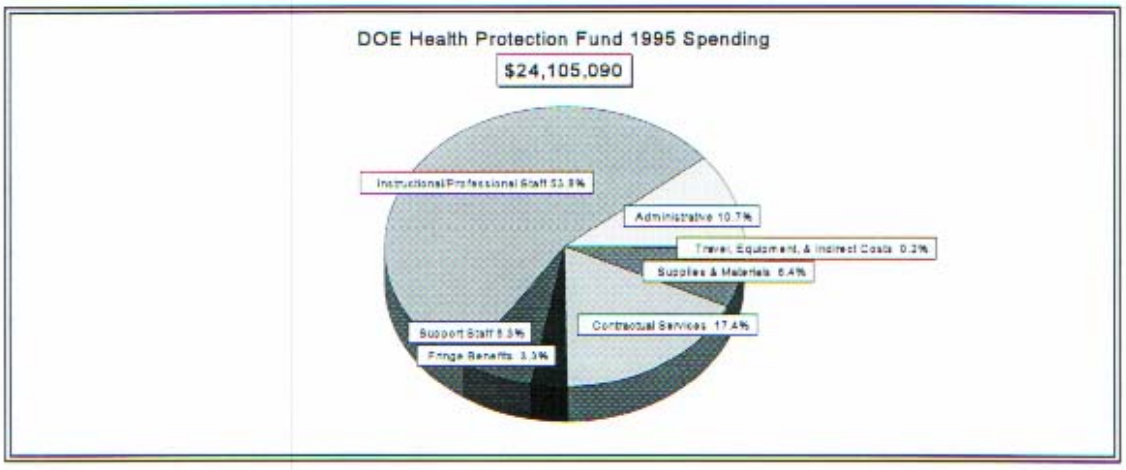


Figure 3

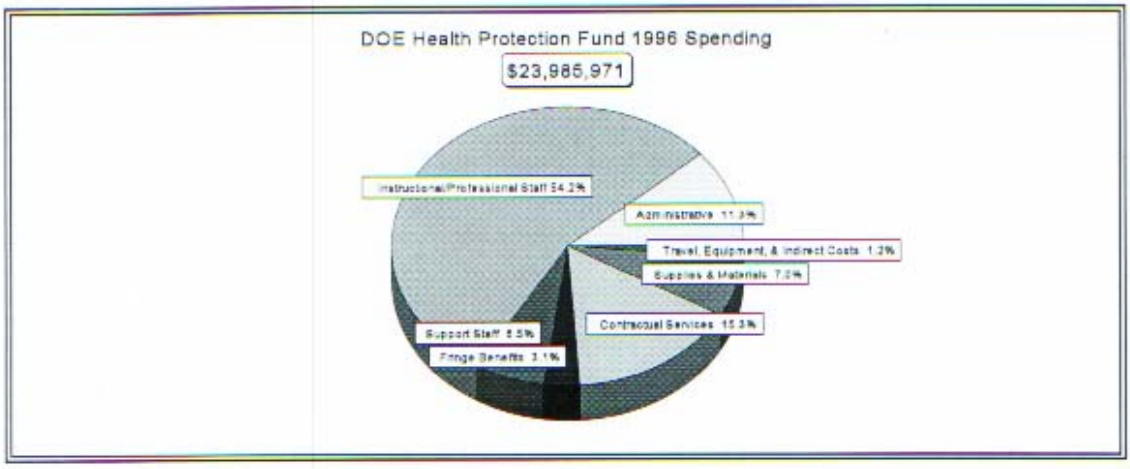


Figure 4

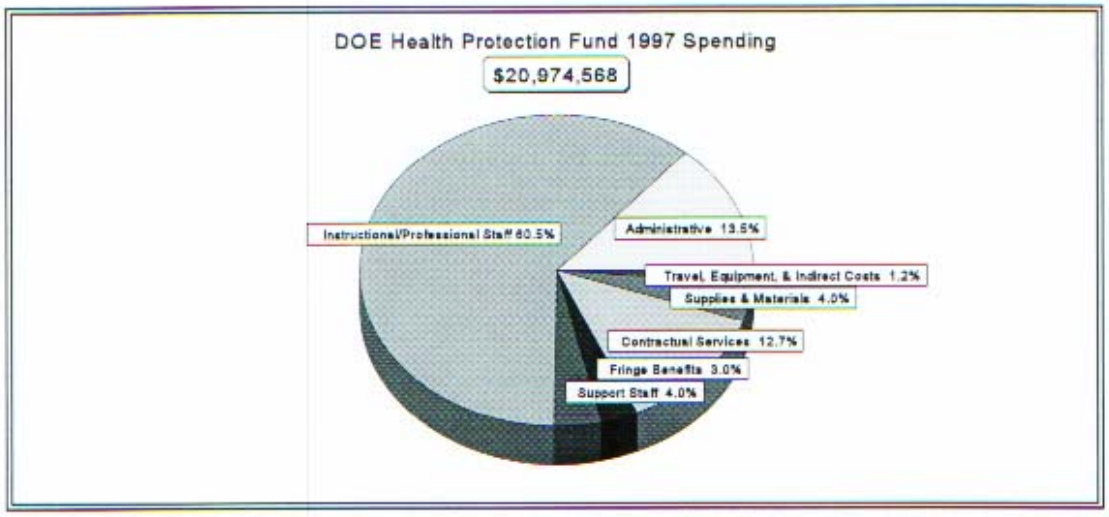
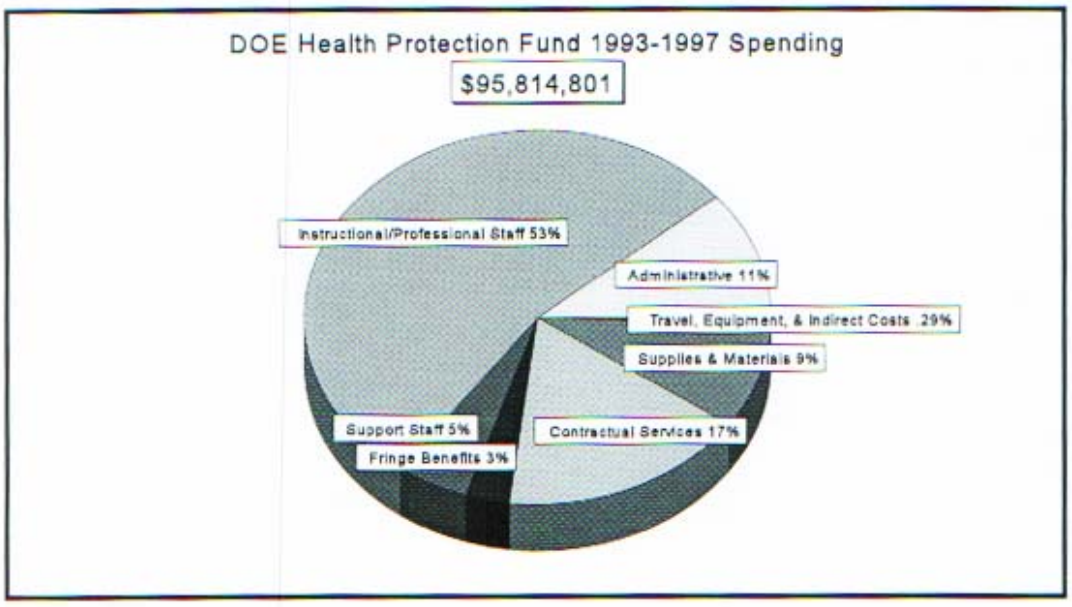


Figure 5



Despite budget cuts, the percentage being spent in each category has remained remarkably stable. This demonstrates a consistency across HPF school health education programs throughout the state. The focus on Contractual Services (e.g., outside trainers, consultants paid hourly with no benefits, stipends) and Instructional/Professional Staff from Year I (1993-94) and continuing through Year IV (1996-97) demonstrates a focused effort by districts to have staff in place who would be available, accessible, and better able to locally provide services for students in health education. The major purchasing of materials was also done in the first year and after this districts have continued to buy materials but to a lesser extent. The monies have gone for personnel that provide students with direct services.

Themes in Resilience-Relationships between Program Practices and Student Behavior

Resilient factors derive from individual characteristics, family, community, and the school. The findings in this report focus on school-related program practices that foster resiliency; which is the ability to thrive, persevere, and maintain a positive attitude and healthy body. In the present evaluation, two major areas were found to be related to decreased student risk behavior--one in exposure to the health education curriculum and the second in the participation of important others in the school health education program. These themes parallel two of the most crucial factors necessary for resilience in health, a forum for the learning of knowledge13, 14 and the opportunity to form social support relationships with important others, such as parents,15, 16, 17 school staff,18, 19, 20and peers.21 The majority of the relationships is between health education program practices and decreases in tobacco use by students. The findings in the report are organized within these two major areas with results relative to student tobacco use presented first. All findings are statistically significant at the .05 level or better. Detailed statistical information relative to the findings and about the "stayed the same" group is found in the Appendix.

I. Exposure to Health Curriculum

A. Hours of Health Education

The starting point and often most prominent piece of comprehensive school health education programs is the offering of courses in health.

€A health education program practice found to be related to decreased student *tobacco use, alcohol use, drug use, and violence* was:

- **more hours per year of required health education during middle school.**

The finding that health instruction in the middle school years is instrumental for students not engaging in risk behavior is one of the most consistent in the literature.22, 23, 24 A sizable school health education evaluation found the full benefits of health instruction in reported practices was achieved when a commitment for classroom hours was made to a health program.25

B. The Health Curriculum Framework

Massachusetts has developed a health curriculum framework, **Building Resilience**,26 to assist local districts in developing and implementing comprehensive school health education programs specifically designed to foster resilience in students, with the major task to facilitate a comprehensive and sequential health curriculum for all students. With respect to the health curriculum framework, three findings emerged in relation to decreased tobacco and drug use.

€Two health education program practices found to be related to decreased student *tobacco use* were:

- **perceptions of support from district and non-health staff for implementing the health curriculum framework, and**
- **a local school level directive to use a state health curriculum framework (suburban and rural districts, but not urban).**

€A health education program practice found to be related to decreased student *drug use* was:

- **perceptions of more time for curriculum planning and scheduling of courses for implementing the health curriculum framework.**

School health education programs are making strides in finding their place in the educational setting and this was related to decreases in student risk behavior. The meaningfulness of this is supported by the Education Commission of the States which articulated in a handbook developed for state policy makers on school health education that when school health education has a place in the curriculum it leads to better support, time in the curriculum, and a coordinated sequential program throughout the grades.27

II. Involvement of Important Others

A. Adults

Findings of relationships between parent and school staff involvement in health education and decreased student risk behavior were present in the current evaluation study. These findings are particularly timely in light of just published results from the National Longitudinal Study on Adolescent Health (NLSAH).28 The premise of the NLSAH study involves issues of vulnerability and resilience to identify protective factors in young people's lives, 11,572 of whom participated in school and home interviews. The authors write that "of the constellation of forces that influence adolescent health-risk behavior, the most fundamental are the social contexts in which adolescents are embedded; the family and school contexts are among the most critical."29

1. Parent Involvement

Parents being involved in health education was related in several instances to decreased tobacco use for adolescents.

€Three health education program practices found to be related to decreased student *tobacco use* were:

- **sending educational materials to parents to involve them in health education,**
- **including parents in homework assignments to involve them in health education (urban districts, but not suburban and rural), and**
- **including parents on the school health advisory council (suburban and rural districts, but not urban).**

The National Longitudinal Study on Adolescent Health30 found that less frequent cigarette use was associated with higher levels of connectedness to parents and family members for high school students. Additionally, a greater number of shared activities between teenagers and their parents and higher levels of perceived levels of parental expectations with regard to school completion were related to lower adolescent tobacco use. The program practices described above would likely have parents and their adolescents working together. Researchers found in studying many school health education programs that in order to promote comprehensiveness, both classroom and outreach activities need to "inform, involve, and facilitate education"31 of parents and family.

There was also a relationship in the present evaluation study between parent involvement in health education and decreased violence.

€A health education program practice found to be related to decreased student *violence* was:

- **parents participating in health education curriculum development and review.**

According to researchers, the family is crucial and vital in the education of students and the views and input of the family into the health curriculum can be "extremely productive."32 The National Longitudinal Study on Adolescent Health33 found that parental and family connectedness was related to lower levels of interpersonal violence. For older adolescents, higher parental expectations for school achievement were related to lower levels of teenagers engaging in violence.

2. School Health Staff Support

The working together of school personnel creates a healthy school climate that is productive, nurturing, positive, and supportive.34 Collaboration of this type raises the likelihood that the school health program will be grounded in fundamental goals of education such as intellectual and intrapersonal skills, scientific thinking and problem-solving skills, self-assessment and self-management practices, advocacy, and participation in democratic processes.35

Two findings emerged from the evaluation with respect to school personnel working with health education teachers and decreased risk behavior in tobacco use and violence for students.

€A health education program practice found to be related to decreased student *tobacco use* was:

- **health education teachers planning and coordinating health-related projects or activities with school health services (urban districts, but not suburban and rural).**

€A health education program practice found to be related to decreased student *violence* was:

- **health education teachers planning and coordinating health-related projects or activities with school counseling/psychological services.**

Higher levels of connectedness to school were related to lower levels of both tobacco use and violence in the National Longitudinal Study on Adolescent Health.36

One additional finding revolving around adult involvement in health education was in the area of community-based organizations.

€A health education program practice found to be related to decreased student *tobacco use* was:

- **including community-based organizations on the school health advisory council.**

One of the program practices found in the literature to be essential for comprehensiveness in school health education is having the community play an active role in school health education.37

B. Peer Participation

The use of trained peer educators and student participation on the school health advisory council were related to decreases in student risk behaviors. There is substantial evidence that involving students in their own health education is a productive approach.38, 39, 40

€Two health education program practices found to be related to decreased student *tobacco use* were:

- **using trained peer educators (suburban and rural districts, but not urban), and**
- **including students on the school health advisory council (urban districts, but not suburban and rural)**

€Two health education program practices found to be related to decreased student *alcohol use* were:

- **using trained peer educators to teach about health in discussion/support groups, and**
- **including students on the school health advisory council.**

€Two health education program practices found to be related to decreased student *violence* were:

- **using trained peer educators in conflict resolution/mediation sessions, and**
- **using trained peer educators in assembly programs.**

Insight into how student involvement translates into reduced risk behavior may be found in the most effective approach known to prevent risk behavior in young people, the social influence model. Using peer led activities, students learn skills to deal with social pressures and about accurate normative expectations, with documented long-term effects of several years for preventing tobacco use.41, 42, 43 It is perhaps informative that the type of peer activity related to decreased student alcohol use is in a support group form, analogous to the successful program Alcoholics Anonymous. The relationship between decreased violence and conflict resolution activities was validated. The association between assembly programs and decreased violence might be driven by such programs reaching many young people at one time.

Conclusions

This evaluation may assist in program development and policy decision making by identifying relationships between comprehensive school health education program implementation and reduced student risk behaviors. In general, researchers in the field of health education are calling for evaluation around the effectiveness of various intervention programs44, 45 In particular, local groups are interested in evaluation demonstrating effective use of monies specific to the Massachusetts Health Protection Fund.46, 47

Following designs used in the field of comprehensive school health evaluation, health education program practices were investigated to determine which were related to changes in student risk behavior after four years of HPF. The findings revealed that decreases in tobacco use, alcohol use, violence, and drug use have occurred for some adolescents and that there are effective health education program practices related to these decreases. Exposure to health curriculum and activities that promote relationships among students, their peers, and adults such as school-based health professionals, parents, and community members dedicated to health education were at the forefront of effective programs. The findings are in line with published health education research literature, reiterated below.

Exposure to health curriculum: Both classroom teaching and implementation of the health curriculum framework were related to decreases in student risk behavior. To highlight research cited in the body of the report, studies in the area of effective comprehensive school health education support having a solid health curriculum and students having exposure to this curriculum.48, 49, 50

Involvement of Important Others: Parent involvement, school staff support, community member representation, and peer participation were all related to decreases in student risk behavior. Involving parents in the health education curriculum is important in students receiving frequent exposure to positive health messages.51, 52 The National Longitudinal Study on Adolescent Health 53 found the strongest result to be that adolescents reporting feeling close and connected to their families were the least likely to engage in risk behavior. Collaboration between members in the school setting enhances health and academics.54 Connectedness with school was found to be a protective factor for teenagers not engaging in risky behavior in the National Longitudinal Study on Adolescent Health.55 Peer programs are known to be among the most effective in preventing risk behaviors56, 57 and effective school health programs have students involved in the presentation and delivery of the program.58 Further, large scale studies of resilience have found that social support is a protective factor and related to higher academic achievement.59,60, 61

What has been found to be effective in other studies of school health education programs is also effective in Massachusetts school health education programs, reiterating consistent trends.

While much work remains and replication is essential, particular note can be made of the many relationships between health education program practices and decreases in tobacco use as well as decreases in other unhealthy behaviors in adolescents. The differences between health education program practices in urban districts and in suburban/rural districts and reduced tobacco use for students will need subsequent study. For now, it appears that those practices in urban settings revolve around students participating in health-related activities outside of the school day, parent involvement through home-based activities, and health-related services more likely to be offered in larger school districts; while the practices related to decreased tobacco use in suburban/urban settings may be explained by a somewhat less fixed milieu where implementation of the health curriculum framework may occur more quickly, parent involvement is more school-based, and students are more involved in the daytime activities of the school. However, by far the majority of the health education practices are similar across districts.

Most informative may be that these changes were observed in the context of a *comprehensive* school health education approach, the approach established by the legislation for the Health Protection Fund. In future, more attention should be given to building an expanded and more complete understanding of the effective program practices found in this study. Resiliency is not only linked to behaviors that determine a healthy lifestyle, but to cognitive functioning. In this way, the work done by comprehensive school health education programs supports school districts in improving student academic achievement.

Recommendations

Tobacco

Tobacco is the focal point of the Health Protection Fund. The majority of the relationships in the evaluation were between program practices and decreases in student tobacco use. The following activities would promote and reinforce the place of tobacco prevention education and cessation in comprehensive school health education programs:

- Gather more detailed information of schools' tobacco control programs relative to decreases in student tobacco use.

- Focus on the identification of and recognition of how successful tobacco cessation programs are implemented and maintained.

Health Curriculum Framework - Building Resilience

Exposure to concepts and learning standards contained in the Health Curriculum Framework was related to decreases in student risk behaviors. The following activities would promote further implementation by districts and provide for more fine-tuned study of the effective program practices identified:

- Support districts' implementation of the Health Curriculum Framework through content institutes and other professional development opportunities.

- Revise the Health Protection Fund Mid-Year Report to mirror the framework and collect information on the status of health education program implementation of districts.

The Timing of Health Education

A health education program in all grades is the key component of a comprehensive school health education program. In order for the prevention message to be best assimilated, research supports the middle school years as among the most important for students in receiving instruction in health topics. The relationship found in the evaluation between required middle school health education and decreased risk behavior was in line with such research. The following activities are specific to addressing the timing of delivery:

- Review the amount of health education offered at all grades and compare the amount offered in the middle grades with other grades.

- Consider making the health education program most intensive during middle school years.

Involvement of Important Others

A central component of resiliency supported by the literature is meaningful relationships with others. This theme was prominent in the evaluation through the relationship between school staff, parents, and peers being involved in health education activities and decreases in student risk behavior. Activities that would facilitate these relationships would be:

- Focus on collaboration and coordination of activities and instruction between health education teachers and other health-related programs--specifically, these would be the physical education teacher, school health services, and school counseling and psychological services.

- Expand health-related activities in which parents can participate, both at home (e.g., receiving materials, homework assignments) and at school (e.g., being involved on the School Health Advisory Committee).

- Encourage peer educators' work with students in health related activities and student involvement on the School Health Advisory Committee.

Needs Assessment

Not all districts have adequate information about their students' behavior. Using nationally or state specific data may not be accurate on a district level. Using disciplinary records tends to underestimate behavior. The following activities would facilitate more accurate tracking of changes in student behavior over time which is critical to seeing relationships with program practices:

- Provide support for health coordinators' efforts to advocate in the local community for student behavior needs assessment. Help them articulate both the point of view of the necessity of a student-based needs assessment for the HPF grant application and its usefulness for knowing the rates of behavior for young people in their own community in order to plan better programs.

- Train health coordinators on the administration of such needs assessment. Offer a list of contacts of companies that can reasonably do data entry and basic frequencies for districts.

- Engage in work between the Department of Education liaisons and health coordinators to effectively present the needs assessment findings, their meaning, and their possible uses to various school and community audiences.

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Appendix

School districts were asked to indicate how student behaviors in the areas of tobacco use, alcohol use, drug use, and engaging in physical violence had changed over the four years of the Health Protection Fund (HPF) from 1993 to 1997. Categories of greatly decreased, slightly decreased, slightly increased, greatly increased, or stayed the same were self-chosen by districts for each of the four behaviors. The slightly and greatly categories were combined, thus three groups of decreased, stayed the same, and increased were formed and are called CHANGE GROUPS. Only districts having accurate information on the change in behavior were included in these analyses (113 or 39%). As averaged across all behaviors, twenty-five percent of these districts reported decreases, thirty-five percent reported behaviors stayed the same, and forty percent reported increases. As districts could indicate change for each behavior separately, different patterns emerged on direction of change.

The main body of the report focuses on the differences in health education program implementation between the districts that reported that student behaviors decreased or increased. Following this section of the appendix, the stayed the same group is compared to the increased and decreased groups on program practices. Data from these program implementation practices came from the1996 School Health Education Profile (SHEP) developed by CDC and completed by randomly selected lead health teachers and principals and the 1997 Telephone Interview Project (TIP) developed by Health, Safety and Student Support Services at the Department of Education completed by health coordinators. The change group data came from the TIP and was based on data collected at the district level to provide needs assessment information for yearly HPF grant applications.

A prerequisite to analyses was that a match be present between change group status and having responded to each particular question on the TIP or SHEP. This resulted in different size groups (Ns) and sometimes groups of small size. Multivariate analyses were done first and interactions among variables ruled out. Consequently, univariate analyses were used to study relationships in the data. The influence of two demographic variables, amount of Health Protection Fund monies and type of community (rural, suburban, urban), on change group were checked. There was no relationship with money, but a relationship between type of community and tobacco on some of the SHEP items was present. The relationship was between urban and suburban and urban and rural, but not between suburban and rural; therefore, suburban and rural districts were combined. To control for the influence of this demographic variable on the tobacco change group, analyses for these items were done *within* the two types of community (urban and suburban/rural) on those seven SHEP items where it was applicable. Analyses revealed the relationships between program practices and student behavior held in four cases for urban districts, but not suburban/rural; and in three cases for suburban/rural districts, but not urban.

Overall statistical tests of the relationships between the items on the instruments and the change groups were conducted first. If a relationship was present, statistical follow-up tests to determine differences between the decreased group and the increased group on that item of the instrument were carried out. The TIP was analyzed using anova, with post-hoc comparisons follow-up. Two questions on the TIP were treated with a factor analysis and then the above procedure applied. The SHEP was analyzed using independent samples t-test, with binomial comparisons follow-up.

For follow-up tests to determine differences between the change groups; for the TIP, a statistically significant relationship represents a higher mean for one group compared to the other group on that program practice. For the SHEP, a statistically significant relationship represents that one group was implementing a particular program practice in a proportion that was significant and the other group was not implementing that same practice in a proportion that was significant.

The majority of the statistically significant relationships were with the SHEP. The statistical tests chosen are very robust to threats of data normality. For the binomial test on the SHEP (used for almost all the analyses), the only assumption, randomization, was met. The binonmial test is also able to handle variations in N sizes. Additionally, for all analyses on both the SHEP and the TIP, the results generated using the more conservative unequal variances

are reported. The 1996 SHEP report is available at the Department's web site: www.doe.mass.edu. The TIP results are presented at the end of this Appendix.

The nature of this study is exploratory. These findings represent associations and do not answer questions of cause and effect. All the program practices investigated in the evaluation are naturally occurring as a part of local level implementation of comprehensive school health education. Therefore, context validity is enhanced as the decreases in risk behavior are associated with programs *already* in place as opposed to implementations that were put into place expressly for the purpose of evaluation.

A statement of the relationship between the risk behavior and the health education program practice is presented and followed by a table with the following information: **Behavior**: The risk behavior that the program component is referencing.
Instrument: The name of the instrument and the question that represents the program practice.
Proportion or Mean: The proportion is the number of schools in each of the Change Groups answering yes to implementing the program practice (the proportion that answered no is the remainder adding to 100). The mean is the district's average score derived from adding responses and dividing by the number of cases.
N: The number of cases (schools for SHEP, districts for TIP).
Significance: The significance level gives an assurance that the finding did not occur by chance. The actual **p** value (probability that the finding is by chance) is given as well as asterisk(s) to indicate the range of probability. The lower the **p** value, the less likely the finding is by chance. The majority (17 out of 23, 76%) of the findings were significant (**p** = .05). A FEW (SIX OUT OF 23, 24%) SELECTED MARGINAL RELATIONSHIPS (**p** = .06 to .10) are presented where especially relevant. For proportion, when a high enough number of the respondents said yes compared to saying no to that practice being in place, the difference was significant. While each change group was implementing that component, one group was doing it to a significantly or marginally significantly greater degree. The **p** value reported is for the group presented first in the table; showing that after finding overall significance for a relationship between that program practice and change group status, that group was implementing that program practice to a statistically significant degree while the **p** value for the other group is non-significant and is not shown. Further, it is the group with the significant **p** value that is driving the overall significant relationship.

mar	marginal
*	significant at the .05 level
**	significant at the .01 level
***	significant at the .001 level
****	significant at the .0001 level

Health Curriculum Framework

Locally required to *use state health curriculum framework* (suburban and rural districts but not urban)**

Behavior	Instrument	Proportion that Responded Yes	N (Number of Schools in Each Group)	Significance Level
Tobacco use	SHEP Teacher Question 2a	Decreased Group (78%) Increased Group (46%)	Decreased Group (n=27) Increased Group (n= 25)	**p**= .004

Combined lack of *district and non-health staff support* as less of an obstacle to implementing the health curriculum framework*

Behavior	Instrument	Mean Factor Score on Obstacle	N (Number of Districts in Each Group)	Significance Level
Tobacco use	TIP Question 9	Decreased Group (-.25) Increased Group (.26)	Decreased Group (n=36) Increased Group (n=54)	**p**= .05

Combined lack of *time for curriculum planning and scheduling of courses* as less of an obstacle to implementing the health curriculum framework*

Behavior	Instrument	Mean Factor Score on Obstacle	N (Number of Districts in Each Group)	Significance Level
Drug use	TIP Question 9	Decreased Group (-.00) Increased Group (.60)	Decreased Group (n=36) Increased Group (n=54)	**p**= .05

Area Two: Health Education Delivery

Required a *health education course for graduation or promotion*mar

Behavior	Instrument	Proportion that Responded Yes	N (Number of Schools in Each Group)	Significance Level
Tobacco use	SHEP Principal Question 7	Decreased Group (67%) Increased Group (39%)	Decreased Group (n=27) Increased Group (n= 46)	**p**= .06

More hours per year of required *middle school health education* (6th through 8th grades)*

Behavior	Instrument	Mean Hours Middle School Health Education Per Year	N (Number of Districts in Each Group)	Significance Level
All Risk Behaviors	TIP Question 10b	Decreased Group (94 hrs) Increased Group (66 hrs)	Decreased Group (n=49) Increased Group (n=48)	**p**= .02

More hours per year of received *high school health education* (9th through 12th grades)mar

Behavior	Instrument	Mean Hours High School Health Education Per Year	N (Number of Districts in Each Group)	Significance Level
Alcohol use	TIP Question 10a	Decreased Group (55 hrs) Increased Group (43 hrs)	Decreased Group (n=14) Increased Group (n= 22)	**p**=.10

Taught *health as courses divided* between health education and one other subject (such as health education and physical education)mar

Behavior	Instrument	Proportion that Responded Yes (to divided classes)	N (Number of Schools in Each Group)	Significance Level
Alcohol use	SHEP Principal Question 3b	Increased Group (63%) Decreased Group (35%)	Increased Group (n=30) Decreased Group (n=26)	**p**= .09

Higher percentage of the *health curriculum* that is commercially developedmar

Behavior	Instrument	Mean Percentage of Commercially Developed Health Curriculum	N (Number of Schools in Each Group)	Significance Level
Tobacco use	TIP Question 5a	Decreased Group (43%) Increased Group (31%)	Decreased Group (n=33) Increased Group (n=44)	**p**= .07

Area Three: Student Participation

Used *trained peer educators*mar

Behavior	Instrument	Proportion that Responded Yes	N (Number of Schools in Each Group)	Significance Level
Violence	SHEP Principal Question 13	Decreased Group (65%) Increased Group (46%)	Decreased Group (n=31) Increased Group (n=28)	**p**= .08

Based trained *peer educators* (suburban and rural districts but not urban)*

Behavior	Instrument	Proportion that Responded Yes	N (Number of Schools in Each Group)	Significance Level
Tobacco use	SHEP Principal Question 13	Decreased Group (74%) Increased Group (53%)	Decreased Group (n=23) Increased Group (n=20)	**p**= .02

Used trained peer educators to teach about health in *conflict resolution or mediation* sessions***

Behavior	Instrument	Proportion that Responded Yes	N (Number of Schools in Each Group)	Significance Level
Violence	SHEP Principal Question 14f	Decreased Group (94%) Increased Group (62%)	Decreased Group (n=16) Increased Group (n=13)	**p**= .001

Used trained peer educators to teach about health in *assembly programs**

Behavior	Instrument	Proportion that Responded Yes	N (Number of Schools in Each Group)	Significance Level

Violence	SHEP Principal Question 14c	Decreased Group (77%) Increased Group (43%)	Decreased Group (n=13) Increased Group (n=7)	**p**= .05

Used trained peer educators to teach about health in *discussion or support groups****

Behavior	Instrument	Proportion that Responded Yes	N (Number of Schools in Each Group)	Significance Level
Alcohol use	SHEP Principal Question 14e	Decreased Group (100%) Increased Group (69%)	Decreased Group (n=10) Increased Group (n=13)	**p**= .001

Students represented on the *school health advisory council***

Behavior	Instrument	Proportion that Responded Yes	N (Number of Schools in Each Group)	Significance Level
Alcohol use	SHEP Principal Question 16a	Decreased Group (81%) Increased Group (52%)	Decreased Group (n=16) Increased Group (n=21)	**p**= .01

Students represented on the *school health advisory council* (urban districts but not suburban or rural)*

Behavior	Instrument	Proportion that Responded Yes	N (Number of Schools in Each Group)	Significance Level
Tobacco use	SHEP Principal Question 16a	Decreased Group (100%) Increased Group (69%)	Decreased Group (n=5) Increased Group (n=13)	**p**= .03

Area Four: Parent Involvement

Parents participate in health education *curriculum development and review* to involve them in health education****

Behavior	Instrument	Proportion that Responded Yes	N (Number of Schools in Each Group)	Significance Level
Violence	SHEP Teacher Question 4h	Decreased Group (82%) Increased Group (65%)	Decreased Group (n=32) Increased Group (n=31)	**p**= .000

Sent *educational materials* to parents to involve them in health education**

Behavior	Instrument	Proportion that Responded Yes	N (Number of Schools in Each Group)	Significance Level
Tobacco use	SHEP Teacher Question 4a	Decreased Group (73%) Increased Group (50%)	Decreased Group (n=37) Increased Group (n=64)	**p**= .01

Included parents in *homework assignments* to involve them in health education (urban districts but not suburban and rural)**

Behavior	Instrument	Proportion that Responded Yes	N (Number of Schools in Each Group)	Significance Level
Tobacco use	SHEP Teacher Question 4b	Decreased Group (100%) Increased Group (67%)	Decreased Group (n=10) Increased Group (n=27)	**p**= .002

Included parents on the *school health advisory council* to involve them in health education (suburban and rural districts but not urban)**

Behavior	Instrument	Proportion that Responded Yes	N (Number of Schools in Each Group)	Significance Level
Tobacco use	SHEP Teacher Question 4g	Decreased Group (81%) Increased Group (68%)	Decreased Group (n=27) Increased Group (n=34)	**p**= .002

Area Five: School and Community-Based Support

Health education teachers plan or coordinate health-related projects or activities with *school counseling or psychological services***

Behavior	Instrument	Proportion that Responded Yes	N (Number of Schools in Each Group)	Significance Level

Violence	SHEP Teacher Question 10e	Decreased Group (73%) Increased Group (63%)	Decreased Group (n=33) Increased Group (n=30)	**p**= .01

Health education teachers plan or coordinate health-related projects or activities with *physical education* teachers (urban districts but not suburban and rural)mar

Behavior	Instrument	Proportion that Responded Yes	N (Number of Schools in Each Group)	Significance Level
Tobacco use	SHEP Teacher Question 10a	Decreased Group (80%) Increased Group (62%)	Decreased Group (n=10) Increased Group (n=26)	**p**= .06

Health education teachers plan or coordinate health-related projects or activities with *school health services* (urban districts but not suburban and rural)*

Behavior	Instrument	Proportion that Responded Yes	N (Number of Schools in Each Group)	Significance Level
Tobacco use	SHEP Teacher Question 10d	Decreased Group (90%) Increased Group (67%)	Decreased Group (n=10) Increased Group (n=27)	**p**= .02

Included *community-based organizations* on the *school health advisory council**

Behavior	Instrument	Proportion that Responded Yes	N (Number of Schools in Each Group)	Significance Level
Tobacco use	SHEP Principal Question 16n	Decreased Group (80%) Increased Group (63%)	Decreased Group (n=16) Increased Group (n=24)	**p**= .02

Stayed the Same Group
The Stayed the Same Group was more like the Decreased Group in half of the relationships presented above and more like the Increased Group in half of the relationships. This group is holding steady in light of the increases nationally and locally seen in participation in risk behavior. They are implementing many, but not all of the same health education components to a similar degree as the Decreased Group.

How the Stayed the Same Group is like the Decreased Group:
As does the Decreased Group, the Stayed the Same Group is implementing the **local** requirement to use the state health curriculum framework, is providing a higher number of high school hours received (not required), has strong peer and student participation, and involves parents and the community on the school health advisory council. (See table below for specific questions).

Program Component and Behavior	Instrument	N (Proportion said yes)
Required to Use State Health Framework (Tobacco)	SHEP Teacher 2a	14 (86%)
Provided More Hours Per Year Received High School Health Education (Alcohol)	TIP 10a	34 (62 mean hrs per yr)
Used Trained Peer Educators (Violence)	SHEP Principal 13	30 (67%)
Used Trained Peer Educators (Tobacco)	SHEP Principal 13	13 (85%)
Used Peer Educators in Conflict Resolution or Mediation Sessions (Violence)	SHEP Principal 14f	18 (78%)
Used Peer Educators in Discussion or Support Groups (Alcohol)	SHEP Principal 14e	17 (88%)
Students Represented on School Health Advisory Council (Alcohol)	SHEP Principal 16a	24 (83%)
Parents Represented on School Health Advisory Council (Tobacco)	SHEP Teacher 4g	21 (95%)
Involvement of Parents in Homework Assignments (Tobacco)	SHEP Teacher 4b	4 (100%)
Community-Based Organizations on School Health Advisory Council (Tobacco)	SHEP 16n	14 (93%)
Planning & Coordination by Health Teachers of Health Activities with School Health Services (Tobacco)	SHEP Teacher 10d	4 (100%)

How the Stayed the Same Group is like the Increased Group: While the program components are in place, they are not in place to as high a degree as the Decreased Group. Similar to the Increased Group, the Stayed the Same Group does not require health for graduation or promotion, divides health among subjects, uses fewer commercially developed health curricula, is weaker with respect to parent and school involvement outside of school advisory council, has less peer involvement, and has more obstacles to implementing the health curriculum framework. (See table below for specific questions)

Program Component and Behavior	Instrument	N (Proportion said yes)
Lack of District and Non-Health Staff Support as an Obstacle (Tobacco)	TIP 9	22 (.17 mean factor score)
Lack of Time for Curriculum Planning and Scheduling of Courses as an Obstacle (Drugs)	TIP 9	22 (.49 mean factor score)
Less Requirement of a Health Education Course for Graduation or Promotion (Tobacco)	SHEP Principal 7	16 (69%)
Taught more Health as Courses Divided between Health and One Other Subject (Alcohol)	SHEP Principal 3b	32 (42%)
Lower Percentage of Health Curriculum that is Commercially Developed (Tobacco)	TIP 5a	24 (28%)
Lower Use of Peer Educators in Health Assembly Programs (Violence)	SHEP Principal 14c	10 (70%)
Lower Representation of Students on Health Advisory Council (Tobacco)	SHEP Principal 16a	4 (5%)
Lower Parent Participation in Health Education Curriculum Development & Review (Violence)	SHEP Teacher 4h	36 (53%)
Lower Sending of Educational Health Materials to Parents (Tobacco)	SHEP Teacher 4a	20 (65%)
Lower Planning & Coordination by Health Teachers of Health Activities with School Counseling Services (Violence)	SHEP Teacher 10e	38 (63%)
Lower Planning & Coordination by Health Teachers of Health Activities with Physical Education Teachers (Tobacco)	SHEP Teacher 10a	4 (75%)

EVENTS CALENDAR

March 2003

S	M	T	W	T	F	S
26	27	28	29	30	31	1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31	1	2	3	4	5

NEWS SEARCH

Keyword:

Target: All

Dates:

Past 30 days
Past 90 days
Date Range

Start: Jan 2003
End: Jan 2003

Commissioner's Update Archive
Board in Brief Archive

For Immediate Release
Wednesday, February 18, 1998
Contact: Kevin Carleton

Interim Commissioner Of Education Is Appointed

Malden - The Massachusetts Board of Education today voted unanimously to appoint Frank W. Haydu III, a businessman and former member of the state Board of Education, to serve as Interim Commissioner of Education until a permanent Commissioner is appointed.

The appointment is effective on March 2.

Haydu is Chairman of Haydu and Lind of Wellesley, a developer of senior living projects. He served on the Massachusetts Board of Education from 1992-1996, during which time the Education Reform Act of 1993 was enacted.

Previously, he was a managing director of Kidder Peabody and Interim Chief Executive Officer of the New England Medical Center. He was a member of the Dover, Massachusetts School Committee for three years, on the Executive Committee of the New England Association of Schools and Colleges for six years, and on the Board of the Massachusetts Business Alliance for Education. Recently, he served on the state factfinding team to make recommendations to the Board and Commissioner on the Lawrence Public Schools.

"We are fortunate in gaining the immediate assistance of a talented and experienced administrator and businessman who is well acquainted with primary and secondary education in Massachusetts and with the initiatives of education reform. Frank Haydu, dedicated to public service, will give distinguished leadership to the Board of Education, continuity in the administration of the Department of Education, and major assistance in recruiting a permanent commissioner of outstanding qualifications," said Dr. John Silber, Chairman of the Board.

Dr. Robert V. Antonucci, who served as Commissioner since 1992, recently announced his resignation to become President of ICS Learning Systems, a subsidiary of Harcourt General in Scranton, Pennsylvania.

The Board of Education has initiated a national search for a permanent Commissioner. Applications are due by March 16.

In discussing the appointment of a Commissioner-in-the-Interim, the Board unanimously approved a resolution expressing confidence and support for the Deputy Commissioner of Education, Dr. David P. Driscoll. On a conference call with the Board, Frank Haydu expressed his commitment to work with the Board and Department staff to move forward the Education Reform agenda.

The Board vote took place at a public meeting at 8:00 a.m. at the office of the Department of Education in Malden.