

A Union of Professionals

HELPING CHILDREN THRIVE

CHILD HEALTH
SURVEY REPORT





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OUR MISSION

The **American Federation of Teachers** is a union of professionals that champions fairness; democracy; economic opportunity; and high-quality public education, healthcare and public services for our students, their families and our communities. We are committed to advancing these principles through community engagement, organizing, collective bargaining and political activism, and especially through the work our members do.

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The AFT's new Children's Health, Safety and Well-Being (HSW) program relies on member priorities to promote equity at the intersection of health and education.

HELPING CHILDREN THRIVE IS UNION WORK

We know that children's health and well-being are intimately linked to their ability to learn and grow—and, ultimately, to gaps in achievement and equity that plague too many communities. Yet, too many obstacles still stand in the way as we fight to ensure everyone can climb the ladder of opportunity.

The AFT maintains its strong commitment to children's health. Our resolve weaves through our work: growing community schools, improving access to school nurses and health professionals, retrofitting school buildings and promoting green cleaning, serving school meals high in nutrition, and reducing child labor and trafficking. Recognizing the relationship between health and learning, AFT Secretary-Treasurer Lorretta Johnson recently called for a new program focused on children's health, safety and well-being. To inform the focus of this program, a survey was sent out to AFT members and leaders nationwide in November 2014. The survey responses determined our program's priorities, as set forth in this report.



HELPING CHILDREN
THRIVE
INTRODUCTION

CHILD HEALTH SURVEY

Survey respondents work with some of America's most vulnerable children.

9 in 10

work with a significant number of low-income students.

3 in 4

work with significant numbers of children of color.

2 in 5

work with 1st- or 2nd-generation immigrants.

2 in 3

work with students who receive special education services.

More than
1 in 10

work with significant numbers of children with disabilities.

A total of 455 respondents, represented by 116 AFT locals across 20 states, responded to the survey. Nearly 60 percent are teachers; 25 percent are PSRPs, including school health professionals; and about 15 percent are AFT leaders and staff who do not work in a classroom setting. Based on the results of the survey, respondents' top three concerns in regard to children's health are students' mental health, healthcare access and food security.*

Though public schools are well-poised to address children's health, few AFT members report satisfaction with their schools' efforts. About 1 in 3 disagrees or strongly disagrees that "My school has adequate and appropriate policies, programs and services for the health and well-being of students." Respondents are most likely to report satisfaction with policies and programs related to violence (including bullying), injury prevention and treatment, and illness. Poor staffing is part of the problem; schools need more full-time staff and safe staffing ratios, especially when it comes to positions that address mental health. Another piece of the puzzle is related to training. More than 1 in 5 report being uncertain or very uncertain in their ability to handle children's health issues. Low levels of self-efficacy are likely linked to the fact that less than 1 in 5 receive training on children's health more than once per year.

* Survey participants were asked to rank their top children's health priorities. Here are the full results (in order of importance): Mental health, access to care, food security, sleep and rest, disability, chronic conditions other than asthma, asthma, illness, violence, dental and oral health, physical activity, drugs, environmental health, injury and sexual health.

Survey respondents revealed three overarching themes—staffing and funding, accountability and healthcare coordination—that are relevant to dialogue about school health programs.

There seem to be as many school health models as student needs to address. Some schools partner with pediatric hospitals, while others work with community organizations, insurance providers or county health departments. Students may see nurse practitioners in school health centers, dental hygienists in mobile clinics, social workers in an office or occupational therapists in pull-out sessions.

With this many options, neither the health nor the education sector has clearly articulated best practices in **staffing and funding** school health. Survey respondents' comments reflect many perspectives, generally divided into two groups. "Scholars" highlight the workload required to ensure academic progress. They are comfortable relying on trained school health professionals and generally call for improved staffing. "Community schools advocates" call for more training to identify students' needs and make referrals for coherent services. To be clear, they do not call for reduced staffing of school health personnel but are willing to accept more responsibilities—with more support.

Respondents further diverge on **accountability**. "Scholars" prefer to place responsibility for students' sociocultural challenges with health and social service agencies and families. "Community schools advocates" see work on academic progress as competing with—and losing to—students' other needs. They describe innovative school-based supports to promote students' well-being.

Educators' perspectives are informed by experiences with punitive systems that rely on flawed evaluation frameworks, flawed instruments and flawed timelines to measure student progress. Given the emphasis on high-stakes testing, it's heartening that most AFT members are willing to be responsible for nontested and nonacademic outcomes.

Many survey respondents take on **healthcare coordination**. Often instructional staff rather than school health professionals, these impromptu "care coordinators" are dissatisfied with how they are incorporated (or not) into larger care management teams. A lack of communication and training pose challenges to effective care coordination.



MENTAL
HEALTH

PRIORITY 1



HELPING CHILDREN
THRIVE
PRIORITY 1:
MENTAL HEALTH

Many respondents feel uncertain in their abilities to handle “student behaviors that appear out of control and stem from what I assume may be mental illness.”

PRIORITY 1: MENTAL HEALTH

Mental illnesses such as anxiety, oppositional defiance, attention deficit hyperactivity disorder, depression and grief affect more children than physical health issues, but schools are poorly staffed to address these needs. For example, for every student who receives special education services for severe emotional disturbance, there are up to 10 more who need these services but do not receive them. Without adequate care coordination, kids with mental health disorders are more likely to drop out of school, use and abuse illicit substances, and engage in risky and self-injurious behaviors.¹

Respondents are not satisfied with current staffing levels of mental health practitioners: less than 1 in 5 report that their schools’ policies and programs adequately and appropriately address students’ mental health needs. This dissatisfaction is linked to a widespread perception that children’s mental health issues are both more prevalent and more severe than in the past. Many respondents feel uncertain in their abilities to handle “student behaviors that appear out of control and stem from what I assume may be mental illness,” in the words of one teacher and coach for grades 3-5 in St. Paul, Minn. Beyond safe and responsive staffing, many respondents seek skills training to better understand how to handle students’ mental health needs and their impact on behavior.

Program and policy levers

As part of the Coalition to Support Grieving Students, a group of education-based organizations that helps school employees support bereaved kids, the AFT will develop educators’ capacity to handle children’s bereavement. The AFT has promoted the collection of self-education materials at GrievingStudents.org through Share My Lesson, division-specific newsletters, social media and AFT.org. Additionally, the Children’s HSW program will offer workshops in basic children’s grief concepts and a training-of-the-trainer session at the 2015 AFT TEACH conference.

With expertise in occupational health and safety, members of the AFT’s health, safety and well-being department are well-positioned to develop and implement programs that dually promote both worker and student wellness. And the department will strengthen relationships with research-based programs and partners, such as CARE and Mindful Schools, that better equip AFT members to manage their stress related to children’s needs.

¹Nguyen, T. (2014). Parity or Disparity: The State of Mental Health in America 2015. Alexandria, VA: Mental Health America.



EQUITABLE ACCESS TO
CARE

PRIORITY 2



Good health lays the foundation for school attendance and sustained academic success, yet many children lack access to high-quality healthcare in schools.

PRIORITY 2: EQUITABLE ACCESS TO CARE

A record high 92.9 percent of children have health insurance, and nearly all children have a usual place of care.² Still, too many children do not actually see healthcare professionals, and too many visit the emergency room with severe needs. Good health lays the foundation for school attendance and sustained academic success, yet many children lack access to high-quality healthcare in schools.

Survey respondents see dysfunctional family relationships and/or resource-poor home environments as the primary cause of students' struggles at school. As a result, they stress the value of *whole-family* approaches, especially for mental health, that make sure both children and parents receive appropriate services. More than half of the respondents wish to expand the role of full-time, trained staff to address children's diverse, complex and chronic health needs.

Program and policy levers

In December 2014, in response to the AFT's call, the Centers for Medicare and Medicaid Services changed its interpretation of the Social Security Act's "free care rule." Established in 1997, the rule required schools to investigate *each* student's health insurance status before billing Medicaid for health services provided to kids in the program. The rule made it very challenging to finance any health services at school except those outlined in an Individualized Education Plan.

The rule change removes a key barrier to the equitable funding and provision of school health services. But there is more work to be done. The Children's HSW program is at the forefront of a national effort to raise awareness of this small but impactful policy change through presentations to AFT staff and leadership, a summer 2015 webinar and continued engagement of national stakeholders.

Another way to improve students' access to care is through community schools, which bring together the services and activities that our children and their families need. The Children's HSW program will strengthen the AFT's capacity to address children's health in community schools initiatives by providing technical assistance and facilitating local partnerships. Where we are developing and amending policy to promote and protect community schools, the program will also work closely with AFT national staff to ensure that we consistently and explicitly link this approach to its potential impact on children's health.

²Alker, J and Chester, A. (2014, November). Children's Coverage at a Crossroads: Progress Slows. Washington, DC: Georgetown University Health Policy Institute, Center for Children and Families.



FOOD
SECURITY

PRIORITY 3



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THRIVE
PRIORITY 3:
FOOD SECURITY

AFT members value nutrition education and support structures that ensure all children have regular, nutritious meals.

PRIORITY 3: FOOD SECURITY

Food insecurity plagues too many children. Research links poor nutrition and hunger to poorer physical health, impaired social skills and mental health issues. In school, food insecurity contributes to delayed mental proficiency, higher likelihood of repeating a grade, and slower math and reading progress.

While the Healthy, Hunger-Free Kids Act of 2010 took a bold step forward in the fight for children's nutrition and hunger, the nation must invest in 21st-century kitchen equipment as well as full-time positions and training for food service workers. In addition, survey respondents value nutrition education and access to healthful foods. AFT members also support structures that ensure all children have regular, nutritious meals, such as the U.S. Department of Agriculture's Community Eligibility Provision program, which allows high-poverty schools to offer school meals at no charge to all students.

Program and policy levers

The Children's HSW program has boosted the AFT's work on food security through strategic partnerships and targeted advocacy. For instance, the AFT's partnership with the Healthy Schools Campaign's nutrition education program Cooking Up Change will yield a cookbook to promote students' leadership in the nation's work on nutrition, highlight the valuable role of food service workers and other PSRPs in schools' wellness work, and champion rigorous nutrition standards for school meals. The Children's HSW program has also developed new partners, such as the National Farm to School Network and Action for Healthy Kids, to improve members' access to technical assistance for innovative programs.

Moreover, the AFT will promote its platform for food security in Rep. Robin Kelly's (D-Ill.) *2015 Kelly Report*, thanks to a successful presentation to the Congressional Black Caucus' Health Braintrust. And AFT President Randi Weingarten submitted comments to the USDA explaining members' ideas to improve participation in school meal programs and end stigmatizing "alternate meal" and "no feed" policies that apply when children overdraw their school meal accounts.



HELPING CHILDREN THRIVE

INTRODUCTION / SURVEY / CONTEXT / PRIORITIES / STRUCTURES / THEMES / LEVERS

● Introduction

BACKGROUND

Children's health, safety and well-being are explicit in the core values of the American Federation of Teachers: fairness; democracy; economic opportunity; and high-quality public education, healthcare and public services for our students, their families and our communities. Kids' ability to thrive is linked to union work to amplify the voices of America's workforce and fight the inequitable consequences of poverty. In the words of an AFT high school educator from Costa Mesa, Calif., "Our underprivileged children grow up with parents who need two or three jobs to pay the bills. Our families need good jobs so they have time to help create the safe and secure neighborhoods that children deserve."

Throughout its history, the AFT has maintained strong commitments to children's health:

- The AFT promotes the community schools model. With a structured approach to engage local stakeholders and partners, we design schools for kids' success and make sure that we have "Health in Mind" in ongoing dialogue about both the whole child and school improvement.
- The AFT values the important work of school health professionals. For example, a 2010 resolution, "Recognition of National Board Certification for School Nurses and Other School Health Professionals," supports parity in compensation among employees who achieve professional mastery. The union routinely supports legislation for safe staffing ratios among school nurses. Finally, the Albert Shanker Institute has funded pilot research on indicators that quantify school nurses' impact. The project encourages standardized data collection.
- The AFT is resolved to address asthma rates, school safety and environmental health through green building and green cleaning. For example, the AFT's "Building Minds, Minding Buildings" campaign outlined how members and union leaders could improve indoor air quality through changes to state legislation, school infrastructure investment and personal behavior change.
- The union champions best practices in school meal and snack programs. The AFT advocates for rigorous nutrition standards, such as those introduced in the Healthy, Hunger-Free Kids Act of 2010, innovative breakfast programs, and investment in federal programs and staffing to best support families' and schools' efforts to give kids all they need to thrive.
- The union combats child exploitation at home and abroad. The AFT partners with others in the labor movement—from the Solidarity Center to Education International and other countries' teachers unions—in the fight against both child labor and child sex trafficking.

NEW PROGRAM

To enhance and coordinate this work, AFT Secretary-Treasurer Lorretta Johnson advocated for the development of a program focused on children's health and wellness. As a result, the AFT's health and safety department expanded to become the health, safety and well-being department. Members and leaders across the country had an opportunity to complete a survey to inform the focus of the new program. Their responses structure this report, along with national research on children's health.

● Survey

SURVEY DISSEMINATION

To introduce and disseminate the survey on members' and leaders' priorities in children's health, the AFT's health, safety and well-being department relied on existing AFT networks, including:

- Members of the AFT Teachers program and policy council;
- Members of the AFT PSRP (Paraprofessionals and Support-Related Personnel) program and policy council;
- AFT state educational issues coordinators; and
- Communications directors in select state affiliates where membership includes high concentrations of school-based health professionals.

In states with the most respondents, a social media and Web-based strategy was used, including providing a link to the survey on state affiliate websites. Affiliate presidents who championed the survey among their members were especially helpful.

RESPONDENTS

A total of 455 members, leaders and affiliate staff, represented by 116 different AFT locals across 20 states, responded to the survey, with the majority of responses from California, Connecticut, Illinois, New York and Rhode Island. Members from the Providence (R.I.) Teachers Union, AFT Local 604 (Ill.), the Rochester (N.Y.) Association of Paraprofessionals and the Valhalla (N.Y.) Teachers Association lent a tremendous voice. Of those who provided a professional title:

- 58.8 percent self-identify as "teacher," "instructor" or "educator";
- 25.1 percent are PSRPs, including school health professionals (counselors, health assistants, nurses, occupational therapists, psychologists, social workers, speech and language pathologists, audiologists and pharmacists), paraeducators, parent liaisons and library media specialists;
- 15.2 percent are local leaders and AFT staff who do not work in a classroom setting; and
- 0.8 percent are professors in child development, health and physical education, or nursing.

The full instrument is available in Appendix A.

● Children’s context matters

CHILD POVERTY

Research consistently shows that for generations, while the middle class has been shrinking, the “American precariat”—a class of people struggling to maintain a dignified standard of living—has swelled.¹ More recently, the slow recovery following the Great Recession has been linked to growing wealth for families “at the very top of the income distribution,” while “median income fell 5 percent.”² The stark increase of children living in poverty means that today low-income students comprise the majority of students in America’s public schools.^{3, 4, 5} Furthermore, research shows that 1 in 3 children lives in a family spending an unsustainable 30 percent or more of its income on housing—leading to high mobility, which disrupts relationships with healthcare providers, school personnel and social service agencies. The stressors of surviving in the new American precariat put these kids at a greater risk for abuse and neglect.⁶

The generation of children emerging from the Great Recession faces an elevated risk of health problems. The poorest are the most vulnerable. Compared with children whose family incomes are 400 percent or more of the federal poverty line, impoverished kids struggle with higher rates of:

- Adverse childhood experiences;
- Asthma;
- Living with two or more chronic health conditions;
- Mental illness, including behavioral and conduct problems, depression, developmental delay and learning disabilities;
- Missing at least 11 school days per year;
- Oral and dental health problems;
- Overweight and obesity;
- Repeating a grade; and
- Special education needs.⁷

Many AFT members serve poor families; 90.3 percent of survey respondents report that a significant proportion of their students is from a low-income family.

RACE AND ETHNICITY

The 2010 census reveals that a growing proportion of the nation identifies as “of Hispanic origin” and as people of color. AFT members see this national demographic shift: 3 in 4 survey respondents work with significant numbers of children of color. However, structures and systems that form the “social determinants of equity” have not significantly shifted, and our students still experience gross disparities in health outcomes by race and ethnicity, including when it comes to:

- Access to safe recreational facilities to engage in physical activity;
- Asthmatic episodes and asthma control methods;
- Exposure to aggression and violence;
- Indicators of nutrition and hunger;
- Teen pregnancy and the use of safer sex practices; and
- Visual impairment.^{8, 9, 10}

FIRST-GENERATION IMMIGRANTS AND THE CHILDREN OF IMMIGRANTS

About 2 in 5 survey respondents work with significant proportions of first- or second-generation immigrants. Research on the health of immigrant adults links social isolation and acculturation to increased rates of mental illness, especially when migrants lose a social support system.¹¹ There is also evidence that children emigrating from low-income countries face a higher risk for mental illness.¹²

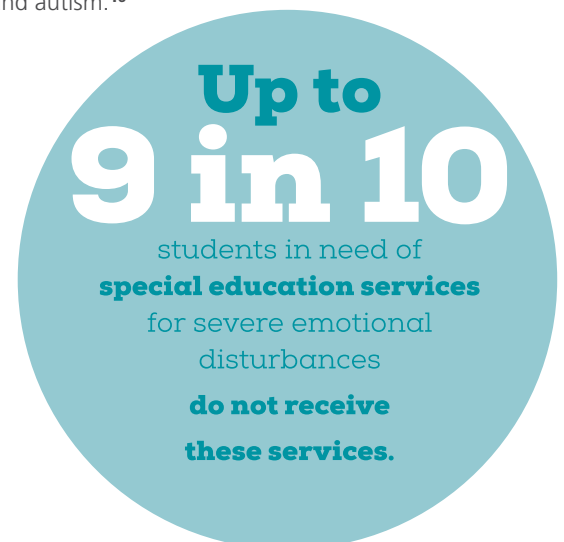
A vulnerable subset of these students, “unaccompanied refugee minors,” are often exposed to trauma such as gang violence, kidnapping, sexual exploitation, robbery, torture, neglect and physical assault. Many go on to struggle with substance abuse, mental illness, suicidal symptoms and attachment problems. For instance, they may demonstrate symptoms of “anxiety, flashbacks, self-injurious behaviors, emotional dysregulation, aggression, [and] behavioral or emotional issues.”¹³

CHILDREN WITH SPECIAL EDUCATION NEEDS

About 7 percent of American children receive special education or early intervention services.¹⁴ Two in 3 survey respondents report that they work with these students, who are highly likely to need immense support for mental health issues, including externalized behaviors of aggression and delinquency.¹⁵

CHILDREN WITH DISABILITIES

Just over 1 in 10 survey respondents work with a significant proportion of children with disabilities, which may include intellectual disabilities, cerebral palsy, autism, seizures, stuttering or stammering, moderate to profound hearing loss, blindness, learning disorders and/or other developmental delays. Children with intellectual disabilities are burdened with higher rates of chronic health conditions, including epilepsy, cerebral palsy, anxiety disorders, oppositional defiant disorder, Down syndrome and autism.¹⁶



MEMBER VOICES

On children's mental health

Respondents emphasize mental health as an immediate and substantive challenge. From questions on self-efficacy to training and staffing, survey respondents repeatedly stress their concerns for students' mental health, as well as their social-emotional well-being and safety.

More than 80 percent of respondents report that their school staff includes at least one mental health practitioner, but they are not satisfied with these staffing levels. Less than 1 in 5 report that their schools' policies and programs adequately and appropriately address students' mental health. This dissatisfaction is linked to a widespread perception that children's mental health issues are both more prevalent and more severe than in the past.

Many respondents feel "uncertain" in their abilities to handle "student behaviors that appear out of

control and stem from what I assume may be mental illness," in the words of one teacher and coach for grades 3-5 in St. Paul, Minn. Many respondents seek to better understand how to handle students' mental health needs and their impact on behavior. Many would like more skills training, such as a second-grade teacher from West Haven, Conn., who asks for "strategies to help children with behavioral/emotional challenges in addition to how to minimize the impact that this type of student has on the rest of the classroom so that their learning is not impaired." Others want to dramatically change their capacity.

Most respondents wish for better staffing to address growing needs. Without appropriate staffing, members' working (and students' learning) conditions are hazardous.

"Behavioral concerns, mental health concerns, accessibility to mental health treatment for children and families."

— SCHOOL SOCIAL WORKER, GRADES K-5, PROVIDENCE, R.I. ●

"Poverty. Many dysfunctional families and mentally/emotionally ill children who don't get the outside help they need. The mental health system in this state is too complicated and limited."

— EDUCATOR, GRADES K-5, PAWTUCKET, R.I. ●

"Mental health issues continue to rise in younger and younger children, including early childhood."

— READING RECOVERY TEACHER, GRADE 1, CHAMPAIGN, ILL. ●

"Severe mental health issues are alarmingly increasing by leaps and bounds!!!!"

— TEACHER, GRADE 2, PROVIDENCE, R.I. ●

"Certification to be: social worker or school psychologist. I have a degree in psychology and secondary ed. This is the area where we need more support!"

— SOCIAL STUDIES TEACHER, GRADE 7, CRANSTON, R.I. ●

"I have several students who struggle with mental/emotional health, as well as some who face hunger on a daily basis. While things like asthma and allergies are also present in my students, they do not have as large of an impact on them as those previously stated."

— TEACHER, GRADE 4, MORGAN HILL, CALIF. ●

"Lack of adequate experienced staff, lack of leadership with health background, administrative ineptitude, especially with regard to mental health and emergency response."

— SCHOOL NURSE, ALL GRADES, WATSONVILLE, CALIF. ●

"Kids that display physical aggression towards others, that display unsafe behavior such as hitting the teacher, throwing objects like chairs, tipping over desks. We only have a part-time social worker and psychologist, and these kids are not getting the support they need to succeed."

— TEACHER, GRADE 1, PROVIDENCE, R.I. ●

"Last year, many students suffered mental health issues to the point where they should have had counseling on a daily basis. Some students were dangerous to have in the classroom."

— HIGH SCHOOL SPANISH TEACHER, PROVIDENCE, R.I. ●



● Members' priorities in children's health, safety and well-being

Each survey respondent ranked the 15 different elements of children's health listed in Figure 1 (right) based on how much they impact students' academic success and general well-being. These rankings, together with respondents' comments, reveal a clear consensus about members' top priorities in children's health.

PRIORITY 1: MENTAL HEALTH

Lifetime mental disorders usually emerge in childhood or adolescence. Half of all adolescents exhibit symptoms of a mental disorder, and about 1 in 5 needs care for a severe mental disorder.¹⁷

- Anxiety disorders, such as posttraumatic stress disorder, panic disorder and social phobia, are most common, affecting nearly 1 in 3 adolescents.
- About 1 in 10 adolescents lives with oppositional defiance disorder or conduct disorder.
- Attention deficit hyperactivity disorder affects 8.7 percent of adolescents.

Furthermore, 40 percent of adolescents with one mental disorder exhibit symptoms of a second.¹⁷ Other mental health issues, such as grief and some forms of depression, are relatively acute, rather than lifetime problems:

- 2.1 million adolescents had at least one major depressive episode in the past year.
- 8.5 percent of children have an emotional, behavioral or developmental issue.¹⁸
- Before age 18, more than 90 percent of children experience the loss of a close loved one.

Without adequate care coordination, kids with mental health disorders are more likely to drop out of school, use and abuse illicit substances, and engage in risky and self-injurious behavior.¹⁸ Unfortunately, 2 in 5 children who need mental health treatment do not receive it. And for every student who receives special education services for severe emotional disturbance, there are up to 10 more who need these services but do not receive them.¹⁸ The National Association of School Psychologists estimates that one school psychologist is available for every 1,653 students. Though few students receive counseling or therapy beyond school, only half of states mandate school counseling services for all grades.^{19, 20} So, though children face a higher lifetime prevalence of mental disorders than physical conditions, many schools are poorly staffed to address severe emotional and behavior disorder.¹⁷

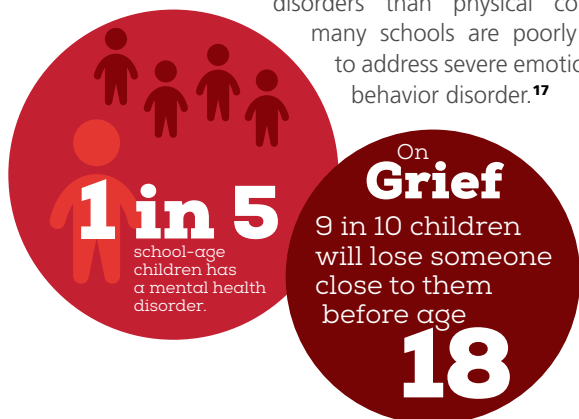


FIGURE 1

Elements of children's health referenced on the survey

In order of survey participants' priorities

Mental health and emotional/behavioral conditions: such as ADHD, aggression, anxiety, autism, defiance, depression and grief

Access to care: such as issues with health insurance, distance from and number of nearby providers, language and transportation

Food security: hunger and/or nutrition

Sleep and rest

Disability (physical, intellectual and learning): such as Down syndrome, dyslexia, epilepsy, impaired hearing and spina bifida

Chronic conditions (other than asthma): such as allergy, anemia and diabetes

Asthma

Illness: such as common cold, headache, influenza, infection, stomachache and vaccinations

Violence: such as bullying, fighting and other violence in the school or larger community

Dental and oral health: such as cavities, caries, mouth pain and tooth loss

Physical activity, active play and sports

Drugs: use and/or abuse of substances such as alcohol, illicit drugs, prescription medications and tobacco products

Environmental and chemical exposure: such as air pollution (industrial waste, secondhand cigarette smoke, vehicle exhaust), lead, light, noise, pesticides/herbicides, poisons and radiation

Injury: such as backpack weight, bone break or fracture, bruise, burn, concussion, cut, scrape and sprain

Sexual health: such as active consent, gender identity, HIV/AIDs, parenthood, partner violence, pregnancy, sexuality and sexually transmitted infections

MEMBER VOICES

On children's healthcare

Survey respondents see dysfunctional family relationships and/or resource-poor home environments as the primary cause of students' struggles at school. As a result, they stress the value of whole-family approaches, especially for mental health, that make sure both children and parents receive appropriate services.

More than half of the respondents would like to see expanded support roles for students' mental health. For example, a school nurse in Watsonville, Calif., wishes to expand the role of a "prevention specialist for both mental and physical health."

Survey respondents also emphasize the importance of full-time, trained staff to address children's diverse, complex and chronic health needs.

Full-time positions, while a promising indicator of a school's commitment to children's health, are not sufficient.

Safe staffing levels are imperative, as well. For example, a high school nurse in Houston is her school's sole health professional, even though her school has more than 2,600 students. In the absence of safe staffing from a broad array of school health professionals, including counselors, social workers, psychologists and behavioral therapists, schools risk creating roles for professionals who are "too overtaxed to support effectively," in the words of a math teacher for grades 8-9 in Providence, R.I.

"Social services to educate/support family outside of school are needed."

— OCCUPATIONAL THERAPIST, GRADES K-12, FORT EDWARD, N.Y. 

"Specialized staff to teach students conflict resolution skills, especially in high crime neighborhoods. Also as support to teachers and "cushion" before security is needed."

— TEACHER, GRADES K-8, CHICAGO 

"We only have one social worker, one psychologist—we need more!"

— TEACHER, GRADES K-1, PROVIDENCE, R.I. 

"Full-time social worker AND full-time counselor."

— SPECIAL EDUCATION TEACHER, GRADES PREK-5, HOUSTON 

"More social-emotional support staff and a full-time psychologist."

— TEACHER, GRADES 6-8, PROVIDENCE, R.I. 

"My school would significantly benefit from an increase in the number of mental health professionals."

— TEACHER, GRADES 1-3, BROOKLYN, N.Y. 

"School nurse that is in attendance every day instead of just one day a week."

— TEACHER, GRADE 5, CHICAGO 

PRIORITY 2: EQUITABLE ACCESS TO HEALTHCARE

Thanks to the Affordable Care Act, as well as child-friendly programs like Medicaid and the Children's Health Insurance Program, a record high 92.9 percent of children have health insurance and nearly all children have a usual place of care for physical health.²¹ Still, research shows that:

- 2.6 percent of children have not seen a care professional for more than two years;¹⁴
- 6.7 percent of children receive delayed or no medical care despite need;²² and
- More than 12 percent of children visit the emergency room each year.¹⁴

Good health lays the foundation for school attendance and sustained academic success. Yet many children lack access to high-quality healthcare in schools. The National Association of School Nurses reports that just 45 percent of the nation's schools are staffed with a full-time nurse every day, while another 30 percent have a school nurse "who works part time in one or more schools." About 1 in 5 school districts nationwide has at least one school-based health center (SBHC).²³ However, the School-Based Health Alliance has data for just 1,931 SBHCs in 2011, representing density in less than 2 percent of public schools.^{24, 25}

Impact of school nurses

Health and education are mutually reinforcing. Though studies demonstrate that staffing school nurses improves health outcomes while achieving cost savings for schools and districts, too often members' jobs—and children's health—are at risk due to a lack of clear data.

The Albert Shanker Institute funded a groundbreaking pilot study in 2014, "The Feasibility of Collecting School Nurse Data," to demonstrate the feasibility of using regular data collection to quantify the impact of school nursing. For the pilot study, school nurses collected four data points for five days to develop an impressive snapshot of their daily work:

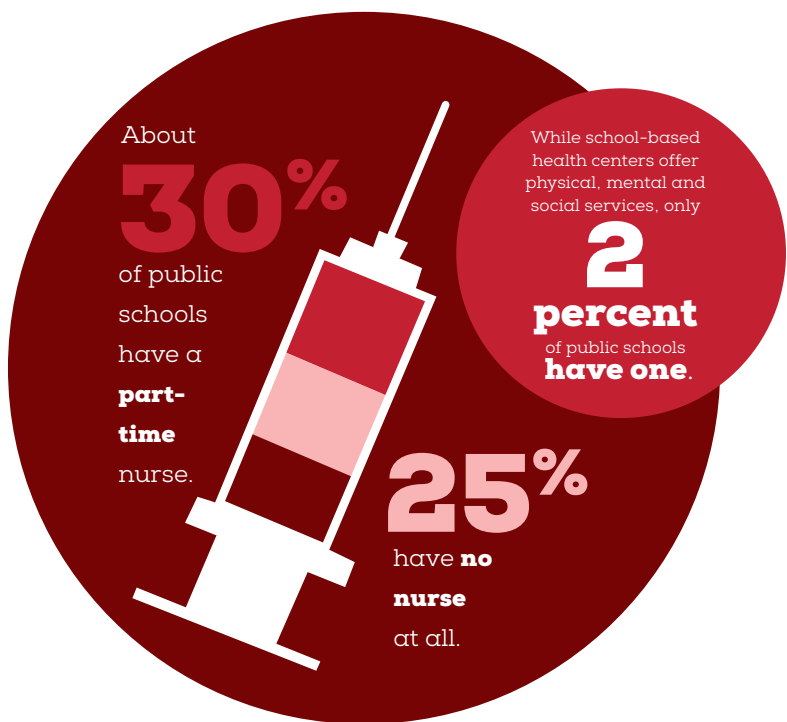
- One school nurse sees an average of 43.5 students each day for health issues, such as pertussis (whooping cough) outbreaks, allergies and head injuries.
- One school nurse administers an average of 14 medications per day, including psychotropics for serious mental health disorders.
- School nurses return a large majority of the students they see to class. During the five days, about 1 in 1,000 students was sent to an outside healthcare provider, such as a hospital, emergency room or primary care provider.
- To coordinate care and follow-up, a school nurse communicates with an average of eight parents, eight school personnel and one health provider each day. Some report spending as much as an hour with individual families to address anxiety and special healthcare needs.

Respondents embraced the opportunity to report additional information about their efforts:

- School nurses also participate in meetings about Individualized Education Plans, prepare educators for field trips that include students with special health needs, and use special procedures, such as catheterization, tube feeding and tracheostomy care.
- Nearly 1 in 3 respondents report that in their absence, their school lacks a nurse or person with training in healthcare to serve children.

The study validated members by providing a structure to numerically account for their daily work. Participants expressed satisfaction at having a record of their own accomplishments:

- "Loved doing this. I like looking back at what I actually did during the day."
- "Glad to participate. Interesting to see #'s, for ourselves as well! Important to define and quantify what we do; thank you for these efforts. Will be glad to participate in future projects!"



PRIORITY 3: FOOD SECURITY

Food insecurity is defined as “limited or uncertain availability of nutritionally adequate and safe foods,” while hunger is “the uneasy or painful sensation caused by a lack of food” and “the recurrent and involuntary lack of access to food.”²⁶ About 40 percent of poor children’s families struggle with food insecurity and/or hunger, on top of issues with disease and illness, injury and physical trauma, inadequate or nonexistent healthcare, exposure to environmental toxins, exposure to and/or victimization by violence, chronic illness and familial stress.²⁶ Moreover, many indicators suggest that children are increasingly consuming food and beverages of poor quality. For example, research shows that:

- At least 1 in 5 children was food insecure in 2011.²⁷
- Children did not meet the Healthy People 2020 target of 1.1 cups per 1,000 calories of fruits and vegetables between 2003 and 2010.²⁸
- Sodas were the biggest source of calories among 14- to 18-year-olds in 2005-06.²⁹

Food insecurity and hunger are linked to poorer physical health, such as:

- Lower bone mineral content;
- Iron deficiency anemia;
- More frequent illnesses;
- Higher hospitalization rates; and
- Higher numbers of chronic health conditions.

Impaired social skills, such as:

- Impaired development of self-control;
- Behavioral problems;
- Poor psychosocial development; and
- Insecure relational attachment.

Mental health issues, such as:

- Higher rates of depressive disorder and suicidal symptoms;
- More anxiety; and
- Internalized anxiety.²⁷

In school, food security and hunger manifest as less advanced mental proficiency, higher likelihood of repeating a grade, and slower math and reading progress. With the Healthy, Hunger-Free Kids Act of 2010, Congress took a bold step forward, using dietary guidelines developed by the Institute of Medicine to restructure expectations for the nutritional content of foods served in schools. However, the Act did not couple the mandate to improve meal quality with a significant boost in reimbursements to schools for each meal served. To reach ambitious goals in children’s nutrition and hunger, the nation needs to invest in 21st-century kitchen equipment, full-time positions and training for food service workers, and procurement processes that make sure fresh, local foods are just as easy to get to cafeteria trays as frozen, boxed options.

“Cheese sandwich” policies

School meal programs do not operate with only children’s health in mind but also consider financial solvency. “Cheese sandwich” policies, also called “unpaid balance” and “alternate meal” policies, are implemented when these competing priorities collide. These policies apply when a student has surpassed some threshold, such as five unpaid meals or a negative balance of \$12. When that happens, the child must forgo the school’s hot, nutritious lunch and instead receive an alternate meal, such as a cheese or peanut butter sandwich and milk. They even may be asked to return a hot meal that has already been set on their tray, ready to be eaten. The child may be given a sticker to wear or a letter to take home as a reminder for adults to pay up. Parents or

MEMBER VOICES

On children’s food security

Though ranked as their third priority, few survey respondents added open comments on nutrition and hunger issues. Commenters equally value nutrition education and access to healthful foods.

“Whole, organic, real food is an absolute imperative to children’s health, and most children eat processed crap, which affects their overall health and growing brains! I believe if children were fed real food, test scores, mental health, chronic illnesses and overall well-being would be improved and/or eliminated!”

— HEALTH ASSISTANT, GRADES PREK-5, PORTLAND, ORE. ●

“Students need to learn about healthy eating— what it looks like, why it’s important.”

— TEACHER, GRADES 9-12, NEW YORK CITY ●

HELPING CHILDREN
THRIVE
MEMBER
VOICES

guardians may be called, texted or emailed about adding to their account balance.

In fall 2014, the AFT conducted a survey of members on the effects of cheese sandwich policies on children's health. 39 percent of respondents report that these policies are implemented at students' expense:

- Nearly 1 in 3 report seeing children go hungry. A high school teacher's aide in West Virginia commented that in her school, "Some students don't eat due to the lunch bill."
- More than 1 in 4 have witnessed children stigmatized and marginalized. Said one Florida middle school teacher, "Students with a negative balance may not participate in some school functions and field trips."
- More than 1 in 10 have seen an alternate meal policy negatively affect a child's academic, cognitive and/or athletic performance.

Furthermore, members explain that implementing alternate meal policies stresses important relationships. For example, in one school, "It falls to students' homeroom teachers to collect money from families to cover the charge. [The responsibility of collecting money] severely challenges the relationship between teacher and family, and has led to families no longer answering the phone when school calls, most often for outstanding balances less than \$5."

Many AFT members take it upon themselves to ensure a child receives a good meal or a family is spared embarrassment: "Truth be told, there are a few of us who make sure the students don't go without lunch," said a former chef and cafeteria manager from West Virginia. "We pay their bill."

Respondents also champion structures that ensure all children have regular, nutritious meals, such as the U.S. Department of Agriculture's Community Eligibility Provision

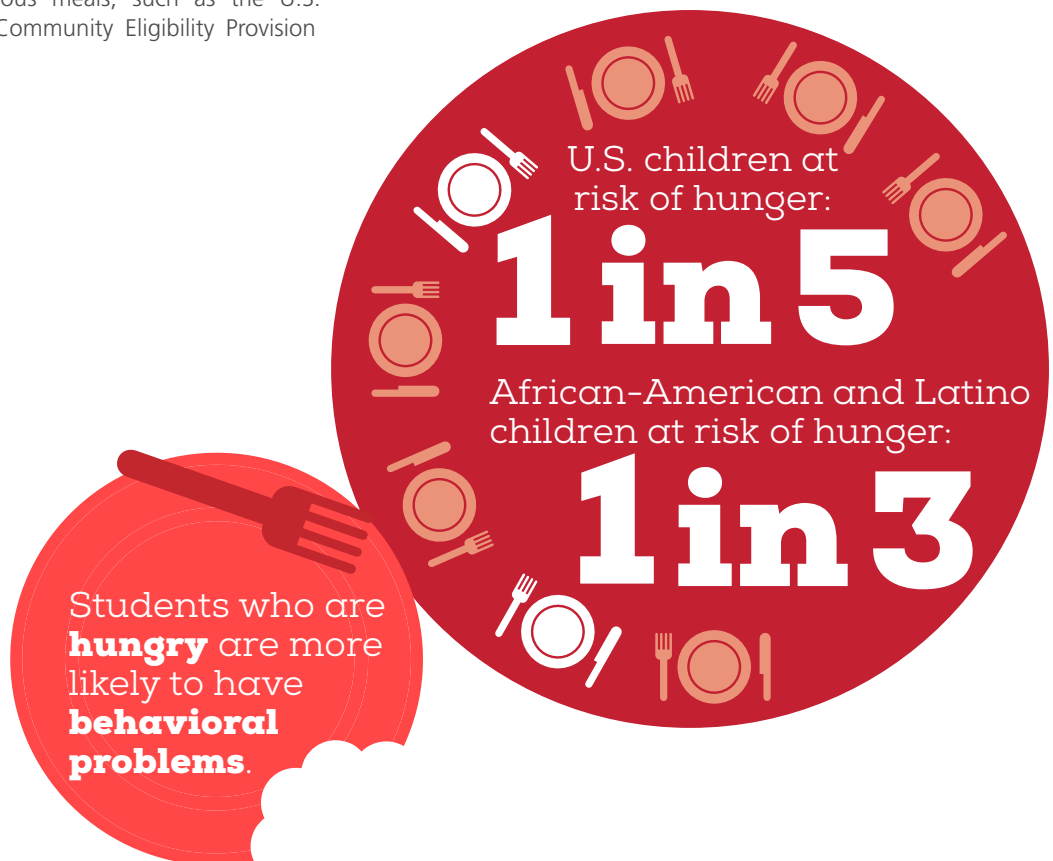
program, which allows high-poverty schools to offer school meals at no charge to all students while eliminating the traditional application process.

"Truth be told, there are a few of us who make sure the students don't go without lunch. We pay their bill."

— FORMER CHEF AND CAFETERIA MANAGER, WEST VIRGINIA

In schools and districts that continue to use alternate meal policies, respondents support efforts to:

- Clearly communicate the policy before the school year, such as in student handbooks.
- Develop protocols to ensure that eligible families receive applications for free and reduced-price meals.
- Directly enroll eligible children by data sharing with the Supplemental Nutrition Assistance Program (formerly food stamps) and other programs.



● Existing school health structures

SCHOOL CAPACITY

Survey respondents indicated the extent to which they agree with the statement, “My school has adequate and appropriate policies, programs and services for the health and well-being of students.”

- Just 3.1 percent of respondents strongly agree.
- About 1 in 3 agrees. However, the same proportion disagrees or strongly disagrees.
- About 1 in 4 neither agrees nor disagrees.

Using the same 15 elements of children’s health as they did to rank their top priorities (see Figure 1), survey respondents could indicate up to three specific areas in which their schools’ policies and programs are adequate and appropriate. About 1 in 3 respondents report satisfaction with their schools’ work on one of the following:

- Violence, including bullying;
- Injury prevention and treatment; or
- Illness.

Conversely, less than 5 percent of respondents chose any of the following areas as something their schools handle well: sleep and rest, environmental health and sexual health.

Respondents also identified school health roles currently filled on their faculty and staff:

- 93.2 percent of respondents report that a school nurse works on campus.
- 85.6 percent report that their students have access to mental health professionals.
- 81.4 percent report that their school staff includes a speech pathologist and/or audiologist.

Less than half of survey respondents work with a health teacher. It is possible that school nurses offer health education in their absence. Indeed, three Rhode Island-based respondents report their professional title as both “school nurse” and “teacher.”

EDUCATORS’ CAPACITY

Respondents reported their confidence in their ability to handle children’s health problems. Among the findings:

- Less than 10 percent report being very confident.
- About 40 percent report being confident.
- More than 20 percent report being uncertain or very uncertain.

These low levels of self-efficacy are likely linked to the fact that less than 1 in 5 receive training on children’s health more than once per year.



One-fifth

of educators are uncertain in their ability to handle children’s health problems; few receive training in this area more than once a year.

● Core themes

The survey revealed three overarching themes—accountability, staffing and funding, and healthcare coordination—that are relevant to dialogue about excellent school health initiatives with members, schools, districts and other stakeholders.

ACCOUNTABILITY

“Accountability” has become a contentious, even “dirty,” word in education. Conversations about school health implicitly challenge traditionally scholarly institutions to expand their mission, accepting some level of responsibility for students’ health outcomes as well as cognitive and academic ones. Survey respondents generally diverge into two groups when thinking about how to best (and who is best to) address the needs of the whole child. Members in the first group, who we refer to as “Scholars,” stress the role of schools as academic institutions. Such institutions, they contend, are not well-equipped to facilitate students’ well-being—and do not need to be. They are generally uncomfortable with being held responsible for students’ sociocultural challenges, preferring

instead to place responsibilities with social service agencies, the health sector and families.

Members in the second group, who we refer to as “Community schools advocates,” see their work to advance students’ academic skills as competing with—and losing to—students’ other needs. They craft long lists of school-based supports that could promote students’ well-being, further enabling them to engage students instructionally.

Educators’ perspectives on accountability are inevitably informed by their experiences with increasingly punitive systems that rely on flawed evaluation frameworks, flawed instruments and flawed timelines to measure important concepts like “student progress” and “instructional impact.” In today’s high-stakes-testing-crazed world, it’s heartening that most AFT members are willing to take on responsibility in their school context for nontested and nonacademic outcomes. Successful school health models will build on educators’ alacrity without compromising their trust.

MEMBER VOICES

On accountability

Survey respondents generally diverge into two groups when thinking about how to best (and who is best to) address the needs of the whole child.

Scholars*

“We are losing our focus as educators, because some people in our industry feel we need to take over the majority of the parents’ jobs, instead of making those parents accountable.”

— TEACHER, GRADES K-12, WEST HAVEN, CONN. ●

*Who Are Our Survey Respondents?

Generally, members who answered our survey diverged into two groups when thinking about the best ways and the best people to address the needs of students: “Scholars” and “Community School Advocates.”

Scholars generally feel students’ nonacademic challenges are better addressed by social service agencies, the health sector and families.

Community Schools Advocates want to support students’ academic success with school-based programs that promote overall well-being.

Community Schools Advocates*

“First you need to change the way that schools are designed, built and directed. Teachers cannot raise standards in violent environments with students with severe emotional problems. School administrators expect teachers to “pass all of the students” but “raise standards” at the same time, but we are not supported in doing this. If we raise the standards, more students will struggle and that struggle must be supported. Students cannot learn without struggle, and they struggle with so many other problems already that academic struggle is not valued or pales in comparison to life problems. The students here have major problems. There are too many students in one school with so many problems. The students need to be split up into small communities with leadership and character development constantly attended to.”

— MATH TEACHER, GRADES 9-12, PROVIDENCE, R.I. ●



STAFFING AND FUNDING

Perhaps as a reflection of the varied responses to tension around accountability, there seem to be as many school health models as student needs to address. An era of tight budgets for both public health and public education has led to creative staffing models in an attempt to answer the question, “Who pays?” For example, school health staff may be employed directly by a school district or by partners, such as pediatric hospitals, community organizations, insurance providers or county health departments. Such diverse staffing models raise questions about responsibility for program oversight, employee management and the extent to which school health personnel are included in union efforts.

Care sites are varied, as well. Students may see nurse practitioners in school health centers, dental hygienists in mobile clinics, social workers in an office or occupational therapists in pull-out sessions. Furthermore, recent legislation has muddied the waters around some specific medical responsibilities, enabling some student medications, such as insulin and epinephrine, to be administered by support staff without clinical training. Such diversity in models highlights the challenges to ensure students have consistent, equitable access to appropriate care professionals.

Survey respondents’ comments on these issues are again divided into the two overarching groups. “Scholars” focus on their role as instructional experts and are satisfied with a minimal role in students’ health. They highlight the workload required to ensure students’ academic progress and are comfortable relying on trained professionals for students’ health needs. Generally, they call for improved staffing.

“Community school advocates” comprise a larger cohort of respondents. They call for more robust and more frequent training. As with “Scholars,” most of the educators in this group are not school health providers but instructional experts. They describe their role in children’s health as including:

- Identifying students’ needs;
- Referring students to appropriate school staff and community partners;
- Coordinating relevant care; and
- Following up to make sure student needs are being or have been adequately addressed.

“Community school advocates” want more than information; they seek to strengthen their skills to navigate the landscape of students’ communities and to best advocate for coherent services. Among other things, they seek support to:

MEMBER VOICES

On staffing and funding

Survey comments on these issues are again divided into the two overarching groups. Generally, both groups call for improved staffing.

Scholars*

“I would actually like a professional other than me to support the mental health of my students. I have never received training in this.”

— TEACHER, GRADES K-1, PROVIDENCE, R.I. ●

“I am hired to educate, not to diagnose or treat, nor document multiple times per day another indirect instructional need of the 35-120 students I may teach on a daily basis. Doing my job well with proper data-driven instruction and plans, response to intervention documentation, management and disciplinary duties, as well as behavioral anecdotes is enough.”

— TEACHER, GRADES K-8, CHICAGO ●

“I don’t think I need more training. I think we need more staff to help students with these issues.”

— TEACHER, GRADES K-5, PROVIDENCE, R.I. ●

Community Schools Advocates*

“I would like to receive more training on how to communicate health concerns to the families of our students, as well as information on agencies in our local community that can support students (hopefully for free or minimal cost) when health concerns arise. I would also like more supports in the schools to combat health concerns, as well as hopefully prevent them, more than anything.”

— TEACHER, GRADE 4, MORGAN HILL, CALIF. ●



- Address the intergenerational impact of poverty;
- Facilitate work with local partners and families related to parents' incarceration;
- Ensure students receive vision screenings and eyeglasses prescriptions; and
- Safely implement protocols in the absence of a healthcare professional.

For instance, one social worker for students in grades preK-4 in West Haven, Conn., calls for more training “on engaging families and accessing community supports.”

To be clear, “Community school advocates” do not call for reduced staffing of critical school health personnel. Yet they are distinct from “Scholars” because they express a willingness to accept more responsibilities—provided these come with more support. For “Community school advocates,” training takes place in the context of a community school, in response to the real-time needs of their current student population, in conjunction with families and in the presence of colleagues—so that all school stakeholders can support each other and maintain clear communication. They recognize that finding the time to conduct and attend such training sessions will be challenging. They also name “timeliness” as a concern, seeking access to trainings that best address the needs of their students as they happen or are identified.

HEALTHCARE COORDINATION

Respondents understand their students' lives beyond school, naming “rats in the home,” “unsafe environments to play” and “domestic violence” among the issues students face. With such an intimate appreciation for students' challenges, many survey respondents take on the responsibility of managing students' complex or chronic care needs, as well as problems that arise as a result of difficult family circumstances. Often instructional staff rather than school health professionals, these impromptu “care coordinators” are dissatisfied with how they are incorporated (or not) into students' larger care management teams.

Historically, health and education have functioned in distinct institutional silos. As more educators adopt the community schools mindset, they expect to be better included in wraparound care models and holistic teams. Communication is one challenge to effective follow-up. For example, several survey respondents express frustration at not receiving information about whether their students have received care or treatment after referral or school-based care.

Of respondents who added comments on training they would like to receive, more than 15 percent mentioned care coordination. They are especially interested in learning how to coordinate care that serves whole families, linking them to social services and health providers in the larger community.

However, school health initiatives must address more than effective communication channels or capacity. To include educators in students' healthcare coordination will necessitate critical discussions about redundancy in service delivery and student privacy in data-sharing agreements.

MEMBER VOICES

On healthcare coordination

Many survey respondents take on the responsibility of managing students' complex or chronic care needs, are dissatisfied with how they are incorporated into larger care management teams and call for training on coordinating student care.

“Three students in my grade needed to be hospitalized for mental health needs, mostly for depression, one a suicide attempt. One had to go in two different times. With only one counselor for 1,300 students, it is impossible to make sure when students return they are adjusting well to being back. The communication between the hospitals and the teachers is virtually zero. Therefore, unless the family is forthcoming, we have little to no information on how to help the child when they return. I often felt it is dangerous when teachers do not know the nature of the problem so we can give special attention and monitor the progress when they return. If we don't know what to watch for, we can't warn families of a possible problem.”

— TEACHER, GRADES 7-8, CHICAGO ●

“Creating a home-school connection and giving parents education on how to set their children up for success and provide appropriate services if necessary.”

— SPECIAL EDUCATION TEACHER, GRADE 8, FORESTDALE, R.I. ●

“How to work with families to ensure proper physical health and mental healthcare for children.”

— SPECIAL EDUCATION TEACHER, PRESCHOOL, PROVIDENCE, R.I. ●



● Policy and program levers

Both respondents' priorities and the three core themes above inform the AFT's Children's Health, Safety and Well-Being (HSW) program.

PRIORITY 1: MENTAL HEALTH

Coalition to Support Grieving Students

As part of the Coalition to Support Grieving Students, a coalition that helps school employees support bereaved kids, the AFT develops educators' capacity to handle an "everyday" mental health issue: children's bereavement. Self-education materials are available at GrievingStudents.com, and the project has been promoted through division-specific newsletters, through social media and on AFT.org.

Additionally, AFT conferences and events host workshops that review the materials and train members in basic children's grief concepts. Finally, a training-of-the-trainer session was held at the 2015 AFT TEACH conference. The new trainers learned how to develop local union capacity to address child grief, such as through the development of district policy, through training sessions for union members and colleagues, and/or by strengthening relationships to existing agencies and organizations that can support educators working with grieving students.

Whole-school mindfulness

Students' mental disorders and related behaviors are a large contributing factor to AFT members' workplace stress. With expertise in occupational health and safety, members of the AFT's health, safety and well-being department are well-positioned to develop and implement programs that dually promote both worker and student wellness.

The department strengthens relationships with research-based programs and partners that better equip AFT members to manage their stress related to children's needs. For example, CARE and Mindful Schools train educators to regularly practice mindfulness techniques, which have been shown to improve students' in-class behaviors, reduce workers' and students' stress, and improve relationships. The Children's HSW program is also interested in developing a national network of certified instructors in youth mental health first aid to support their colleagues and students in difficult times.

PRIORITY 2: EQUITABLE ACCESS TO CARE

"Free care rule" change

In December 2014, in response to the AFT's call, the Centers for Medicare and Medicaid Services changed its interpretation of the Social Security Act's "free care rule." Established in 1997, the rule required schools to investigate each student's health insurance status before billing Medicaid for health services provided to kids in the program. The rule made it very challenging to provide any health services except those outlined in an Individualized Education Plan.

The free care rule change removes a key barrier to the equitable funding and provision of school health services. But there is more work to be done. The Children's HSW program

is at the forefront of a national effort to coordinate the union's work around this small but impactful policy change. From the AFT's program and policy councils, to state affiliate leaders and interested locals, the program is raising awareness and facilitating capacity development.

Ultimately, the rule change will only be impactful if state and district policies are aligned with federal intent. As a result, the Children's HSW program works with AFT Executive Vice President Mary Cathryn Ricker and AFT national staff to provide assistance to reform district practices and amend state Medicaid plans. The program also continues to engage national leaders in school health policy, researchers in children's health, and essential implementation stakeholders to share and apply lessons learned.

Addressing the whole child with full-service community schools

The AFT's educational issues department provides technical assistance to local leaders and sites interested in adopting and enhancing their work in community schools, hosts ongoing dialogue with national stakeholders to share lessons learned and ensure that policy advocacy matches field experience, and identifies policy opportunities to promote and protect the work of community schools.

New community schools initiatives often select a particular issue area as the focus of burgeoning partnerships and collaborative efforts; these may include family engagement, after-school enrichment or housing. The Children's HSW program strengthens the AFT's capacity to address children's health in its community schools initiatives by developing messaging, providing technical assistance and facilitating local partnerships focused on children's health, safety and well-being.

The Children's HSW program also works closely with AFT national staff on policy advocacy and messaging. Where we are developing and amending policy to embrace and endorse community schools, the program ensures that we also consistently and explicitly link the model to its potential impact on children's health outcomes.

PRIORITY 3: FOOD SECURITY

Partnerships

The Children's HSW program has boosted the AFT's work on food security through strategic partnerships and targeted advocacy. For instance, the AFT has long supported the Healthy Schools Campaign's nutrition education program Cooking Up Change, which challenges high school students in culinary arts programs to learn how to apply their skills within the same constraints that food service workers face. For the first time, that partnership will develop a cookbook to promote students' leadership in the nation's work on nutrition, highlight the valuable role of food service workers and other PSRPs in schools' wellness work, and champion rigorous nutrition standards for school meals.

The Children's HSW program has also developed new partners, such as the National Farm to School Network. In 2014, an AFT holiday fundraising campaign featured the NFSN, generating thousands of dollars. Another new partner, Action for Healthy Kids, will soon be linked to more AFT affiliates, providing technical assistance on district wellness policies and school-based wellness committees to boost members' capacity to address nutrition and hunger.

Policy advocacy

The Children's HSW program is expanding the AFT's footprint in policy advocacy around children's hunger and nutrition. For instance, the Congressional Black Caucus' Health Braintrust on health equity heard a presentation on the AFT's investment priorities related to U.S. Department of Agriculture programs, such as the Community Eligibility Provision. As a result, CBC leader and U.S. Rep. Robin Kelly (D-Ill.) asked the AFT to submit a piece on federal approaches to equity in children's wellness for her *2015 Kelly Report*.

AFT President Randi Weingarten submitted comments to the USDA explaining members' ideas to improve participation in school meal programs and end stigmatizing "alternate meal" and "no feed" policies that apply when children overdraw their school meal accounts.

ADDITIONAL PROGRAM EFFORTS

Intersectoral dialogue

With membership in both sectors, the AFT is uniquely positioned to advance solutions, partnerships and collaborations at the nexus of health and education. To help bridge the two sectors, the Children's HSW program provides staff support to AFT Executive Vice President Mary Cathryn Ricker for the National Collaborative on Education + Health. The program also represents the AFT in multisectoral spaces such as the Defending Childhood Initiative and the School Health Advisory Council, and at conversations hosted by the Brookings Institution on how schools can be hubs for care and prevention.

Foundational partnerships

The program fosters new partnerships to lay a strong foundation for future work in other areas of children's health, especially environmental health. Several new partners have been invited to develop accounts on Share My Lesson, the AFT's free online collection of teaching resources, including the U.S. Green Building Council's Center for Green Schools, "Mr. Eco" (a rapper on environmental issues) and the Nature's Voices Project of the Green Schools Initiative. Each new account shares instructional resources and other helpful materials for educators interested in integrating topics such as nutrition education, physical activity and environmentalism into their curriculum.

Coordinated media presence

With a dedicated position, the AFT is producing more regular content on a variety of children's health, safety and well-being issues. For example, the program regularly contributes sample posts for organizational and executive social media accounts, and there is now a dedicated section of **AFT.org** for children's health.

The Children's HSW program also allows the AFT to quickly and strategically link pressing issues in the media to long-term goals in children's health. For example, when the nation was gripped with a flurry of new measles cases in schools following an outbreak at Disneyland that began in December 2014, the Children's HSW program spearheaded the AFT's response, creating a fact sheet, text for **AFT.org** and social media content to keep members informed and to advance research-driven strategies to keep children safe, especially in communities with low vaccination rates. Those materials were used to prepare AFT leaders for television appearances and press statements on the issue. The materials also revisited the importance of investing in a responsive public health infrastructure, a key message that directly links to the AFT's work on Ebola and infectious disease preparedness, safe staffing and school health more broadly.

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APPENDIX A

SURVEY INSTRUMENT: Determining priorities in children's health

The American Federation of Teachers (AFT) Health and Safety department recently added a new component to its programming: Well-being, along with a new staff person, Chelsea Rae Prax. She is responsible for launching and coordinating national work in children's health.

Please help shape the program by answering the following questions.

1. We want to be sure to hear from many AFT voices.
Please tell us a bit about you.

Name: _____
AFT affiliate name & number: _____
Title: _____
City / Town: _____
State: _____
Email Address: _____
Phone Number: _____

2. Please identify your role within the AFT.

- I am an AFT leader or staff person.
I do not work in a PreK-12 setting.
- I am an AFT member, leader or staff person.
I work in a PreK-12 setting.
- I am not affiliated with the AFT.
[This answer led to automatic disqualification]

SECTION 1: FOR AFT LEADERS AND AFFILIATE STAFF

3. Please identify the best contact for children's health issues in your local.

Name: _____
Title: _____
Email Address: _____
Phone Number: _____

4. Many leaders and members are engaged in innovative efforts to promote children's health. We're interested in featuring and highlighting that work. Please check the box to be contacted about great work in your local or region.

- I am not aware of anything to share at this time.
- Please contact me about children's health work.
- Please contact the person entered for the last question about children's health work.
- Please contact another person about children's health work:

5. We want to be sure that any outreach or partnership is relevant to your members.

My local includes the following types of members.
Please select all that apply.

- K-12 educators
- Other school-based personnel
- Nurses / health professionals
- Higher education faculty / staff
- Early childhood educators
- Public employees

6. Every school staff is different, which impacts how children's health issues are handled. We're interested in determining what kinds of staff are most prevalent where our members serve children.

Please identify types of members in your local whose school-based positions often directly impact children's health. Select all categories that apply.

- Community health worker, health aide, nurses' assistant
- Custodian, groundskeeper, gardener, maintenance worker
- Dental hygienist
- Dietitian, nutritionist, food service worker
- Health educator
- Mental health practitioner
(counselor, psychologist, social worker)
- Physical educator
- Public health worker, prevention specialist
- Nurse
- Secretary, office staff
- Special educator
- Speech pathologist, audiologist
- Teaching assistant
- Other: _____

7. We know great work is taking place. We want to support you in the most relevant and effective ways. Please identify areas in which you would like support to assist members, district or state with work on children's health. Select all that apply.

- Advocacy for new or improved district, local or state policy (access, staff, school wellness committee) or implementation (transparency, oversight, accountability)

- Education on relevant federal policy, or policy in other states / cities, as well as advocacy strategies
- Education on innovative approaches to school health service provision or wellness programming
- Leadership development and networking
- Promoting community / wraparound schools and/or school-based or school-linked health centers
- Sample contract language
- Securing training for members

Please add or highlight any areas in which you would like more support.

SECTION 2: FOR ALL RESPONDENTS

8. Many health, safety and wellness issues impact children. We're interested in narrowing our focus to the ones that will best support members' work. Please rank children's health issues from 1 (most important) to 15 (least important) based on how much you believe they impact members' ability to support students' academic success and general well-being.

- #__ Access to care: health insurance, distance from & number of nearby providers, language or transportation barriers, etc
- #__ Asthma
- #__ Chronic conditions (other than asthma): diabetes, allergy, anemia, etc
- #__ Dental & oral health: cavities, caries, tooth or mouth pain, tooth loss, etc
- #__ Disability (physical, intellectual & learning): impaired hearing, spina bifida, epilepsy, dyslexia, Down syndrome, etc
- #__ Drugs: tobacco, alcohol, prescription medication, and illicit drug use and/or abuse
- #__ Environmental and chemical exposure, including in school: air pollution (secondhand cigarette smoke, vehicle exhaust, industrial waste), lead, noise, light, pesticide / herbicide, radiation, poisons, etc
- #__ Illness: vaccinations and immunizations, common cold, flu, headache, stomachache, infection, etc
- #__ Injury: cut, scrape, bruise, concussion, burn, bone break or fracture, sprain, backpack weight, etc
- #__ Mental health & emotional/behavioral conditions: ADHD, defiance, aggression, grief, anxiety, depression, autism, etc
- #__ Nutrition and hunger
- #__ Physical activity, active play, sports
- #__ Sexual health: HIV/AIDs, other STIs, consent, pregnancy, parenthood, partner violence, gender identity, sexuality, etc
- #__ Sleep and rest
- #__ Violence: bullying, fighting, other violence in the school or larger community

Please add or highlight any children's health issues of interest.

SECTION 3: FOR RESPONDENTS WHO WORK IN A PREK-12 SETTING

9. Please identify the grade level(s) of students you work with regularly.

- Pre-K
- Kindergarten
- 1st grade
- 2nd grade
- 3rd grade
- 4th grade
- 5th grade
- 6th grade
- 7th grade
- 8th grade
- 9th grade
- 10th grade
- 11th grade
- 12th grade

10. Different groups in the United States have unique health needs. Please identify whether a significant proportion of your students (~25 percent or more) belongs to any of these groups. Select all that apply.

- Special education
- Disabled
- Immigrant (1st or 2nd generation)
- Low-income
- Students of color
- Institutionalized (juvenile justice system, foster care, etc)

11. Each school handles children's health issues differently. We're interested in determining what kinds of staff work on children's health in your school. Please identify roles that are filled in your school.

- Community health worker, health aide, nurse's assistant
- Dental hygienist
- Dietitian, nutritionist, chef
- Health educator
- Mental health professional (counselor, psychologist, social worker)
- Physical health educator
- Public health worker, prevention specialist
- School nurse
- Special educator
- Speech pathologist, audiologist

Please write in the job title of any other professional in your school whose work primarily includes children's health.

12. We're also interested in determining what kinds of staff you believe would better impact children's health in your school. Please identify any roles that you believe should be expanded in your school.

- Community health worker, health aide, nurse's assistant
- Dental hygienist
- Dietitian, nutritionist, chef
- Health educator
- Mental health professional (counselor, psychologist, social worker)
- Physical health educator
- Public health worker, prevention specialist
- School nurse
- Special educator
- Speech pathologist, audiologist

Please write in the job title of any other professional whose work on children's health you would like to see expanded in your school.

13. To what extent do you agree with the following statement?
"My school has adequate and appropriate policies, programs and services for the health and well-being of students."

- Strongly disagree Disagree
- Neither agree nor disagree Agree Strongly agree

14. Thinking through personal experiences in the last 12 months with children's health at school, how confident were you in your ability to handle the problem or problems that arose?

- I was very uncertain in my ability to handle the problem(s).
- I was uncertain in my ability to handle the problem(s).
- I was neither confident nor uncertain in my ability to handle the problem(s).
- I was confident in my ability to handle the problem(s).
- I was very confident in my ability to handle the problem(s).

Please explain the general nature of the children's health problems you faced in the last year.

15. How often do you receive training, professional development or other education related to children's health and wellness? Choose one.

- Less than once per school year About once per school year
- About once each semester About once each quarter
- About once each month More than once each month

Please share details about training you have received or would like to receive.

16. Thinking about policies, programs and procedures, what does your school do well? Please select up to three (3) areas.

- Access to care: health insurance, distance from & number of nearby providers, language or transportation barriers, etc
- Asthma
- Chronic conditions (other than asthma): diabetes, allergy, anemia, etc
- Dental & oral health: cavities, caries, tooth or mouth pain, tooth loss, etc
- Disability (physical, intellectual & learning): impaired hearing, spina bifida, epilepsy, dyslexia, Down syndrome, etc
- Drugs: tobacco, alcohol, prescription medication, and illicit drug use and/or abuse
- Environmental and chemical exposure, including in school: air pollution (secondhand cigarette smoke, vehicle exhaust, industrial waste), lead, noise, light, pesticide / herbicide, radiation, poisons, etc
- Illness: vaccinations and immunizations, common cold, flu, headache, stomachache, infection, etc
- Injury: cut, scrape, bruise, concussion, burn, bone break or fracture, sprain, backpack weight, etc
- Mental health & emotional/behavioral conditions: ADHD, defiance, aggression, grief, anxiety, depression, autism, etc
- Nutrition and hunger
- Physical activity, active play, sports
- Sexual health: HIV/AIDs, other STIs, consent, pregnancy, parenthood, partner violence, gender identity, sexuality, etc
- Sleep and rest
- Violence: bullying, fighting, other violence in the school or larger community

THANK YOU FOR YOUR FEEDBACK AND INTEREST.



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