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Merrill Eisenberg

*Health Promot Pract* 2009; 10; 284 originally published online Mar 13, 2008;  
DOI: 10.1177/1524839907301405

The online version of this article can be found at:  
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# ***Integrating a School-Based Health Intervention in Times of High-Stakes Testing: Lessons Learned From Full Court Press***

Merrill Eisenberg, PhD

*Because of the growing focus on the production of favorable academic standardized test scores, schools have become increasingly resistant to sponsoring nonacademic programming, such as tobacco cessation services for students. Nevertheless, the need for such programs has not diminished. The purpose of this article is to provide descriptive information about the logistics of establishing and delivering a health intervention in schools that are resistant to nonacademic programming. The data were collected as part of a qualitative retrospective process evaluation of Full Court Press, a 5-year youth tobacco demonstration project funded by the Robert Wood Johnson Foundation and implemented in Tucson, Arizona. Lessons learned about recruiting schools, integrating programs, and managing facilitators are presented.*

**Keywords:** *school health; process evaluation; tobacco cessation*

Schools are a convenient and effective location to test and to provide a wide variety of health-related prevention and intervention programs, including asthma screening and treatment (Anderson et al., 2005; Yawn, 2006), mental health services (Fisher, Masia-Warner, & Klein, 2004; Fox, Rossetti, Burns, & Popovich, 2005; Han & Weiss, 2005; Possel, Baldus, Horn, Groen, & Hautzinger, 2005), as well as programs that address obesity (Carrel et al., 2005; Edwards, 2005; Steckler et al., 2003; Veugelers & Fitzgerald, 2005; Wang et al., 2005), illicit drug use (Griffin, Botvin, & Nichols, 2004; Sun, Skara, Sun, Dent, & Sussman, 2006), physical

activity (Bayne-Smith et al., 2004; McMurray et al., 2002; Pate et al., 2005), nutrition (Auld, Tomaniello, Heimendinger, Hambridge, & Hambridge, 1999; Kelder et al., 2005; Lytle et al., 2004), and safe sex (Amin & Sato, 2004; Kirby et al., 2004). However, these types of school-based programs compete with academic class time, which is at a high premium as a result of the No Child Left Behind Act (NCLB) of 2001.

The NCLB was designed to improve academic performance, as measured by high-stakes testing in math and reading, for all children (U.S. Department of Education, 2002a). Schools that fail to demonstrate improvement in academic performance face a range of corrective actions that can threaten the autonomy of the school (U.S. Department of Education, 2002b). The pressure on teachers and principals to prepare students to perform well on standardized tests in math and reading is considerable, and schools throughout the nation have reduced or eliminated many subjects and programs, including health-related ones, that are not directly related to the content of these tests (National Education Association, 2003–2004).

One approach to countering this trend is to convince school authorities that health-related programming is associated with improved academic performance (O'Rourke, 2005). There is a growing literature supporting this contention (Fleming et al., 2005; Geierstanger, Amaral, Mansour, & Walters, 2004; Symons, Cinelli, James, & Groff, 1997). Another approach is to focus lobbying efforts on school policy makers. Wiley and

**Author's Note:** *This research was supported by the Robert Wood Johnson Foundation. The author would like to acknowledge Nancy Moyer, Hye-ryeon Lee, Ralph Renger, Carmen Garcia Downing, and Zachary Naiman for reading and commenting on drafts of this article. Address correspondence concerning this article to Merrill Eisenberg, The Mel and Enid Zuckerman College of Public Health, The University of Arizona, Tucson, AZ 85719; phone: 520-626-3085; fax: 520-626-8009; e-mail: Merrill@u.arizona.edu.*

## **Health Promotion Practice**

April 2009 Vol. 10, No. 2, 284-292

DOI: 10.1177/1524839907301405

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Howard-Barr (2005) provide important contextual information for lobbying school board members on the educational benefits of coordinated school health programs in order to ensure their viability in the school environment.

Although addressing the issue at the policy level is necessary, advocates of school-based health programming must also rethink the way their programs are delivered so that they are more compatible with the realities of the school setting (Kaftarian, Robertson, Compton, Davis, & Volkow, 2004). This article, which is based on a process evaluation of a school-based tobacco cessation intervention, documents implementation strategies that were used to overcome resistance to public health programming in school settings. The intervention was delivered in Tucson, Arizona, middle and high schools in three consecutive school years from 1997–1998 through 1999–2000. Although the intervention described in this article was delivered prior to implementation of the NCLB, Arizona schools had begun high-stakes educational testing in 1995 with the introduction of the Arizona Instrument to Measure Standards (AIMS) testing (Smith, Heinecke, & Noble, 1999). Thus, the competition between academics and enrichment activities during school time was already present in Arizona schools during this time frame.

The school-based cessation program was one component of the Full Court Press (FCP) project, a 5-year, comprehensive, community-based demonstration project funded by the Robert Wood Johnson Foundation that was aimed at reducing adolescent tobacco use. The FCP project used a wide range of community settings, including schools, youth organizations, community organizations, and the media, to address tobacco use among youth. During the FCP years, there was a 27% reduction in youth tobacco use prevalence in Tucson, 20% of which was attributed to FCP programming (Levy, Bauer, & Lee, 2006).

The American Lung Association of Arizona (ALAA) was one of several partners in the FCP project. The ALAA was responsible for delivering cessation clinics in school settings using a modified version of their adult cessation curriculum, titled Freedom From Smoking (Fena, Field, & McBride, 1996). It called for 9 hour-long group sessions held during a 4-to-7-week period of time. Tobacco cessation clinics were delivered in 6 Tucson middle schools

and 13 high schools in at least 1 academic year between 1997–1998 and 1999–2000. A total of 63 clinics were conducted, although an additional 19 clinics were scheduled but cancelled because of lack of enrollment. A total of 371 students enrolled in a clinic, and 234 (64%) completed the program. School personnel, designated as site coordinators, were responsible for making arrangements to accommodate the program within the school. Students were recruited by the school personnel and by recruiters who were hired and trained by the ALAA. Facilitators who were hired and trained by the ALAA led the clinics.

The purpose of this article is to provide descriptive information about the logistics of establishing and delivering a public health intervention in school settings. These issues can have a profound impact on program effectiveness, and documenting them is crucial for the informed interpretation of outcome data (Chen, 2005). The lessons learned from the FCP experience may also assist others who seek to establish health-related programs in school settings, especially in an era in which schools are reluctant to use instructional time for nonacademic purposes.

### **► BACKGROUND AND LITERATURE REVIEW**

Although prevention efforts have been widely used to address the issue of adolescent smoking, youth who are already smokers can rapidly become addicted to nicotine and therefore require tobacco cessation services (Colby, Tiffany, Shiffman, & Niaura, 2000). Efficacy studies of adolescent cessation interventions are still needed (Fiore et al., 2000). Given the current understanding of this issue, treatment approaches that are recommended for children and adolescents include (a) clinical screening of adolescent patients and their parents for tobacco use coupled with strong messages about the importance of cessation, (b) adult counseling and behavioral interventions that have been modified to be developmentally appropriate for youth, (c) pharmaceuticals, and (d) counseling parents with regard to limiting exposure to secondhand smoke (Fiore et al., 2000).

Behavioral tobacco cessation interventions for adolescents have been delivered in a variety of contexts. Sussman (2002) reviewed 25 years of research on the efficacy of adolescent and young adult tobacco use cessation programs and reported on 66 studies that provided data on tobacco cessation or quit attempts. He identified seven contexts for the delivery of cessation programs that target adolescents. These include programs that were delivered in medical or recovery clinic settings, in school clinic settings, in classroom settings, by computer, in family settings, and one study that utilized a

sensory deprivation chamber. School clinic settings, defined as small group interventions delivered on school grounds, but not as part of classroom work, were the most common context for delivering tobacco cessation interventions for adolescents, accounting for 43% of all studies reviewed. Sussman's (2002) analysis demonstrated that classroom programs had the highest quit rate (17%), computer-based programs followed with a quit rate of 13%, and school-based clinics had a quit rate of 12%.

Research on school-based cessation programs largely addresses intervention design and content (Gullespie, Stanton, Lowe, & Hunter, 1995; Yamaguchi, O'Malley, & Johnston, 2003), or outcomes (Adelman, Duggan, Hauptman, & Joffe, 2001; Horn, Fernandes, Dino, Massey, & Kalsekar, 2002; O'Connell et al., 2004; Riley, Jerome, Behar, & Zack, 2002; Robinson, Vander Weg, Riedel, Klesges, & McLain-Allen, 2003; Rohde et al., 2001; Sussman, Dent, & Lichtman, 2001; Tingle, DeSimone, & Covington, 2003). Issues regarding the implementation of smoking cessation programs in school settings have not been widely addressed in the literature, with the exception of studies of student recruitment and participation (Massey et al., 2003; Turner, Mermelstein, Berbaum, & Veldhuis, 2004) and one study that addresses facilitator recruitment and training (Horn, Dino, Gao, & Momani, 1999). This article contributes to the literature on implementation issues for smoking cessation programs in school settings and presents lessons learned that could inform the development of other types of school-based health programming.

## ► METHOD

A qualitative process evaluation of the FCP school-based cessation program was conducted retrospectively in the winter/spring of 2000. The purpose of the process evaluation was to describe the activities related to developing and implementing school-based cessation programs, including the recruitment of schools, integrating the program into the school-specific context, facilitator issues, recruitment of students, retention of students, and unanticipated results. The process evaluation utilized secondary data (program documents, statistics, and transcripts of focus groups that had been conducted with students who had attended the clinics), supplemented by qualitative primary data collection to integrate the perspectives of the key players involved in school-based cessation programming.

Table 1 summarizes the content of the structured, open-ended interview outline that was developed explicitly for the purpose of this evaluation. These questions

were developed by the evaluator and the ALAA staff as a way to glean what was learned from the experience. However, recognizing the potential for bias in formulating the general breadth of the interview, the interviewer also asked interviewees if there was anything else about the experience that had not been covered that they wanted to share. The interview outline was used in both the individual and group interviews that are described below. All interviewees were promised confidentiality. Interviews were conducted until the information gleaned from new interviews became redundant. This is a common practice in qualitative research (Lincoln & Guba, 1985). The Human Subjects Committee at the University of Arizona approved the research protocol.

A list of schools and contact personnel in which FCP had delivered tobacco cessation classes was obtained from the ALAA. Starting at the beginning of the list, the evaluator contacted school-based personnel to arrange a face-to-face interview. All who were contacted agreed to participate. A total of nine interviews were conducted by the evaluator in five high schools, including five interviews with high school administrators (principals and vice principals) and four interviews with tobacco site coordinators. These interviews took place in private offices in the school setting and lasted approximately 45 min each. In addition, two site coordinator meetings, which brought together site coordinators from the participating schools, were observed at the ALAA offices.

The ALAA's individual staff interviews included three separate interviews with the program administrator and individual interviews with the two student recruiters. These took place at ALAA offices and lasted approximately 45 min. In addition, two group interviews with a total of eight clinic facilitators were conducted at ALAA offices. These each lasted approximately 1 hr 15 min.

Handwritten notes were taken during the individual and group interviews. The notes from the individual interviews were transcribed and sent to the individuals who were interviewed so they could clarify and/or expand their content or correct any misrepresentations of what they had said. The notes from the group interviews were also transcribed and reviewed for clarity and accuracy by one individual who had participated in the interview. The evaluator then conducted a content analysis of the interview materials, first compiling comments for each of the questions and then using an iterative process to identify common issues and themes. These were then presented to the ALAA staff, who were given an opportunity to provide clarification and comment.

**TABLE 1**  
**Structured Interview Content**

<i>Topic</i>	<i>School Personnel</i>	<i>Program Administrators</i>
First approach	How were you first approached about participating? What concerns did you have? How were your concerns addressed?	How did you approach the schools? What concerns did they have? How did you address them?
Administrative load	What did you have to do administratively to make it possible for the program to begin? What have been your responsibilities with regard to this program?	What have been your responsibilities with regard to this program? What aspects took more attention than anticipated? Why?
Integration	How did the program activities fit in at your school?	What did you do to integrate the program into the school environment?
Problems	What kinds of problems have you had that have been related to the program? How did you address them?	What kinds of problems have you had that have been related to the program? How did you address them?
What worked?	What aspects of the program do you think worked well? Why?	What aspects of the program do you think worked well? Why?
Program support	Who within your school champions the program? How do the administration and teachers feel about the program? What objections have there been? By whom? How have you dealt with them?	Not asked
Lessons learned	What lessons have you learned about integrating programs like this into your school environment? What advice would you give to someone planning to do cessation in schools?	What lessons have you learned about integrating programs like this into your school environment? What advice would you give to someone planning to do cessation in schools?
Staff changes	Has having the clinics in the school had a behavioral or attitudinal impact on your staff? Explain.	Not asked
Benefits	What benefit do you believe the program provided to the students? To the school?	Not asked
Support from Full Court Press	What kind of support have you gotten from Full Court Press? What has been most/least valuable? What do you suggest they provide?	Not asked

## ► DISCUSSION

### ***Strategies for Recruiting Schools***

The ALAA staff recruited schools to serve as sites for delivering adolescent cessation services. There was no cost of participation for the school. An ALAA staff member contacted school principals to explain the nature and purpose of the program. Some principals referred the recruitment request to the assistant principal, guidance counselor, school nurse, or someone who was responsible for other substance abuse programs. During face-to-face meetings with the appropriate person, ALAA staff would ask about the school's policies for dealing

with students who had been caught smoking. In most cases, it was reported that these students were required to serve a detention. The ALAA staff would then suggest that detention is not an effective intervention and that requiring smoking cessation clinic attendance would better serve the school and student. The ALAA staff also mentioned that if the school were to participate, ALAA would generate press coverage in the local newspaper. Several barriers were encountered in these recruitment meetings.

One barrier was denial that the school had a "smoking problem." Some administrators denied that their students smoke, and several administrators said that

although many students smoke, they had far more serious problems than smoking, including drug and alcohol use and gang activity. The ALAA staff addressed this issue by pointing out that the students who do smoke are likely to also be involved in those other risky behaviors and that those issues would also be addressed if they came up in the tobacco clinic context. School recruiters believe that this assurance was one key to participation for some schools. Further, the concern proved to be true. Many risk issues in addition to tobacco use were addressed in the tobacco clinics.

Another barrier to recruitment was the schools' concern that the program would interfere with academic activities. As anticipated, increasing pressure on schools for students to pass standardized academic examinations put a premium on instruction time, and many principals and teachers expressed misgivings about the cessation clinics because they feared they would take away from instructional time. As one principal stated,

Principals are being held to an absolute [standard]—you're not gonna see the same principals around next year if they don't have achievement. The idea of pulling kids out of class—it's gotta be delivered in another format. As a principal you have to be nuts to be supporting that right now.

The ALAA addressed this issue by offering to schedule cessation clinics either before or after school or during lunch periods. Although this type of scheduling resulted in other implementation challenges (discussed below under "Integrating the Program"), agreeing to a schedule that did not impose at all on instructional time frequently proved to be a necessary compromise for getting established in the school.

Several schools that had originally declined to participate subsequently agreed after receiving a letter that championed the program from a well-known assistant principal at one school who had taken a personal interest in tobacco. Another approach to convincing reluctant schools to participate was to identify a teacher or school employee from within the school who was sympathetic and willing to advocate within the school to establish the program. The sponsoring community organization, in this case the ALAA, can use its established community network to identify champions in the community; at the school level, the sponsoring organization can contact likely champions (e.g., health teachers, school nurses, parent/teacher organizations) and either ask them to be a champion or to identify someone else within the school who has an interest in the program content.

Finally, some schools were already participating in a competing tobacco education and prevention program

offered through the Pima County Department of Health. This program had established a school-based site coordinator who was trained and paid a small stipend to deliver the Tobacco Education Group (TEG; Pendell, 1996a) and Tobacco Awareness Program (TAP; Pendell, 1996b) curricula that is prevention oriented but also has a cessation component. In contrast, the ALAA cessation program did not require school personnel to deliver the program. Many schools preferred the ALAA program because it put less responsibility on school personnel. One recruiter noted, "[The site coordinators] were bombarded with responsibilities and thought [the Full Court Press cessation program] was a better idea because it would alleviate some of the pressure they were feeling."

### ***Strategies for Integrating the Program Into the School-Specific Context***

*Site coordinators.* Once a school agreed to participate in the FCP cessation clinic program, the ALAA worked with the school to integrate the program into the specific school context. This required someone from the school to work with the ALAA to develop a methodology for implementing the clinics. Many schools already had tobacco site coordinators in place as a result of their participation in tobacco activities sponsored by the Arizona Tobacco Education and Prevention Program (TEPP). Site coordinators for that program were given the responsibility of working with the ALAA to implement the cessation clinics. In other schools, site coordinators were recruited either by the school administration or by the ALAA. The site coordinators were expected to schedule the clinics, secure the space, and make sure the necessary equipment would be available. Without the site coordinators, the ALAA would not have been able to deliver the program in the school setting.

Site coordinators were individuals who held a range of different school positions, including guidance counselors, campus monitors, snack bar staff, and health, journalism, and language teachers. They were usually people who enjoyed working with students above and beyond their other school responsibilities. Some site coordinators had volunteered for the position, others had been asked by the principal to take it on. Some had a personal interest in tobacco issues as a result of having experienced tobacco-related illnesses and death in their personal social network. Site coordinators were typically very busy people. The clinic facilitators, who had the most contact with the site coordinators, describe the site coordinators as being "swamped." In discussing their responsibilities, the site coordinators stated that having the support of other school staff members helped them to fulfill their obligations. A team approach was used successfully in several schools.

However, difficulty in maintaining school staff interest in tobacco issues was a common challenge mentioned by the site coordinators. Reasons for attrition of school staff members that were mentioned by the site coordinators included the need to reimburse staff for extra time, teachers are “burned out” trying to raise testing scores, and teachers and school staff are busy with other extracurricular activities.

Support from the ALAA was also critical in helping the site coordinators to do their jobs and was greatly appreciated.

They come out and want to help. They give me materials and resources. They have activities all the time. They are good about calling and asking [what I need]. That feels good. I don't feel so alone, I can get some support. (High school site coordinator)

*Clinic scheduling.* Although agreeing to conduct clinics before and after school was a key to convincing schools to participate, the ALAA found that very few, and sometimes no students attended these clinics. Being able to demonstrate that before- and after-school programs did not work was helpful in convincing school officials to try a *pullout* schedule, whereby participating youth miss a regular class to attend the clinic. The ALAA staff also met with academic teachers to discuss the problem and gain their support. One site coordinator who was also a classroom teacher explained:

[The ALAA staff] suggested [conducting the clinics] during school. I'm not happy with it—I'm a teacher and I hate to have kids gone. . . . The kids have to make up the work they miss. Unfortunately, these are also the kids who miss school—their teachers are concerned. [The teachers say] “I never see this kid!” It's typical of kids who use tobacco. There isn't a perfect time though. We have to capture them when they are here, and the teachers are supportive because they want the kids to quit.

There were several pullout scenarios used to balance academic needs against cessation needs. For example, some schools rotated pullout periods so that students did not miss the same class every time. Others would allow pullouts, but not on *block days*, when the time for each period was doubled. The ALAA staff was willing to try any scenario to accommodate the schools' concerns. Participation in clinics improved significantly when clinics were scheduled during school time.

*Addressing anticipated disruption.* Whenever an outside program comes on to school grounds, it is bound to

create some degree of disruption or extra work for someone at the school. One principal described this disruption as “punishment for participating.” The ALAA staff was always very careful to minimize the degree of disruption they created. For example, they would make sure there were no fliers left on the ground, put the classroom furniture back as it was found, and use their own materials at all times. This was commented on and greatly appreciated by school personnel.

## ► CONCLUSION

As school systems are under ever more pressure to produce acceptable academic test scores, interest in providing enrichment and other nonacademic programming has declined. When the impetus for providing school-based health programs comes from a nonschool source, such as a state tobacco program or a community organization, program promoters must convince school officials to accept their programs on school grounds. Even when programs are offered free of charge, they require space for program delivery and time, either out of the school day or before or after school, for students to attend as well as administrative support from school resources. Encountering these issues in Tucson, Arizona, in the late 1990s and early 2000s, Full Court Press learned a series of lessons about how to accommodate school concerns while delivering tobacco cessation services to middle and high school students on school grounds.

Lessons learned about recruiting schools to participate in tobacco cessation clinics include

1. Point out that addressing tobacco is a catalyst to addressing other youth risk issues and be prepared to address these in tobacco cessation clinics.
2. Find a champion for the program who is in a respected position from within the school system. This individual can be someone from outside the individual school who has established leadership and credibility or someone from within the school who advocates for the program and is seen as understanding the local system and constraints.
3. Be flexible about how you will initially schedule the program. If concern about the program taking instructional time is expressed, try it before or after school first. Be willing to compromise to get your foot in the door.
4. Offering a turnkey operation is more attractive to schools than asking them to start providing a new service. Ask as little of school personnel as possible.

Lessons learned about integrating cessation programming into the school environment include

1. Work closely with a designated contact person placed within the school—they are important advocates and liaisons for the program.
2. Encourage the contact person to enlist a team of school personnel to assist with cessation activities and, if possible, provide incentives for the contact person and team members.
3. Be available to provide assistance and support to the contact person. Respond quickly and appropriately to requests for materials and information.
4. Teachers and administrators are more receptive to pullout scheduling when they have seen that before- and after-school scheduling does not work. Always accommodate the schools' scheduling constraints.
5. Be self-sufficient and minimize disruption.

Lessons learned about program personnel include

1. Individuals from the community who deliver school-based health-related programs should have some personal experience with the health issues they are addressing.
2. Program implementers should be prepared to accommodate the school's scheduling constraints and expect many last minute changes.

Although these findings provide insight and direction for school-based cessation implementation in other communities, the study is limited by several factors. Most obvious is the fact that the individuals who were interviewed did not reflect a random sample of all individuals who had been involved with the project. Using a qualitative methodology, we conducted interviews with additional individuals until we reached the point of redundancy (Lincoln & Guba, 1985). It may be that those individuals shared characteristics or experiences that are not representative of the individuals who did not participate.

Another limitation stems from the methodology used to document the interviews. The interviews were not tape recorded, but were recorded on paper by one individual who may have recorded responses selectively. This limitation was mitigated by the vetting of all interview notes with the individuals who were interviewed. Analysis was also conducted by only one individual, thereby precluding alternative interpretations of the data. Again, vetting of the analysis with those who participated in the program mitigates this limitation to some degree.

A final limitation is the fact that the situation in Tucson in the late 1990s and early 2000s may have been more conducive to acceptance of cessation programs in the schools than is the case other communities today. For one thing, during that time period the issue of youth tobacco

use was of high salience in Tucson because of the FCP efforts to reduce youth smoking on many community levels, as well as the local tobacco education and prevention efforts and the statewide media campaign that was sponsored by the State of Arizona. Further, the advent of the NCLB has likely increased pressure on the schools to focus on academic performance only, thereby decreasing opportunities for school-based cessation programs on school campuses. Nevertheless, schools remain the most expedient channel for accessing teen smokers. Our findings regarding infrastructure issues for school-based cessation programs may help others to implement health-related programs in school settings in an ever more restrictive school environment.

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