Abell Salutes:  
*The Barclay-Calvert Experiment; Four-Year Results Are Promising*

Barclay Elementary School is an urban public school that against the odds is turning out students testing above and well above national levels, and whose scores are even beginning to compare with those of private school students. What became known as “Barclay-Calvert” started out as an experiment and then became a cause. It is now an idea whose time has come.

Four years ago The Abell Foundation provided approximately $400,000 to support a collaboration between the highly regarded (and private) Calvert School and Baltimore City’s struggling Barclay Elementary School. Calvert brought to the program its teaching methods, teacher training, curriculum coordination, and a curriculum that stresses mastery of the basics.

A fourth-year evaluation of the program, prepared by Sam Stringfield, Ph.D., Principal Research Scientist, Center for the Social Organization of Schools, Johns Hopkins University, has recently been released. Here are only some of the findings—and all of them, are promising:

- Absentee rate for Barclay-Calvert students was 4.0 percent; for students in the years prior to the program, 6.2 percent.

(continued on page 8)

---

Hopkins School of Hygiene and Public Health Is “Making A Difference—from Baltimore to Bangladesh.”

Dean Alfred Sommer says, “We want to add more years, and more to the quality of those years, that an individual and a society can enjoy. The world must learn that prevention is cheaper than the cure.”

When in March of 1994 the results of a Business Week survey placed the Johns Hopkins School of Hygiene and Public Health first in the nation among public health and hygiene schools (Harvard placed second), the news drew a yawn in Baltimore. And when, a few days earlier, the School of Hygiene was named to lead a $15,000,000 partnership of mental health services in East Baltimore, the media reported that the partnership was between the network of services and “Johns Hopkins University.” In the habit of Baltimoreans, this same media didn’t bother to single out the school from the entire university, or they got the school and the university mixed up.

Whatever, the school’s administration will tell you that the school may be renowned in the world but in Baltimore it gets no respect. That is so, first, they believe, because the school finds itself one of many in the university’s large family of schools and facilities; and second, because of what the school does.

It focuses on disciplines that lead to prevention of sickness. “Preven-

---

HEALTHY START:

“We asked ourselves, ‘How can we cut the infant mortality rate by 50 percent in five years?’”

Pat O’Campo, PhD, Assistant Professor, Maternal and Child Health

In 1993 the Baltimore City Health Department, funded by a five-year grant from the federal govern-
ment, invited the School of Hygiene to undertake with them the development of programming designed to reduce infant mortality in Baltimore City. The school, in its role in the partnership, was charged, too, with evaluating the effectiveness of the interventions.

At the outset of the initiative, Dr. O'Campo observed: “In some Baltimore neighborhoods, the infant mortality rate mirrors that of Third World countries. To deal with the problem, to bring the rate into line at least with the national average, the lifestyle in these neighborhoods must be fundamentally changed. As societies, these neighborhoods and the families living within them must be made to function differently. And you begin the process by going out into the streets and asking hard questions.”

Dr. O'Campo and her colleagues needed to know: What are the problems in the community that have to be solved? Why is the proportion of infants born with low birth weight nine percent among whites, but 19 percent among African-Americans? How do you change the structure of the community to create a healthier environment for mothers and children?

They learned by listening—on the streets and in the homes and in the churches of Baltimore, one-on-one and in groups. Dr. O’Campo says, “We wanted to know what their problems were. We wanted to know how the structure of the community contributes to those problems. We held a mirror up to their lives and looked into it.”

What Dr. O’Campo and her colleagues saw was a simple matter of cause and effect. Low birth weight and infant mortality were the effects; the causes were poverty, inadequate housing, drug abuse, and lack of parenting skills. The marching orders to Healthy Start—to reduce the infant death rate in Baltimore by 50 percent in five years—now had a road map.

In order to effect material change in the culture, the program called for the setting up of neighborhood centers in two carefully-selected neighborhoods. Each of the centers offers walk-in psycho-social services. These include: on-site health education, child care, breast feeding promotion, male involvement in parenting classes, job training and parenting classes, and links to social services.

“We sought to provide a kind of ‘one-stop shopping’ for pregnant women and new mothers . . .”

On any given day, residents in the project areas are visiting the neighborhood centers (one on Baltimore’s east side, one on the west side) and are talking one-on-one with health professionals. In the course of these meetings, a pregnant mother or new mother’s emergency psycho-social and economic needs are ascertained and attempts are made to deal with them. If a resident needs a refrigerator to keep food fresh, the program provides one; if she needs rent money, the program provides it; if she needs food, clothing or housing, the program provides all of that, too. The program also offers experience and training to mothers who want to work in the program and to acquire skills they need to find jobs. The theory and the hope is that a lower infant mortality rate will be a consequence of the program’s restructuring of neighborhood lifestyle.

Dr. O’Campo says, “We sought to provide a kind of ‘one-stop shopping’ for pregnant women and new mothers who have a whole host of psycho-social and economic needs not being met. As for results, we cannot say that these interventions can achieve measurable results in the four or five months of our relationship. But we are encouraged to believe that what we are providing now will count heavily in positive ways months and years from now—in these women’s lives and in the lives of their babies yet unborn.”

PREVENTION RESEARCH CENTER

“Over the last ten years in Baltimore we have been carrying out the largest prevention intervention research program in the world aimed at helping children who are behavior risks.”

Dr. Sheppard G. Kellam, Director, Prevention Research Center

The School of Hygiene’s Prevention Research Center works on the theory that in talking to young people early on it can spot trouble coming 10 years ahead. Anticipation, it is hoped, is a leg up on prevention—of drug addiction, school dropout, teenage parenting and pregnancy, and antisocial behavior.

What Dr. Kellam and his staff are looking for are the predictors—hints in students’ behavior in the classroom, at home, and among peers that might foretell which students today are candidates for disruptive behavior tomorrow. Dr. Kellam says, “Medical tradition would have us help a child who has trouble adapting to first grade. From a public health point of view, however, we ask the question, how many such children are there? Where are they—that is, in what classrooms, schools and neighborhoods, and what specifically could we do to reduce the risk for these children—all of them, not merely one or two or a handful?”
“We should think less about treating the problem as the child’s problem, and more about treating it as a population’s problem. The correcting experience might occur in the context of the classroom, or both in the classroom and within the family, for all such children, rather than a few children in the clinic.”

Programming operates at three different levels: identifying the children and the problems; providing support for children with more complicated problems; and forming appropriate linkages to specialized support services.

“Results,” Dr. Kellam says, “are notable. First-grade children reported many more depressive symptoms than we expected. We learned that if children reported a great deal of depressive symptoms in the fall of first grade and were left unattended, they were at a markedly increased risk for poor achievement across first grade. These children lost 20 to 30 points on achievement tests over the first-grade year.

“We are meeting (our) goal, carrying it out with strong community support...”

“As a result of the intervention aimed at achievement, reading scores were raised from roughly 50 percent making the required progress to about 70 percent who were making the required progress.

“For those children participating in what we called our ‘Good Behavior’ game intervention, there was marked improvement with problems of aggression that was evident at life transition times, including at the time the children entered middle school.

“Our goal here at the Prevention Center is to strengthen socialization.

We are meeting that goal, carrying it out with strong community support and avoiding the need for remedial care later, with all its stigma, expense and hopelessness.”

**OCCUPATIONAL HEALTH**

“The goal of the Johns Hopkins Occupational Health program is really the same as the Congress’s Occupational Safety and Health Act of 1970—to assure that every person in America, rich and poor and black and white and union and non-union, employee and employer, has a safe and healthy workplace.”

Dr. Clifford Mitchell, Instructor in the Division of Occupational Health

On any given day, someone in Baltimore calls 550-2322. The caller hasn’t been feeling well and can’t say exactly why, but there are hints that maybe it’s because of the work that he or she does. The conversation turns to the product being handled, or the way it’s being handled: something in the air, perhaps.

The caller has reached the clinic where Dr. Clifford Mitchell and other physicians from the Division of Occupational Health of the Johns Hopkins School of Hygiene and Public Health see more than 200 patients with work-related problems every year. For more than 15 years, physicians, nurses and scientists in the division have been providing help to area workers, companies, and citizens in Baltimore.

Dr. Mitchell says that patients come to him and other physicians reporting a broad range of problems. “We see patients with lead poisoning, carpal tunnel syndrome, sick-building syndrome, occupational asthma, work-related dermatitis, and a host of other problems.” Patients may be referred by other physicians, self-referred, or they may be sent by an employer.

“Our specialty demands an understanding of toxicology, industrial hygiene, and medicine, so that we can evaluate a patient’s potential exposures, the likely health effects, and the appropriate clinical management. We advise the patient on treatment—not only in terms of medical management, but also in terms of staying healthy on the job. That can mean working with the employer and in the workplace, as well as with the employee. The goal is to help the individual get better and lead a productive life—in whatever capacity he or she is able—and to prevent diseases in the workplace. Preventing diseases is what the public health part of our job is all about.”

“Our work should mean a healthier and more productive population in Baltimore’s workplaces.”

Along with providing day-to-day clinical support to the community, the division also serves as an important information resource on occupational and environmental problems. Physicians, employers, government officials, the media, and ordinary citizens frequently call with questions about everything from multiple chemical sensitivity syndrome to sick-building syndrome, to the structure and delivery of occupational medicine services. The division draws on the considerable research interest of its own family, as well as other faculty in the school, to answer the questions. As an example, Dr. Mitchell cites an audit he conducted of Baltimore’s occupational medicine and safety
The purpose of the audit was to help the city more effectively provide these services to employees.

The program also serves as a valuable community resource for training doctors in the field of occupational medicine, through its residency program and continuing medical education. According to Dr. Mitchell, “Many physicians don’t know how to manage occupational illness and injury, which in some cases requires dealing with employers and the workers’ compensation system. That need, to reach beyond the patient into the workplace, is viewed by many physicians as beyond their area of expertise. But it is what we do all of the time.

“Our work should mean a healthier and more productive population in Baltimore’s workplaces. Not simply healthier for workers and their families, but for employers and their companies as well.

“In a perfect world, we would have solved all of the health-related problems and would have put ourselves out of business. But the world is not perfect and health problems persist in the workplace.”

Fortunately for Baltimore, the Johns Hopkins Division of Occupational Health is very much in business.

And they still answer the phone at 550-2322.

ALIVE

“We’re looking to stop HIV transmission among injecting drug users. Working toward that end, we first had to learn how to access the difficult-to-reach population at risk for infection. Then, in turn, we needed to learn from them. Finally, we had to convert findings into programs.”

David Vlahov, PhD.
Associate Professor, Epidemiology,
Director, ALIVE Study

The ALIVE Study, chasing the killer AIDS, is committed to probing where researchers have seldom probed before. Dr. David Vlahov, who heads the project for the School of Hygiene and Public Health, believed from the start of the program in 1988 that what his team needed to know lay deep within the culture of a historically-wary street population: What were the behavior patterns that put injecting drug users at risk for HIV infection, and how could this behavior be changed?

The team’s first job then, as Dr. Vlahov saw it, was to find such a group and get inside of it. Dr. Vlahov says, “We had to learn about the experience of injecting drug users from the users themselves. Only they really knew the why and how of it.”

The team spent over a year talking one-on-one with injecting drug users. In addition to learning the range of behavior associated with injecting drug use, the team found out that users perceived hospitals as inhospitable, so that any hope of drawing large numbers of drug users into a hospital for interviewing and counseling was doomed.

“Every day, ALIVE is adding to the store of information we need to solve the problems…”

Dr. Vlahov’s team concluded that facilities designed to fact-gather or counsel would have to be off premises, preferably in walk-in clinics. They also discovered that drug users were very interested in their health and also wanted a say in how the effort would be managed.

One walk-in clinic was established and devoted solely to the needs of this population; and a community advisory board was created to support it, comprised of former and current drug users. In the first 13 months of clinic operation, 2,921 injecting drug users walked into a “user-friendly” clinic to participate in the school’s HIV testing, counseling, and behavioral interviews. Ninety percent returned to receive HIV test results. Twenty-four percent were HIV infected.

Findings made clear that HIV infection was associated with the sharing of contaminated needles and the challenge to the groups was how to change this behavior. Education would be the key. However, although 98 percent of the drug users knew that HIV could be transmitted by sharing needles, none of the less 70 percent persisted in sharing needles. Education, although perceived as necessary, was not sufficient to affect behavior change.

Although traditional views of injecting drug users conclude that needle sharing is a ritual embedded within the subculture, the ALIVE study found that many drug users have a pragmatic reason for sharing needles. Possession of needles is prohibited by law and drug users are wary of carrying their own needles lest they be arrested. “In this view,” Dr. Vlahov says, “the paraphernalia law which was intended to curb drug use might have had the unintended consequence of facilitating transmission of HIV infection.

“While drug abuse treatment is an important HIV prevention strategy, only 10 to 15 percent of drug users are in treatment at any given time. Furthermore, many are not ready for treatment.”

For the majority of drug users, access to sterile needles seemed to be a sensible strategy to prevent HIV transmission. Dr. Vlahov and his team worked diligently with Mayor
Schmoke to establish a needle exchange program in Baltimore, which opened in August, 1994. Dr. Vlahov is director of the evaluation of the program.

In this program, drug users get legal access to sterile needles which, when returned, can be exchanged for additional sterile needles. "In addition," says Dr. Vlahov, "program participants, many of whom avoid the traditional care system, have access to testing for sexually transmitted diseases, tuberculosis, and referrals to treatment for drug abuse. The goal is to engage drug users, establish trust and rapport, and then offer services to reduce incidence of infections that are of public health concern."

The ALIVE Study has also identified other issues, including the need to target interventions to combat sexual transmission of HIV infection among drug users. "While many drug users have changed injection behavior, sexual behavior is more difficult to change," says Dr. Vlahov. "This is a current focus of the ALIVE study."

"The community is faced with a major health problem," he says. "Information is playing a vital role in the continuing struggle to solve the problem. Every day, ALIVE is adding to that store of information."

LEAD ABATEMENT

"You will see by it that the Opinion of this mischievous Effect from Lead, is at least above Sixty Years old; and you will observe with Concern how long a useful Truth may be known, and exist, before it is generally receiv'd and practic'd on."

quote from Benjamin Franklin letter to Benjamin Vaughan in 1786

Mark Farfel, PhD, who is Director of the Lead Abatement Program at the Kennedy Krieger Institute and on the Faculty of the Johns Hopkins School of Hygiene and Public Health, likes to quote Mr. Franklin when the topic turns to the deleterious health effects of lead in humans. "The problem was well recognized at least a century ago. There is even evidence that the ancients knew about it. And though the Baltimore City Health Department was in the forefront in both recognizing the problem in children and attempting to deal with it as long ago as the 1930's, the problem persists today as an epidemic of chronic low- to moderate-level toxicity in children who usually exhibit no specific signs or symptoms."

In 1993, 23 percent of tested children (7,631) aged six years or younger in Baltimore City had elevated blood lead levels, of whom 1,517 required medical and environmental case management due to higher blood lead levels. Nationally, 8.9 percent of children in this age range have elevated blood lead levels, including about 35 percent of urban, non-Hispanic black children from low-income households.

"Three quarters of private housing built before 1980 is estimated to contain lead-based paints . . ."

With the virtual phase-out of lead in gasoline, food and beverage cans with lead-soldered seams, and lead in residential paints produced after 1978, the major source of high lead exposures in children is lead-containing paint in older housing. As the lead-containing paints age and deteriorate, they peel and chalk and so become an integral part of interior house dust and exterior soil adjacent to houses which, in turn, are major pathways of lead into children via ordinary breathing, fingersucking and mouthing behavior. Past use of lead as a gasoline additive contributed another 7,000,000 tons of lead to dusts and soils in and around housing.

The problem of lead-containing paint in the older houses is the focus of the work of Dr. Farfel and his colleagues at the Kennedy Krieger Institute and the School of Hygiene and Public Health: they are engaged in field studies in minority urban neighborhoods. Their findings in turn are enabling them to design interventions calculated to reduce children's exposure to residential lead in dust and paint, and to determine the effectiveness of the respective interventions. A key ingredient to their work has been the continued involvement of a wide spectrum of collaborators, including families, private property owners, City Homes, Inc., Baltimore City Health Dept., Maryland Departments of the Environment and Housing and Community Development, and the U.S. Environmental Protection Agency.

The lower-cost repair and maintenance approaches currently under investigation in Baltimore houses may provide a practical means of reducing exposure for children who will continue to occupy lead-painted housing. The reduction in exposure will be an accomplishment with high promise, considering that an overwhelming number of the homes built in America, going back as far as 300 years, were built using lead-based paints, and in particular where a white pigment was needed. Based on a national survey, three quarters of private housing built before 1980 is estimated to contain lead-based paints on some interior and/or exterior surfaces. The paint problem is not limited to low-income, inner-city housing; half of the lead-painted houses with dete-
riorated paint are estimated to be owned by families with incomes over $30,000, which is approximately the median income for all U.S. households.

The problem manifests itself in young children (usually poor) living in houses (usually old) where the lead paint has remained on walls, woodwork, and windows; and where lead dust is created as paint is abraded, for example, when window sashes are opened and closed. However, the problem also manifests itself when "do-it-yourselfers" or contractors renovate or remodel lead-painted housing without taking proper precautions, and as a result expose themselves and their children, pets, and belongings to lead dust and debris generated when the lead paint is disturbed.

"My children's blood level is down. I think they are getting better."

Charnita Smith

Children exposed to lead are at risk of reduced attention span and ability to read, mental retardation, inability to keep up with school work, lowered birth weights, and some or all of the complex of mental, physical and social problems that grow out of these interlocking deficiencies. Currently, there is no known drug treatment that reverses the adverse health effects of lead. Consequently, the main thrust of clinical treatment and primary prevention programs must be reduction of the sources of exposure.

"Given this background," Dr. Farfel says, "our research objective is to develop a scientifically sound standard of care for lead-painted housing as a basis for framing public policy for prevention. As with clinical drug therapies for children, environmental interventions for children's health should be documented to be safe and effective."

Charnita Smith (not her real name) lives in a narrow rowhouse in East Baltimore. A single mother, she is raising three-year-old twin boys. She is a statistic come to life. "Both of my children developed lead poisoning in the house where we had been living," she says. "The kids were sick. We took them to the Hopkins clinic and while we were there the doctor did a blood lead test. That's how I found out the kids had lead poisoning. So they moved us out of our other house and into this one. This one has been made lead-safe. We've been here a year; my children's blood lead level is down. I think they are getting better."

There are lots of Charnitas all over East Baltimore—mothers whose children could benefit from improved housing with reduced lead exposure. Charnita was fortunate in two ways—her children were tested and her family was relocated to better housing. Although lead testing is on the increase, it's not routine everywhere and parents need to know how to ask for the test. Even some high-risk children are not periodically tested as recommended. Moreover, once children are identified, finding suitable housing is a major challenge, particularly with the acute shortage of "lead-safe" housing in older, low-income neighborhoods.

Dr. Farfel says, "By identifying cost-effective housing interventions, we can work toward primary prevention—total elimination of lead poisoning from ingestion of lead-containing paint and settled house dust. We have learned what works and what doesn't work. Now we are in the process of documenting the costs and long-term effectiveness of practical repair and maintenance strategies for lead remediation so that it can be more easily adopted as public policy. We need to figure out not only short-term relief but long-term prevention, since children are at highest risk of lead poisoning throughout their pre-school years.

"And as we continue to learn, we continue to work with our public and private sector collaborators to apply new knowledge to practice so that the population of Baltimore and other affected communities gets healthier."

Proving that a "useful Truth" is being "received and practiced on" at long last.

Ben Franklin would have liked that.

Dean Alfred Sommer, M.D.:
Dean, Johns Hopkins School of Hygiene and Public Health

He greets visitors warmly in his shirtsleeves, and he gives no short answers . . .

The School of Hygiene and Public Health occupies an unimposing sandstone-colored, nine-story, 100,000-square-foot building at Wolfe and Monument streets and several satellite buildings nearby in the East Baltimore area. At any given time it employs as many as 350 full-time faculty members; it is training 1,200 students from 75 countries; and operating major health programs in 40 countries. It is collaborating with the World Health Organization on blindness prevention and mental health, and it is training health leaders for responsibilities around the world. Dr. Alfred Sommer runs this gargantuan institution from a modest-size, sparsely-decorated office on the first floor, close to the main entrance off of the street. He greets visitors warmly, and he gives no short answers.
In the complicated business of community health and disease prevention, there aren’t any. Dr. Sommer says, “There is this huge gap between molecular and quantitative techniques in the field, the searching to understand the distribution and impact of disease and injury, and the actual delivering of prevention on the street—I should say ‘streets,’ ‘from Baltimore to Bangladesh.’ A lot has to happen before research becomes prevention, and we are committed to making all of it happen—whatever it takes. I sum it up with ‘Sommer’s Maximum’: ‘We want to add more to the years and more to the quality of years that an individual and a society can enjoy.’”

The history of the school’s relationship with the city does not run in a straight line . . .

Dr. Sommer and his colleagues point out that though the work of the school makes itself felt around the world, there is what they call an “immediacy” to the school’s involvement with the city. Immediacy, however, characterizes the relationship today; it did not earlier. The history of the school’s partnership with Baltimore does not run in a straight line.

As long ago as 1916 the school was active with the city and state—a relationship powered by grant money from the Rockefeller Foundation. In what was known as the Eastern Health District of Baltimore City, students and doctors from the school were making rounds in the neighborhood, looking for diseases and determinants. There was a strong linkage between a great institution and its neighborhood. But in the 1950’s the foundation moved on. The Baltimore City Health Department would not or could not pick up the tab. A disestablishment occurred and relationships between the school lost their vigor.

“Then,” Dr. Sommer says, “in the late 1960’s something happened. Societal changes were occurring. There was a great national focus on committing resources to help failing cities. In the school, and partly in response to these changes, new faculty members with this kind of orientation became part of the leadership of the school, and helped it to reshape its mission. Dozens of initiatives followed.” What are they? It is the long-answering, physician-director, proselytizer-for-prevention Alfred Sommer who responds: “The Sandtown-Winchester program, training program for inner-city healthcare workers, collaborations with the Baltimore City Public Schools, violence prevention, substance abuse, maternal child health, lead poisoning, teenage pregnancy, childhood immunization, AIDS prevention—did you know that right here in Baltimore we have the largest and best integrated AIDS prevention program anywhere in the world? And we are adding to the list all of the time.”

There is no more a limit to the school’s agenda than there is a limit to the diseases that afflict and confound. “The challenges never let up,” Dr. Sommer says. “They include the study of cancer prevention. We need to know why some people get cancer and some people don’t. We need to identify the carcinogenic agents and develop protective mechanisms against them. Then there are the perplexing problems of heart disease. Again, why do some people get heart attacks and others don’t, and what can we do to prevent them? What part does diet play? Exercise?”

There is a particular goading problem that haunts the school’s culture, and Dr. Sommer and his colleagues ask it of each other often: Given the school’s renown and accomplishments, why is so little known of its work, and why is there so little recognition for it? Here Dr. Sommer comes as close to a short answer as he can: “Simply put, it’s cheaper to prevent illness than to cure it. Nobody takes time out to be grateful because he or she is not dying of smallpox.”

“I would like to be remembered . . . as the man who drew community interest to the idea of prevention being cheaper than cure.”

Although a relatively young man, highly regarded and still in the early stages of what is already a successful career, Dr. Sommer can still reflect on how, in the fullness of time, he would like to be remembered. “First,” he says, “for my discovery that mild Vitamin A deficiency is responsible for the poor health conditions of the Third World. It is the single most cost-effective intervention that exists. But secondly, I would like to be remembered as the man who, in the interest of advancing the public health agenda, drew community interest to the idea of prevention being cheaper than cure.”

Dr. Sommer sees the day when people will understand that and support it; when ordinary citizens will take time to be grateful for not dying of a dread disease; and when Baltimoreans and people around the world will recognize the difference between “Johns Hopkins” and The Johns Hopkins University School of Hygiene and Public Health.

That day’s coming—Dr. Alfred Sommer is still in shirtsleeves.
Abell Salutes:
Barclay-Calvert
(Continued from page 1)

- The number of Barclay-Calvert students eligible for Chapter 1 services (federal funding for educational support) testing below 32 percent in third grade reading skill (as an example) was 28 students; for the pre-Barclay-Calvert group testing below 32 percent, 40 students.

- As for incidence of disciplinary removal (DR), during the 1989–90 school year, the last year before the Barclay-Calvert experiment was begun, the principal reported a total of nine DR's in grades kindergarten through four. In the four subsequent years, there have been zero DR's for students enrolled in the Barclay-Calvert program.

- “Data... indicates that in every comparison point students in the Barclay-Calvert program have performed at a higher level on the Comprehensive Test of Basic Skills (CTBS) Total Reading test than have their peers (including brothers and sisters) in the Barclay-Pre-Calvert cohorts.”

- In math, Barclay-Calvert cohorts consistently scored above the national average. Barclay-Calvert students generally outperformed the Barclay-Pre-Calvert cohorts.

“In summary, the Barclay-Calvert students have made academic gains far above those achieved by the preceding Barclay-Calvert students. The gains have come on two separate norm-referenced tests in the areas of reading, language arts/writing, and math. The differences are educationally and statistically significant, and often dramatic. These achievement differences were found in spite of the fact that the two groups of students are from the same community and often from the same families.”

In his report, “Fourth Year Evaluation of the Calvert School Program at Barclay School,” Dr. Stringfield writes that, taken collectively, the progress of achievement at Barclay-Calvert “indicates a very successful school improvement project.” He then addresses the question, “What factors have contributed to this unusual level of success?”

His conclusions: “Part of the explanation must lie in the more demanding curriculum, the greater content coverage, the integration of content, the increase in writing requirements, the insistence on students’ reworking projects until they achieve 100 percent correct products, and the consistency of instruction.” He added that the Calvert program “steadfastly clings to proven basics—they avoid going for the latest thing—and uncompromising standards.”

And if, as is surely the case, the program is successful for the children at Barclay-Calvert, then, Baltimore City School Superintendent Dr. Walter Amprey suggests, “The real value of the program is that it shows what is possible for the children of Baltimore City—not just for Barclay, but for more than 100,000 children in the Baltimore City schools.”

The Abell Report
Published bi-monthly by
The Abell Foundation
111 S. Calvert Street
Baltimore, Maryland 21202
(410) 547-1300

Some Recent Grants
By The Abell Foundation

Advocates for Children and Youth $5,000
For research on a comprehensive approach to welfare reform and development of a policy guide for legislators in order to ensure responsive continuum of services for children and families with special needs.

Archdiocese of Baltimore $45,000
First-year funding for the implementation of “True Love Waits”, an abstinence program for adolescents and young adults.

Baltimore Development Corporation $15,000
Toward a study of the Howard Street Market Center Corridor to examine transportation issues inherent to the revitalization process.

Baltimore Neighborhoods $44,690
To develop a mobility counseling strategy for Baltimore City recipients of tenant-based housing assistance.

Compulsive Gambling Center $15,650
Toward costs related to an accreditation process for its long-term residential treatment program for the compulsive gambler.

Cultural Arts Institute $4,000
To underwrite the cost of an after-school cultural arts program at Collington Square Elementary and to assess subsequent impact on attendance and test scores of participants.

Episcopal Social Ministries $30,939
In support of the Women’s Initiative at Cathedral House, a job readiness program for homeless addicts and alcoholics with small children.

Living Classrooms Foundation $300,000
Toward costs of construction of a new Education Center for the Maritime Institute. The Center will provide programs serving at-risk youth by providing applied learning of math, science, language arts, history, economics and ecology in a maritime setting.

Maryland Alliance for Responsible Investment $20,000
Toward cost of an outreach counseling program which promotes homeownership in low- and moderate-income neighborhoods in Baltimore City.

Maryland Food Committee $35,000
For direct feeding of the hungry at regional soup kitchens and emergency pantries and shelters.