Healthy Children 2010: Next Steps?

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In the past, mental health efforts, because of the health-illness model of individual treatment, have been largely restricted to illness-oriented interventions. We believe, most urgently, that effective primary prevention efforts will be more social and educational than rehabilitative in nature.

— Report of the Task Panel on Prevention
President's Commission on Mental Health (1978)

Founded in 1994 by Eileen Rockefeller Growald and Tim Shriver, the Collaborative for the Advancement of Social and Emotional Learning (CASEL) has an overall mission to support the development of schools that foster knowledgeable, responsible, and caring students. We have the following primary goals:

- Identify and enhance the scientific and theoretical foundation for social and emotional education.
- Foster the international dissemination of scientifically sound SEL educational practices.
- Increase training opportunities for educators to foster implementation of high-quality SEL programs and practices.
- Encourage collaboration and communication among scientists, practitioners, and advocacy groups in their efforts to promote effective SEL programs and practices.
- Increase the awareness of educators, policy-makers, funders, and the public regarding the need for and effects of quality SEL programming.

CASEL currently supports two active work groups comprised of SEL experts from around the world. Each group collaborates on projects to advance the quality of school-based efforts to enhance children's healthy development. The Research and Guidelines Work Group (co-chaired by Mark Greenberg of Pennsylvania State University and Joe Zins from the University of Cincinnati) conducts original research and synthesizes current SEL research to provide a firm empirical foundation for future research, practice, and policy.

For example, work group members recently co-authored *Promoting Social and Emotional Learning: Guidelines for Educators* (Elias *et al.*, 1997), which has been distributed to 100,000 educators by the Association for Supervision and Curriculum Development. With funding from the U.S. Department of Education, work group members are currently conducting a systematic review of nationally available drug prevention, violence prevention, and health education curricula with the intent of creating a consumer's guide for educators. Also, in collaboration with the Center for the Advancement of Health, we are examining empirical studies on relations between children's social-emotional competence and health outcomes in order to articulate the implications of this research for the practice of health care providers and educators.

The Educator Preparation Work Group focuses its efforts on preparing the educational community to integrate SEL programming into the standard preschool through high school educational curriculum. Two current initiatives include (a) writing a new book for educators describing the best SEL practices, and (b) developing pre-service and in-service courses for educators that emphasize scientifically based approaches for implementing SEL programs and practices.

Current updates about CASEL's research, training, and advocacy efforts are continuously posted on our web site: www.casel.org.

SCHOOL-BASED SEL AND HEALTH-PROMOTION PROGRAMS

There is widespread concern that too many children engage in risky behaviors that interfere with their academic performance and development as responsible, productive, healthy citizens. Approximately 25 percent of American youth are vulnerable to the negative consequences of engaging in multiple high-risk behaviors such as school dropout, substance use, violence, and early unprotected intercourse. Another 25 percent experiment with some risky behaviors. The remaining 50 percent, who currently do not participate in such behavior, nonetheless require effective education and strong, consistent support to avoid such involvement.

One could cite many statistics to highlight concerns about the social and health status of our youth. For example, Dryfoos (1997) reviewed national data sources for 14- to 17-year olds and reported the following:

- 30% engaged in binge drinking (5 or more drinks on one occasion) during the past 30 days.
- 30.5% were smokers.
- 25% had engaged in sexual intercourse without a condom.
- 7.9% acknowledged carrying a gun during the past 30 days.
- 8.6% had attempted suicide.
- 25% were one year behind in school and another 5% were two years behind.

Many social, emotional, and physical health problems among America's young people are caused and/or exacerbated by significant changes that have taken place during the past few decades in families, schools, neighborhoods, and the media (Weissberg, Kuster, & Walberg, 1999). One major change in American families has been the dramatic increase in dual-earner and one-parent homes. For example, percentages of children with mothers in the labor force rose from 10 percent in 1940 to 68 percent in 1995 (Hernandez, 1999). These factors, in combination with the breakdown of traditional neighborhoods and extended family networks, have reduced the amount of supportive contact and guidance provided to young people by positive adult role models.

Changing societal circumstances and the high prevalence of adolescent problem behaviors have prompted widespread calls for innovative school, family, and community programming to address children's social, emotional, and health needs. Takanishi (1993, p. 87) challenges us: "As members of U.S. society, we stand at the crossroads: We can make a commitment to support the full development of adolescents into productive adults or we can continue to waste the lives of significant numbers in the youth cohort." Unfortunately, the majority of well-intentioned efforts to prevent students' social and health problems are short term and categorical (*e.g.*, dropout prevention, health education, sex education, violence prevention).

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Although such prevention programs are well-intentioned, one unintended negative consequence is that schools have become inundated with brief, categorical programs that are introduced in independent, isolated ways rather than through systematic, coordinated programming. Introducing these programs in a piecemeal fashion results in disjointed programs that can be confusing to students and overwhelming to teachers.

In addition, schools typically lack organizational structures and resources to support short-term prevention programs. When implementing categorical efforts, schools are less likely to: provide high-quality training and on-site coaching to teachers who introduce programs; monitor the

integrity of program implementation; evaluate program effects on children's skills, attitudes, and practices; and modify and improve programs based on student, teacher, and parent reactions. Lacking an adequate infrastructure to support ongoing implementation, most categorical prevention programs are not given sufficient priority in school- or district-level planning. As a result, they are not allotted sufficient instructional time to affect student social and health behaviors, nor do teachers who implement the programs receive adequate training. Without systems-level supports, these programs have little opportunity of becoming institutionalized efforts that evolve and strengthen over time.

In recent years, investigators have begun to integrate the strengths of currently available prevention programs into coordinated school-family-community partnerships to promote positive academic, social, emotional, and health behaviors. CASEL is committed to helping educators effectively implement scientifically based, multiyear SEL programs that educate students so that they:

(a) are motivated to learn and achieve academically;

(b) engage in positive, safe, health practices;

(c) are socially skilled and have positive relationships with peers and adults;

(d) contribute responsibly and ethically to their peer group, family, school, and community; and

(e) acquire a basic set of skills, work habits, and values as a foundation for a lifetime of meaningful work.

Research indicates that it is possible to teach children a variety of SEL competencies that mediate positive academic performance, health, and citizenship. Such competencies include:

- knowing one's emotions: self-awareness or the ability to monitor feelings from moment to moment;
- managing one's emotions: emotional regulation skills such as self-control and stress management;
- self-efficacy: confidence in one's ability to handle situations effectively;
- perspective taking: accurate perceptions of situational demands and the feelings and perspectives of the people involved;
- prosocial goal setting: attitudes and motivation to establish adaptive goals;
- problem solving: capacity to access/generate goal-directed alternatives and link them with realistic consequences;
- decision making: choosing responsible, effective solutions;
- means-end planning: developing elaborated implementation plans that anticipate potential obstacles;
- communication and social skills: carrying out chosen solutions with behavioral skill;
- self-monitoring: observing behavioral impact with the capacity to abandon ineffective plans, try backup strategies, and reformulate goals as needed; and
- emotion-focused coping or self-reward: engaging in emotion-focused coping when a desired goal cannot be reached, or providing self-reinforcement for successful goal attainment.

Researchers have developed and evaluated a variety of SEL programs designed to address diverse social and health problems. For example, in Weissberg, Barton, and Shriver's (1998) social-competence promotion program for young adolescents, teachers train students to employ a six-step social-information processing framework for solving a wide range of real-life problems. A traffic-light poster is used to display the following, sequential six-step process:

1. Stop, calm down, and think before you act.
2. Say the problem and how you feel.

3. Set a positive goal.
4. Think of lots of solutions.
5. Think ahead to the consequences.
6. Go ahead and try the best plan.

Through explicit instruction in the six steps, teachers, parents, and students learn a common language and framework for communicating about problems. Furthermore, the traffic-light poster is a visual reminder to prompt students to apply problem solving throughout the school and at home.

The best school-based SEL programs involve multiyear, multicomponent intervention approaches that:

(a) enhance the capacities of children and adolescents to coordinate cognition, affect, and behavior so that they may adaptively handle developmentally relevant social tasks; and

(b) create environmental settings and resources that support using adaptive behavior and achieving good developmental outcomes (Weissberg & Greenberg, 1998).

Comprehensive, multi-year SEL programs have produced positive effects on children's problem-solving skills, academic performance, social behavior, and health. They also have positive impact on teachers who have reported improvements in problem solving, handling stress and communicating with students.

An exemplary district-wide comprehensive social development effort has been established by the New Haven Public Schools (Weissberg, Shriver, Bose, & DeFalco, 1998). At the core of the New Haven Social Development Project, kindergarten through high school teachers provide 25 to 50 hours of planned, ongoing, and systematic classroom-based SEL instruction at each grade level. Instruction focuses on self-management, problem solving, communication skills, and prosocial attitudes and values about self, others, and tasks. Students learn to apply SEL skills to health concerns, relationships, and constructive participation in classroom, school, and community activities. Classroom-based SEL education is coordinated with school, family, and community initiatives that reinforce children's positive social and health behavior.

Comprehensive, multi-year SEL programs, such as the New Haven Social Development Program, have produced positive effects on children's problem-solving skills, academic performance, social behavior, and health (Weissberg, Gullotta, Hampton, Ryan, & Adams, 1997). They also have positive impact on teachers who have reported that their own problem solving in their personal life improved, their ability to communicate with students improved, and their capacity to deal with stress in their own lives improved.

There is a growing consensus regarding the following perspectives on effective SEL programs:

- SEL programs that involve school-family-community partnerships produce more positive effects than initiatives that include only school-based programming.
- One-year SEL programs do not permanently inoculate children, especially from high-risk environments. Multiyear programs have had more impact.
- Many high-risk behaviors cooccur and result from common protective and risk factors, so in the long run, it may actually be more cost effective and beneficial for SEL programs to target multiple rather than single categorical outcomes.
- Program designers often start by designing and evaluating short-term approaches that address a specific problem behavior, like substance use or violent behavior. However, with experience over time, they begin to think of more holistic, multicomponent approaches that target multiple behaviors.
- Programs that promote positive academic, social, and health behavior in the context of the same coordinated effort will be best received by schools and are more likely to be institutionalized. Thus, the goals of drug or violence prevention programs must

go beyond affecting those categorical outcomes and also emphasize ways that SEL skills can promote positive academic performance.

- The quality of training and support for people who implement SEL programs and the personal skills and characteristics of program implementers are vital to the success of SEL programs.
- Collaborative, interdisciplinary research — involving researchers, program designers, practitioners, and participants — is critical for the creation of coordinated, comprehensive SEL efforts.

HEALTHY CHILDREN 2000 AND 2010

The research on school-based SEL and prevention programming (Weissberg & Greenberg, 1998; Weissberg et al., 1997) supports Objective 8.4 from Healthy People 2000 which proposed to increase to at least 75 percent the proportion of the nation's elementary and secondary schools that provide planned and sequential kindergarten through 12th grade quality school health education.

Providing only one year of health education contradicts the research evidence, which suggests that more systemic approaches and multi-year approaches are needed.

The Centers for Disease Control Division of Adolescent and School Health defined comprehensive school health education in a way that complements the perspectives and findings discussed in this overview. They identify the following key elements of comprehensive school health education:

- a documented, planned, and sequential K to 12 program;
- a curriculum that integrates education about a range of categorical health issues at developmentally appropriate ages;
- activities that help young people develop health-promotion and health-protective skills, not just acquire information;
- instruction is provided for a prescribed amount time at each grade level;
- management and coordination by an education professional who is trained to implement the program;
- instruction from teachers who are trained to teach the subject;
- involvement of parents, health professionals, and other concerned community members; and
- periodic evaluation, updating, and improvement.

CASEL applauds Objective 8.4 from Healthy People 2000, and believes it is an appropriate goal to which researchers, educators, and policy makers should aspire. A critical question then involves how close the nation is to achieving this objective. Unfortunately, *Healthy People 2000 Review, 1995-96* estimated that only 2.3 percent of schools actually provided all recommended components of quality health education (National Center for Health Statistics, 1996). Given the gap between state-of-the-art programming proposed by Objective 8.4 and state-of-practice across the nation, it is appropriate to ask how this objective should be revised in Healthy People 2010.

According to *Healthy People 2010 Objectives: Draft for Public Comment* (September 15, 1998), Objective 4.2 — the proposed revision for 8.4 — offered the following recommendation: "Increase to at least 30 percent the proportion of the nation's middle/junior high and senior high schools that require one school year of health education."

The difference between the two is stunning. While the new objective appears to encourage our nation to strive for a more achievable objective, research suggests the intensity of programming recommended by Objective 4.2 is insufficient to enhance children's behavior. Although it may be realistic to reduce the proportion of schools from 75 percent to 30 percent, it is troubling to read the proposed revision which suggests requiring one year of instruction at the middle/junior and high school level in contrast to offering "planned and sequential kindergarten through 12th grade *quality* (emphasis added) school health education." Provid-

ing only one year of health education contradicts the research evidence, which suggests that more systemic approaches and multiyear approaches are needed.

In addition, it is clearly important to begin such instruction with children before they enter middle/junior high school.

Fortunately, the development of Healthy People objectives is an inclusive, iterative process. Many advocates for quality school-based prevention programming have shared our perspectives on ways that the new objective should be modified, and Objective 4.2 has since been revised based on public comments. The current version now recommends the following: "Increase to at least (figure to be determined) the proportion of the nation's elementary, middle/junior, and senior high schools that require health education on at least the following six categories of priority health risk behaviors: behaviors that contribute to unintentional and intentional injuries; tobacco use; alcohol and other drug use; avoiding unintended pregnancies, HIV infection, and other sexually transmitted diseases; dietary behaviors and nutrition; and physical activity and fitness."

This objective will be subjected to continued scrutiny and revision up until the time Healthy People 2010 goes to press for release in January 2000. There are improvements in this latest revision. For example, it adds "elementary schools" and no longer recommends providing "one school year" of health education for each school level. However, analyses of the best research and practice suggest that it is planned and sequential K to 12 SEL and health education that is most likely to result in institutionalized school programming and to enhance children's social, emotional, and health practices. Scientists, educators, policy-makers, and the public should support the implementation of K to 12, quality SEL and health education — both as an objective for Healthy People 2010 and ultimately for 100 percent of our nation's schools.

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