International Center for Leadership in Education

The Tipping Point

DEVELOPING A STRATEGIC PLAN FOR ADDRESSING SOCIAL/EMOTIONAL LEARNING SYSTEMWIDE

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- ***A kindergarten boy with severe anxiety comes to school every day and hides under his desk.***
- ***A second-grade boy carries a teddy bear to help him cope with his separation issues; his bus driver steps in frequently to prevent or disrupt bullying.***
- ***Three middle school students, all struggling with the family dynamics of divorce, seek support and compassion from their teachers.***
- ***A high school girl's extreme eating disorder negatively impacts her self-esteem and relationships with family and friends.***

Do any of these situations sound familiar?

We know our world is changing dramatically and rapidly. Likewise, so have the needs of our students. The need for social and emotional support has never been greater and is proving critical to success in school and beyond.

Over the past few months, I have been asking educators in urban, suburban, and rural schools across the country if they are experiencing an increase in mental health problems with students. The response is remarkably loud, clear, and consistent: a resounding YES!

This resonates most strongly with teachers and support staff, whose experiences above run the gamut. They experience many facets of multiple student behavioral health issues, like those above, on a daily basis.

This growing challenge has become a major barrier for them to effectively "do their job," i.e., meet the expectations and focus put on standards and tests in the past few years. The changes in the teacher evaluation requirements have further cemented that belief in teachers' minds.

Students issues, from disruptive behavior to lack of focus to mental health, is a huge obstacle for them in "doing their job."

Their concern is not misplaced. There are growing mental health—or what the field of psychology is calling behavioral health—issues with our children. Consider these statistics:

- Mental health and behavioral disorders are diagnosed in 1 out of 7 children ages 2-8, most commonly in non-Hispanic white boys[1]
- 1 in 12 high school students have cut themselves[2]
- 16% of high school students have thought seriously about suicide[2]
- 18% of college students have thought seriously about suicide[2]
- Since 2010, among teen girls:
  - Suicide rates increased 65%
  - Severe depression increased 58%
  - Feelings of hopelessness increased 12%[3]
- According to the World Health Organization, 21% of girls ages 13 to 18 suffer a serious mental/behavioral health condition during the developmental years.

What is causing this phenomenal growth in behavioral health issues?

Technology

- *Lack of deferred gratification*. Our children's constant use of technology has created an expectation of immediate feedback. Deferred gratification, an important skill for good behavioral health, is not being adequately developed.
- *Lack of deep relationships.* While our children are developing relationships, they are not deep, personal relationships needed for good behavioral health.
- *Prevalence of online bullying.* Bullying via social media has become too common of an occurrence.
- *Exposure to inappropriate material.* A simple internet search can lead to explicit content—including unexpected traumatic events and graphic images—that kids do not yet have the emotional capability to deal with.
- *Digital citizenship.* Understanding the impact of plagiarism, one's reputation, and one's digital footprint including internet searches, social media posts, and more.

Medical

- *Drug Use*. From 2000-2012, we've experienced a 383% increase in children born addicted to a substance, often due to legal medication the mother is on for pain or depression.[4]

Home

- *Missing adults.* Many children have little adult contact in the home.
- *Helicopter adults.* Other children are so overprotected by helicopter parents they do not develop adequate emotional and social skills.

School

- *Increasingly stressful environment.* Tests have caused school to be overly stressful for many students.

The increase, in part, may be influenced by the fact that it has become more socially acceptable to discuss mental/behavioral health issues that affect us or our loved ones. We are beginning to appropriately address this as a both a developmental and medical problem that lies along a spectrum, or continuum.

I have personally come to grips with this in my own family. One of my sons struggles with extreme anxiety. It impacts his ability to stay focused at work and in his personal relationships. His children are now exhibiting similar characteristics.

In fact, five of my 11 grandchildren have some form of a behavioral health issue. On the lower end of that spectrum is my granddaughter who has Attention-Deficit Disorder. In the middle are two of my grandchildren who have high anxiety disorders. At the severe end of the spectrum are my two grandchildren who were born to cocaine-addicted mothers and suffered from abuse in multiple foster homes before being adopted by my son. These boys have debilitating behavioral health issues that require intense psychotherapy on an ongoing basis.

Many of us face issues like these on a daily basis—both personally and professionally with our students.
Just as there are developmental and preventative practices to maintain a healthy physiological lifestyle, such as diet, exercise, sleep, and avoiding stressful situations, there are also developmental and preventative practices for mental/behavioral health. However, in our schools, we need to prioritize the identification of these practices and integrate them into teaching and learning, rather than simply addressing at the intervention and treatment levels.

To combat this growing challenge, school boards and administrators have had to use increasingly scarce financial resources to hire social workers, counselors, psychologists, and other staff to support our teachers and building administrators. Those expenditures have, in many districts, come at the expense of shifting to fewer teachers and larger class sizes. The impact of these shifts are obvious to any of us who have ever taught.

We need to be proactive and set students up for success in acquiring knowledge of mental health needs and developing coping skills. We need to develop a plan of action to address these needs, no matter the severity, and collectively create a supportive school culture in which all students can thrive.

These challenges have led to a growing national call for Social and Emotional Learning (SEL) in our schools. While this term is being increasingly used, I respectfully suggest that it has yet to be well defined to effectively create action plans to address in our schools.

DEFINING THE NEED FOR SEL

With SEL now supported by the Every Student Succeeds Act (ESSA), we are faced with a challenge: Do we need to create preventative educational programs focused on social-emotional learning? Or do we need to address mental health at the intervention level in schools? The answer is both.

We also need to shift our mindsets from *"What is wrong with this child?"* to *"What happened to this child?"* The former approach places blame on the child and assumes he or she has made the choice to act out. More often than not, a behavioral health issue is the culprit.

A broken arm or heart disease has a clear path to diagnosis, but clearly identifying behavioral health issues is difficult. When does sadness become depression? Apprehension become anxiety? Fear become phobia?

The preponderance of behavioral health challenges has reached a Tipping Point. We need far more than a discussion and vague plans around SEL. We need to be proactive and set students up for success in acquiring knowledge of mental health needs and developing coping skills. We need to develop a plan of action to address these needs, no matter the severity, and collectively create a supportive school culture in which all students can thrive. As educators, we need to readdress and redefine our roles and responsibilities.

Is it our job to develop core academic skills in our students or is it broader than that? Is it the development of the whole child? I suggest it is the latter; we are responsible for the development of both academics and behavioral health skills and knowledge.

SEL: A CORE RESPONSIBILITY

For 26 years, the International Center for Leadership in Education has identified and showcased the nation's most rapidly improving schools and innovative districts at the Model Schools Conference. Over the past year, I have chaired a national study of these districts for AASA and the Successful Practices Network, funded by HMH. As the study unfolded, I had an epiphany: these innovative model districts approach the issue of behavioral health differently than traditional schools. They do not see it as an issue to be handled by "support staff" so teachers can get on with "doing their jobs" of teaching academics. They see it as a core responsibility of all teachers. It is integrated into all existing courses and school activities. It is regarded as equally, if not more, important than academic preparation of students.

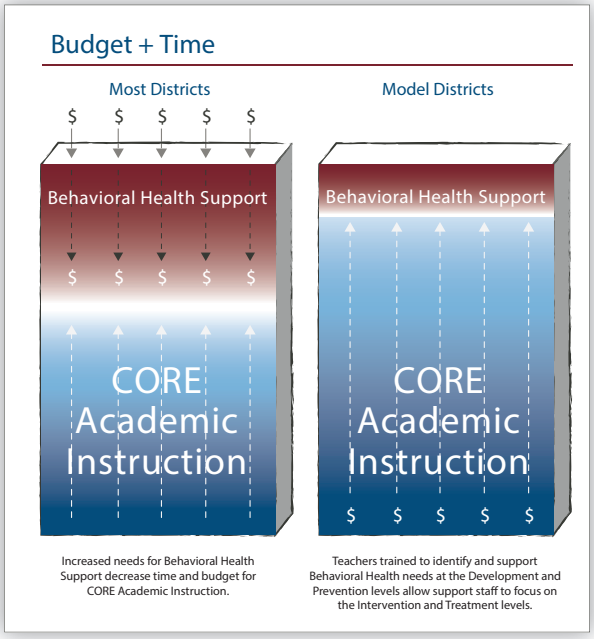

Figure 1

These districts have reworked staffing patterns, teacher evaluation, professional development, student report cards, and much more. They proactively address behavioral health issues at the development and prevention levels with core academic teachers rather than reactive at the intervention and treatment levels requiring more "support staff" at the expense of decreasing teaching staff.

As shown in *Figure 1*, at top right, most districts have added additional staffing and related expenditures as a standalone support system and not directly tied to the instructional program. They have not treated the issue as an instructional issue.

In our study of the nation's most successful innovative districts, we found them addressing this as a core instructional issue, thus not reducing the resources and time in their instructional programs.

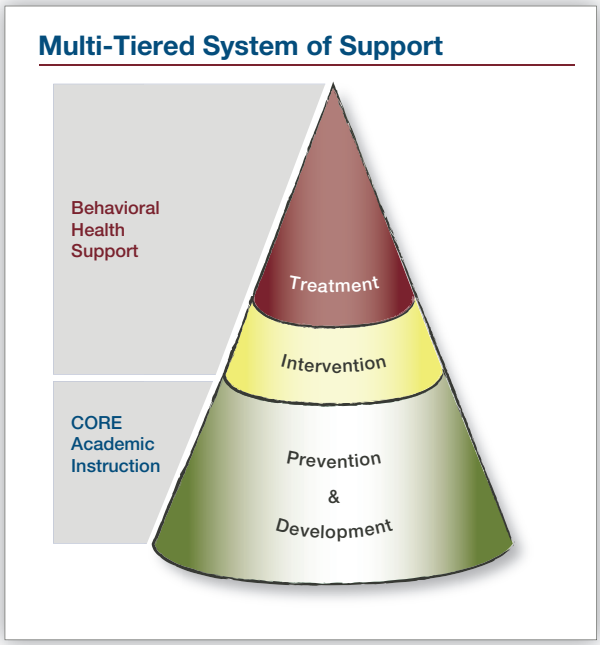

Figure 2

A MODEL TO GUIDE US

Behavioral health issues can be placed on a spectrum, similar to that in *Figure 2* (bottom right). We need to understand issues at all levels, know how to address them, and have strategies to do so. We need a continuum of programs, services, and strategies to address developmental needs at all levels.

We also need to be very thoughtful and strategic in our approach. The first step in doing so is to conceptualize where we are and where we want to go in terms of addressing behavioral health issues in our schools.

A Multi-tiered System of Support, or MTSS, can guide a proactive approach.

I respectfully submit that most schools have addressed this issue at the intervention and treatment levels. As students struggle with behavioral health issues, we pull them out of the classroom and have a growing "support staff" attempt to address the students' issues and challenges. This enables the core academic teachers to get on with their "job", i.e., academic preparation.

However, when teachers are trained to identify and support behavioral health needs at the development and prevention levels, support staff can focus on the intervention and treatment levels. Districts that make behavioral health a core responsibility of all staff, rather than a support service, find that when the majority of the content and time is spent on SEL at the developmental and prevention levels, less time is needed at the intervention and treatment levels.

DEVELOPING BEHAVIORAL HEALTH COMPETENCIES

Organizations such as Collaborative for Academic, Social,and Emotional Learning (CASEL) and a national commission created by the Aspen Institute have developed a series of skills and competencies that comprise behavioral health including:

- *Self-Awareness:* Competence in the self-awareness domain involves understanding one's emotions, personal goals, and values. This includes accurately assessing one's strengths and limitations, having a positive mindset, and possessing a well-grounded sense of self-efficacy and optimism. High levels of self-awareness require the ability to recognize how thoughts, feelings, and actions are interconnected..
- *Self-Management:* Competence in the self-management domain requires skills and attitudes that facilitate the ability to regulate emotions and behaviors. This includes skills necessary to achieve goals, such as the ability to delay gratification, manage stress, control impulses, and persevere through challenges.
- *Social Awareness:* Competence in the social awareness domain involves the ability to take the perspective of and have respect for those with different backgrounds or cultures, and to empathize and feel compassion. It also involves understanding social norms for behavior and recognizing family, school, and community resources and supports.
- *Relationship Skills:* Competence in this domain involves communicating clearly, listening actively, cooperating, resisting inappropriate social pressure, negotiating conflict constructively, and seeking help when needed. Relationship skills provide individuals with the tools they need to establish and maintain healthy and rewarding relationships, and to act in accordance with social norms.
- *Responsible Decision-Making:* Competence in this domain requires the ability to consider ethical standards, safety concerns, and make accurate behavioral assessments to make realistic evaluations of the consequences of various actions, and to take the health and well-being of self and others into consideration. Responsible decision making requires the knowledge, skills, and attitudes needed to make constructive choices about personal behavior and social interactions across diverse settings.[5]

These are the skills needed to deal effectively and ethically with daily tasks and challenges. However, we must be able to effectively measure growth of these competencies, monitor them, and continuously build them into the culture and curriculum in our schools in multiple ways so all staff are equipped to support students like the boy under the desk, the boy with the teddy bear, the girl with the eating disorder and self-esteem issues—and anything in between. Comprehensive and sustained professional learning experiences for all staff are key.

BUILDING RELATIONSHIPS

A well-thought-out scope and sequence for the development of these competencies is also essential. To develop that, a framework is needed to think through what we need to teach in and around behavioral health at the development and prevention levels. ICLE's Rigor/Relevance Framework® (*Figure 3*), a tool useful in examining curriculum, instruction, and assessment based on two dimensions, the Knowledge Taxonomy and the Application Model, can help guide development.

We can further define each quadrant in this framework to encompass SEL competencies, as shown in *Figure 4*. There are strategies we can use in our schools to address all four quadrants. For example, in both Quadrants A and C—Acquisition and Assimilation, respectively—students can be given the task of writing about the five CASEL competencies of self-awareness, self-management, social awareness, relationship skills, and responsible decision-making. The field of psychology has taught us that when we write to describe our feelings with precision, it can give us information we can act upon. In Quadrant A, we can do that at a personal level. In Quadrant C, we can do it to describe what/how we can do it as an individual to create a community that exhibits the desired competencies.

As we learned from the national study of innovative districts, they developed their scope and sequence for developing these competencies by pulling from the lessons learned in and around sex education, drug education, and character education. They also typically leverage staff in the non-core academic instructional programs (the arts, music, physical education, career/technical education) who have expertise and curriculum knowledge in these areas. Outside interscholastic athletics and youth organizations like 4H, Boy Scouts and Girl Scouts, FFA, FBLA, and others were valuable resources as well.

The districts then created specific curriculum by grade spans that were then coordinated into a K-12 comprehensive curriculum.

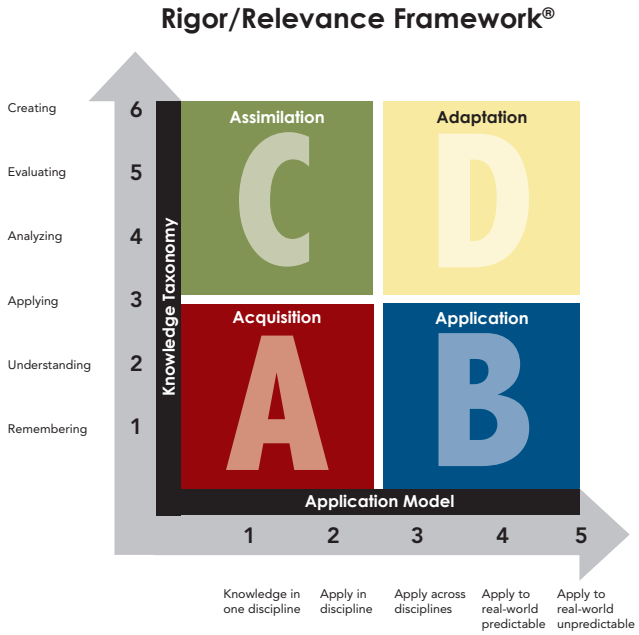

Figure 3

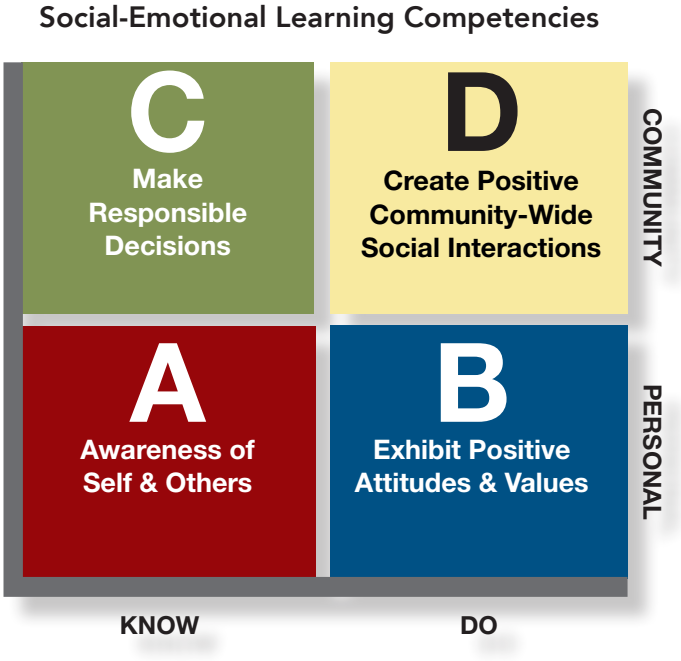

Figure 4

Interestingly, they found in effect the very programs and experiences we had been pulling our students out to double them up in our core academic courses—seen as our number one job by most—was were where much of the solution to building competency in these areas lied.

MEETING THE CHALLENGE

We have reached a Tipping Point on the need to address SEL and behavioral health issues with our children. Fortunately, successful strategies and procedures of how to address this critical challenge have now been developed by our nation's most successful innovative districts.

The AASA/SPN/HMH study of the nation's most rapidly improving schools and innovative districts has evidenced the need for school leaders to:

- Recognize that behavioral health lies on a continuum, from development to prevention to intervention to treatment, and more support is needed on the lower end as a preemptive measure.
- See behavioral development and health as a core responsibility of our schools, not simply a support system for select students.
- Use a framework to guide program development, curriculum, instructional strategies, and professional learning for all staff.

To address SEL and behavioral health challenges, schools and districts must:

- *Define the Problem*: Using survey instruments and discussion/focus groups representing district teachers, administrators, parents, and community members, work to clearly identify the challenges within the district. Districts need to "own the issue" and not treat it as just a national issue.
- *Establish District Goals:* After defining the problem, schools and districts create clearly identified and measureable goals and a plan to monitor progress.
- *Create the Culture*: Through a series of presentations and discussion sessions both within and across the district—and that pull applicable data—create a culture that will support a comprehensive boardroom-to-classroom plan to address district behavioral health challenges.
- *Develop an Instructional Plan:* Create the scope and sequence for the preK-12 instructional content and strategies to integrate SEL into the ongoing instructional program. Instructional content and strategies from the districts that have been most successful in addressing the issue can be used as your point of departure. This will save your district considerable time and expense.
- *Address Needs for Intervention and Treatment:* The above actions will provide your district with a solid plan to address SEL at the developmental and prevention levels. Unfortunately, you will still have some children in crisis that will need intervention and treatment. Fortunately, our experience is showing the number needing this level of support will decline dramatically with a solid development and prevention plan. However, you must still have a plan that includes the best strategies and procedures to assist these students in crisis.

- *Children in Trauma:* Working with the National Dropout Prevention Center, we have identified and shared the most effective practices to assist children in trauma. Traumas such as abuse, parent death, sudden homelessness, etc., need to be addressed differently than the ongoing program designed for all students.
- *Cost Effectiveness of Plan:* Some administrators, boards, and community activists will say SEL is not the responsibility of schools and that the district cannot afford to address it. However, research from both CASEL and the Aspen Institute provides evidence that it actually reduces overall district cost to implement the above actions. These actions lead to a dramatic decrease in intervention and treatment programs that are very expensive. A CASEL research study shows that for every dollar spent on development and prevention leads to an $11 savings on intervention and treatment initiatives.

From both a personal and professional perspective, nearly all of us have struggled with how to help the children we interact with daily cope with stress in their lives. As with all physical- and mental health-related issues, early intervention is very important. SEL needs to be a central part of that early intervention for all of our children.

We have a responsibility to develop the whole child – not just the "academic" child. It is time to love the whole child and to do everything we can to help them become successful in life's most critical skills, which are more than just academics.

WE CAN HELP

- If you would like guidance on how to create the culture that supports the behavioral health for ALL students—at the development, prevention, intervention, and/or treatment levels—please contact the International Center for Leadership in Education.

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