Mary Connolly

SKILLS-BASED HEALTH EDUCATION

SECOND EDITION

Mary Connolly, MED, CAGS
Cambridge College

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Dedicated to pre-service, in-service, and college instructors who are learning or reinforcing how to teach skills-based health/social emotional learning.

Dedicated to my personal editor, soul mate, and best friend—my husband, Richard.

Brief Contents

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Preface

Scenario I

"Mr. Editore, what happened to your arm?" asked Chris, a student at the Trafficanto Middle School. "Were you in an accident?"

"I am fine; I'll tell you in class."

"When I broke my arm, the doctor gave me a cast. What doctor did you go to? Yours is sticks and bandages!"

Mr. Editore smiled and said, "I'll see you inside." When the bell rang, Mr. Editore entered the classroom and observed the students looking at the splints, bandages, and blankets placed at each of five stations. They were curious and eager to begin class.

"So, you are all wondering what happened to me?" Mr. Editore said as he removed the bandages and splints. "Actually, I thought it would be a good way to start the practicing healthy behavior unit on first aid."

"I need a volunteer for a role-play. Anyone? Okay. Thanks, Neil."

"Here is the setup. Neil, you and I are mountain biking, and you tried to jump over a tree trunk but didn't make it. Your lower arm looks broken, and you are screaming in pain! Ready?"

Teacher: It's a good thing I know first aid! Give me your arm.

Neil: (Moans in pain.)

Teacher: First, I'll place these two straight pieces of wood on either side of the break and secure them with strips of an old T-shirt. How are you doing, Neil?

Neil: (Moans in pain.) I thought I could make it over that log.

Teacher: The bone did not come through the skin, so it's a closed fracture. That's good news. I'll make a sling with my jacket to immobilize your arm. I can walk both bikes out of the woods.

Neil: Thanks. Can you call my mom? Man, this really hurts.

After the story and demonstration, students applauded and eagerly went to their stations, motivated to practice the skill of splinting. To help them remember how to splint and increase their self-confidence, Mr. Editore prepares pictures of the sequence. He also includes an analytical rubric to show students how they are assessed.

Mr. Editore coaches the students by comparing their performance to the pictures and the rubric. He determines from this formative assessment that the students understand how to splint. As he walks from station to station, students ask questions, and Mr. Editore offers suggestions for improvement.

A summative assessment, given at the end of the unit, consists of students demonstrating first aid in response to a variety of scenarios. Mr. Editore uses an analytical rubric to grade their performance and a written test for the content.

Scenario II

At the Hightower Middle School, Mrs. Adams began her first aid class by distributing a worksheet and directing the students to complete it during her multimedia presentation on fractures and splinting. Mrs. Adams frequently stops the presentation to correct Kyle and Amy, who are misbehaving. She assesses her students on how accurately they complete the worksheet and answer questions on a written test.

Skills-Based Health/Social Emotional Learning

What is the difference in pedagogy between these two scenarios? If you broke your arm, which student would you want to administer first aid? One who has learned content and skill, or one who has learned only content?

To be prepared for the 21st century, students must be knowledgeable about their health, appreciate the value of social and emotional learning, have the skills to respond to life's challenges in a healthy way, avoid risky behaviors, and develop and maintain healthy behaviors. In other words, they need comprehensive, PreK–12, skills-based health/social emotional learning education.

WHAT IS NEW?

In the second edition of *Skills-Based Health/SEL Education*, college professors, pre-service teacher candidates, and in-service educators learn to align social emotional learning competencies to standards and design and teach skills-based/SEL units and lessons through a step-by-step backward design.

- **Step 1**—Access and analyze student risk behaviors.
- **Step 2**—Select a National Health Education Standard 1 and a skills (Standards 2–8) performance indicator

to reduce the risk factor. Align an SEL competency to the standards.

- **Step 3**—Infuse the performance indicators with content.
- **Step 4**—Design the assessment based on the infused performance indicators and SEL competency.
- **Step 5**—Design the instruction based on the assessment.
- **Step 6**—Outline the lessons for the skills-based/SEL unit.

ORGANIZATION OF THE TEXT

Chapter 1, Health/Social Emotional Education for the 21st Century, provides an overview of the Every Student Succeeds Act of 2015 and examples of comprehensive school and community programs that support safe and healthy students. Also new to the chapter is how social emotional learning (SEL) competencies are aligned with the National Health Education Standards and how brain research supports the skills-based/SEL pedagogy of student-centered learning. The foundation of the text is still the National Health Education Standards and performance indicators and how to teach content through the skill. The CDC/ASCD Whole School, Whole Community, Whole Child (WSCC) section provides an explanation of the model and samples of research that support each component. "How Skills-Based Health Education Supports National Initiatives" is updated and includes information about the Centers for Disease Control and Prevention, Healthy People 2020, Health Education for the 21st Century, and the Common Core State Standards.

Chapter 2, Theoretical Foundations, updates include alignment with social emotional competencies, the WSCC model, and chapter worksheets that challenge the student to demonstrate the application of the theory with classroom practice.

Chapter 3, Curriculum and Instruction, trains the student, step by step, to use the verbs of the performance indicators and SEL competencies to inform assessment and instruction. To accommodate different learning styles, graphic organizers and tables demonstrate how to teach the verbs. The organizers are also linked to chapter worksheets to provide additional practice. The chapter references the CAEP Health Education Teacher Education Standards, which provide the instructional foundation for teacher education institutions. The end of the book includes worksheets that provide reinforcement and practice of content, skill, and SEL competencies.

Chapter 4, Assessment, includes how to align and integrate SEL competencies with the infused performance indicators. The chapter presents additional formative assessments and how to use them to improve teaching and learning. The rubric section presents different types of rubrics and how to score non-standard criteria on a standards rubric.

Chapter 5, Teaching National Health Education Standard 1, demonstrates through the grade spans, how to pair Standard 1 performance indicators with skills indicators and SEL competencies to target instruction and reduce risk factors.

Chapters 6–12 are **the skills chapters.** In each grade span, the student learns how to align SEL competencies using the step-by-step process. To differentiate instruction, directions are provided for the college instructor and in-service teacher. Every table provides time for student practice through the writing of prompts and answering performance indicator/SEL questions, and a space to reflect. Every grade span includes a sample unit plan, rubric, lesson outline, and how the instruction aligns with SEL and the WSCC model.

Instructor and Student Support Material

- Lecture Outlines in PowerPoint format
- Test bank
- Chapter worksheets at the end of the book are also available in electronic format on the companion website. These worksheets reinforce information taught and provide additional practice.

The second edition includes a multitude of chapter worksheets that provide practice in learning to teach a skill/SEL competency: steps for teaching the standard, blank unit plan and lesson outline templates, and classroom skill/SEL practice worksheets for the in-service teacher.

Over the past few years, I have embraced SEL because it strengthens, supports, and reinforces the work of skills-based health and physical educators. As PreK–12 licensed professionals, we are best equipped to teach the SEL competencies and implement school-wide initiatives through the WSCC model. We have been teaching many of the recommended CASEL curricula for years. The research that supports the efficacy of SEL often supports skills-based instruction. Aligning SEL to skills-based health/physical education and 21st-century skills provides a solid foundation of content and skills to prepare youth to cope with life's challenges in a healthy way.

Use the second edition to embrace skills-based health/SEL education, as I have, because it is effective, rewarding, and enjoyable.

Acknowledgments

As a second edition writer, I am excited to share improved instructional strategies and tools designed as a result of using the first edition. I have every confidence this text facilitates and improves teaching and learning. Of course, the main objective is to help youth develop and maintain healthy behaviors. This second edition provides the knowledge and skills educators need to continue to help our youth respond to the challenges of everyday living in a healthy way, improve their academic performance, and prepare them for life in the 21st century.

I could not have completed the book without the guidance and encouragement of the Jones & Bartlett Learning staff. Many thanks are extended to the editors, proofreaders, graphic designers, artists, and support staff who made this experience exciting and rewarding.

I also extend thanks to my family, friends, and colleagues who validated my work and encouraged me throughout this extraordinary endeavor.

Reviewers

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About the Author

Mary Connolly is the Program Chair of Skills-Based Health/Social Emotional Learning at Cambridge College, Charlestown, Massachusetts. At the college, she manages the program and teaches Implementing Curriculum in the Health/SEL Classroom, Assessing Health Literacy, and Assessment in the Health/SEL Classroom. For several years, Mary also taught a Personal Health course to undergraduate students at Curry College in Milton, Massachusetts.

Mary is the author of *Skills-Based Health Education*, Second Edition, a text used by university health teacher preparation programs and in-service health education professionals. The text uses a backward design step-by-step process to train teachers how to teach skills-based health/SEL education. She is a member of SHAPE America, MAHPERD, and ASCD. She was the 2017–2018 vice president for health education for the Massachusetts Association for Health, Physical Education, Recreation, and Dance (MAHPERD). Mary is currently the past health education vice president for MAHPERD.

On the national level, Mary presents at SHAPE America national conferences, designs and webinars for SHAPE America, and participates in SHAPE America Twitter Chats and is the current chair of the HETE/PETE national conference committee. She served on the committee to revise the national Health Education Teacher Education (HETE) standards, the SHAPE America National Health Education Standards committee, the HEAP assessment committee, and has coauthored SHAPE America online professional development courses. She served on the committee that revised the National Health Education Standards and the SHAPE America committee that produced the Appropriate Practices for School Based Health Education.

Mary is a health education consultant and helps districts transform their content-driven curriculum to a skills-based/SEL program. She is also a vendor for the Massachusetts Department of Elementary and Secondary Education.

Mary has been married to her husband Richard for 50 years. They enjoy traveling, ballroom dancing, cooking, having fun with their family, in particular thier five grandsons, and time with friends.

Foreword

A new feature of the second edition of Skills-Based Health Education is the integration of the social emotional learning (SEL) competencies self-awareness, social-awareness, responsible decision making, self-management, and relationship skills[1] into skills-based instruction.

The implementation of SEL includes freestanding lessons, general teaching practices, lessons integrated within academic curriculum, and school-wide initiatives.[2] Skills-based health/SEL education is designed to be taught PreK–12 by licensed educators and implemented through an approved district-wide curriculum. The combination of the two approaches through the Whole School, Whole Community, Whole Child model provides comprehensive skills-based programming that benefits the student, school, families, and the community.

The Collaborative for Academic, Social, and Emotional Learning (CASEL) provides research about the efficacy of SEL and documents the effectiveness of selected health curriculum in the CASEL guidelines. Since skills-based health education shares the same skills as SEL and use many of the curriculum recommended in the CASEL guide, the research also supports skills-based health education.[3]

This text trains educators to combine the National Health Education Standards and the Social Emotional Learning Competencies in planning, assessment, and instruction with the goal of helping youth increase their academic performance and develop and maintain healthy behaviors for life in the 21st century.

References

1. CASEL. (2017, November 10). Core SEL Competencies. Retrieved from http://www.casel.org/core-competencies/
2. CASEL. (2017, November 12). Approaches. Retrieved from http://www.casel.org/what-is-sel/approaches/
3. CASEL. (2017, November 12). CASEL. Retrieved from http://www.casel.org/

CHAPTER 1

Health/Social Emotional Education for the 21st Century

"Skills-based health education may be effective in the more difficult task of achieving and sustaining behavior change."[1]

Introduction

We want our children to have healthy, happy, and productive lives, but how can we make it happen? Achieving this goal requires a group effort that includes family, friends, community, and schools. With sufficient resources, support, and partnerships, schools provide an excellent environment for students to acquire the knowledge and skills to become wholesome, achieving citizens of the 21st century.

Skills-Based Health Education and Social Emotional Learning

Skills-based health education and social emotional learning (SEL) complement each other and provide the content and skills youth need to meet life's challenges. SEL is the process of developing the skills needed for effective self-management as well as managing relationships with others. Acquiring these skills prepare youth for the challenges of establishing a career, being a productive citizen, and becoming a community leader.[2]

The Collaborative for Academic, Social, and Emotional Learning (CASEL) recommends four skill training practices (**Table 1.1**). These practices are aligned with the implementation practices of skills-based health education.

CASEL identifies five SEL core competencies (**Figure 1.1**). Skills-based health education aligns and supports each of these competencies (**Table 1.2**).

The combination of skills-based health education and SEL synergizes the effects of each resulting in greater knowledge and skill for our youth.

Education in America is interwoven with national legislation that mandates state and local accountability, increased flexibility, local control, expanded options for parents, and proven research-based methods of instruction.

"Our mission is to promote student achievement and preparation for global competitiveness by fostering educational excellence and ensuring equal access."[3]

Health/SEL advances these goals by empowering students to be physically, mentally, socially, and emotionally healthy and equipping them with the knowledge and skill to learn, achieve, and succeed in the 21st century.[4]

The Every Student Succeeds Act of 2015 includes English, reading or language arts, writing, science, technology, engineering, mathematics, foreign languages, civics and government, economics, arts, history, geography, computer science, music, career and technical education, *health*, physical education, and any other subject, the state or local educational agency determines as part of a "well-rounded education" with the purpose of providing all students access to an enriched curriculum and educational experience.[5,p298] Placing health education with other courses of study, activities, and programming is a welcome elevation in status. In addition, the legislation provides funding to develop, implement, and evaluate comprehensive programs to support safe and healthy students. The language that supports health education also supports SEL. Examples include programs and activities that

- coordinate with other schools and community-based services and programs;
- foster safe, healthy, supportive, and drug-free environments that support academic achievement;
- promote the involvement of parents;
- partner with institutions of higher education, businesses, nonprofit and community organizations, or other entities that demonstrate success.[5,p177]

Specific examples include

- drug and violence prevention programs and activities;
- school-based mental health services;

TABLE 1.1 CASEL Skill Training Practices and Alignment with Skills-Based Health Education

CASEL Skill Training Practices	Alignment with Skills-Based Health Education
Sequenced—A planned set of activities that sequentially develop skills.	The National Health Education Standards provide grade span, sequenced performance indicators for each standard, PreK–12. Teacher candidates are trained to teach each performance indicator step-by-step: Explain why the skill is important, present the steps for developing the skill, model the skill, provide time for students to practice the skill using age-appropriate prompts, provide student feedback and reinforcement.[6,p14]
Active—Uses active forms of learning such as role-plays.	Skills-based health education is active pedagogy. Students are engaged in skills practice and performance throughout instruction. Examples include role-play, media and live presentations, puppet shows, use of graphic organizers to demonstrate proficiency, Internet presentations, development of goal-setting strategies such as healthy eating and exercise calendars, and public speaking demonstrations to advocate for a health-enhancing cause.
Focused—Devotes sufficient time to exclusively develop social emotional skills.	Districts determine the time allotted to skills-based health education. However, to demonstrate the importance of adequate instructional time, acquisition of health knowledge begins after 15 hours of instruction particularly in grades 4–7. To affect attitudes and practices, students need 45–50 hours of instruction. Maximum learning and attitude or behavior change occurs after 60 hours of instruction in one school year.[6,p63]
Explicit—Target specific social and emotional skills.[34]	Skills-based health education focuses on student need. When data identifies a social and emotional need, instructors design assessment and instruction based on infused performance indicators. The performance indicators of each grade span address healthy behaviors, thereby, facilitating the inclusion of each of the SEL components. The chart that follows specifically demonstrates how each of the SEL components are aligned with the National Health Education Standards.

FIGURE 1.1 Social Emotional Learning Core Competencies
Data from Collaborative for Academic, Social, and Emotional Learning. (2016, July 12). *Social and Emotional Learning Core Competencies*. Retrieved from CASEL: casel.org/social-and-emotional-learning/core-competencies

- programs and activities that integrate health and safety practices into school or athletic programs and support a healthy lifestyle such as nutrition education, structured physical education, chronic disease management, bullying prevention, interpersonal communication, safety education, mentoring and school counseling, decreasing school dropout rates, and establishment of learning environments and activities that enhance effective learning skills;
- high-quality training for school and specialized instructional support personnel related to suicide prevention, classroom management, crisis management, conflict resolution, human trafficking, school-based violence prevention, drug abuse prevention, bullying and harassment prevention;
- child sexual abuse awareness and prevention programs.[5,p179]

In addition to school-based programs, the Every Student Succeeds Act also funds 21st Century Community Learning Centers that provide opportunities for academic enrichment, youth development activities, service learning, nutrition and health education, drug and violence

TABLE 1.2 CASEL Skill Training Practices

Social Emotional Competency	National Health Education Standards
Self-awareness is the ability to accurately recognize emotions and thoughts and their effect on behavior. It includes assessing personal strengths and limits and gaining a sense of confidence and optimism.	Self-awareness aligns with Standard 2, Analyzing Influences, where students analyze the influence of family, peers, culture, media, technology, and other factors on health behavior.[6] If the influence is positive, students reinforce the behavior and if negative, they learn to cope in a healthy way. The acquisition of this skill provides the students with an understanding of their personal strengths and limits. It enhances their confidence, efficacy, and the positive attitude of knowing they have the skill to cope with a variety of influences.
Self-management is the ability to effectively regulate emotions, thoughts, and behaviors in a variety of situations such as those that require stress management, impulse control, self-motivation, and goal setting.	Self-management aligns with Standard 7, Practicing Health-Enhancing Behaviors. In this standard, students demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks. In Standard 6, Goal Setting, students demonstrate the ability to use goal-setting skills to enhance health.[6] Both standards teach the very skills listed as examples.
Social awareness is the ability to understand different viewpoints and empathize with people from different backgrounds and cultures, understand social and ethical norms, and identify family, school, and community resources.	Social awareness is most closely aligned with Standard 4, Interpersonal Communication, where students demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks. Successful acquisition of conflict and negotiation skills include understanding different viewpoints and being empathetic. Standard 2, Analyzing Influences, and Standard 8, Advocacy, where students demonstrate the ability to advocate for personal, family, and community health, align with social and ethical norms. Standard 3, Accessing Information, where students demonstrate the ability to access valid information and products, and services to enhance health, is aligned with identifying resources.[6]
Relationship skills include the ability to establish and maintain healthy relationships with a variety of people. Skills include clear communication, active listening, cooperation, resisting negative peer pressure, conflict negotiation, and asking for help.	Relationship skills are most closely aligned with Standard 4, Interpersonal Communication. The skills in this component are very consistent with the Standard 4 PreK–12 performance indicators.
Responsible decision making includes the ability to make personal behavior and social interaction choices based on ethics, safety, norms, evaluation of possible solutions and consequences, and well-being.[8]	Responsible decision making is directly aligned with Standard 5, Decision Making, where students demonstrate the ability to use decision-making skills to enhance health.[6]

Data from Joint Committee on National Health Education Standards. (2007). *National Health Education Standards, Achieving Excellence*. (2nd ed.). Atlanta, GA: American Cancer Society; Payton, J. W. (2008). *The positive impact of social and emotional learning for kindergarten to eighth-grade students: Findings from three scientific reviews*. Chicago, IL: Collaborative for Academic, Social, and Emotional Learning.

prevention programs, counseling, arts, music, physical fitness and wellness programs, technology education, financial and environmental literacy, mathematics, science, career and technical programs, and internship or apprenticeship programs and parent engagement opportunities.[5,p182]

With the power of the legislation and funding, district administrators, health/SEL educators, and community leaders develop a comprehensive, PreK–12 skills-based health/SEL program that embraces the Whole School, Whole Community, Whole Child (WSCC) Model and prepares students for life in the 21st century.

Why Is Comprehensive Skills-Based Health/SEL Important?

"The academic success of America's youth is strongly linked to their health."[9]

Without our health, life poses many unwelcome challenges. It may be more difficult to concentrate, stay on task, or care about things other than our own feelings. We learn to be healthy, but how? Some of us learn from our parents,

friends, family, media, the Internet, and other sources. While a modicum of this information is valid and reliable, a good portion is hearsay, folklore, or plainly incorrect.

Dr. Pat Cooper, the former superintendent of the McComb School District in Mississippi, said, "Our children must be healthy to learn but first they must learn how to be healthy."[10] To realize this vision that all children learn how to be healthy and receive information and skills that prepare them for personal and academic success in the 21st century, schools provide quality skills-based health/SEL education from pre-kindergarten through grade 12.

Quality school-based health education, according to the American Cancer Society, uses the National Health Education Standards as the foundation for curriculum development. They concentrate on increasing **functional health knowledge** and the skills needed for healthy living such as identifying the influence of family, peers, culture, media, and technology on behavior, accessing and using valid health information, communicating, making health-enhancing decisions, setting goals, practicing healthy behaviors, and advocating for self and others.[11]

If our students learn to be healthy at a young age, consider the positive impact on their personal, social, emotional, and academic lives as they mature and prepare for life in the 21st century. A comprehensive, PreK–12 skills-based health/SEL education program incorporating the National Health Education Standards and the Social and Emotional Learning Competencies helps students establish healthy behaviors that last into adulthood.

Comprehensive skills-based health/SEL education promotes the health, safety, and academic achievement of youth by decreasing risk behaviors and developing and maintaining healthy behaviors.[11] School health/SEL education along with the WSCC team also serves as a funnel through which local, state, and national health programs and funding reach all children in a coordinated, organized, and sequential manner. Each child in every school at all grades has access to a high-quality program and learns the knowledge and skills needed for a healthy and productive adulthood.

A Brain-Friendly Pedagogy

Brain research explains why certain educational strategies work while others do not.[12,pv] Neural networks form as a result of actual experience, so if we increase student engagement and performance-based assessment, we help the brain grow! Role-plays, graphic organizers, cooperative learning, and problem-based learning are examples of skills-based/SEL strategies that work according to brain function.

The role-play is a brain-friendly strategy common in skills-based health/SEL instruction. Here, the student constructs and participates in a role-play, using the performance indicators as the foundation to demonstrate proficiency in content and skill. It is a stimulating, engaging, and student-centered approach to learning that provides practice in meeting everyday challenges in a healthy way.

Graphic organizers are an excellent tool to display content or show the sequence of a skill because they increase understanding and the retention of information. The structure of the organizers is similar to the brains and has many connections and a variety of links. Visualize a graphic organizer for memory, images, and sound. Memory is not stored in one part of the brain but in networks of networks. Images are stored in the visual cortex and sounds in the auditory cortex.[12,p158] The networking (graphic organizer) connects and shows the relationships of all the parts.

Problem-based learning is recognized in skills-based health/SEL education as the performance task (prompt, rubric, and support information). Students work in cooperative learning groups to solve age-appropriate, real-life problems using the content and skills learned in health class. It is self-directed, active, brain-engaged learning that includes reasoning, critical thinking, and collaboration skills activated through intrinsic motivation. Because the brain is naturally inquisitive and collaborative, this pedagogy enhances brain function.[7,p114] Project-based learning engages the student in a complex task that results in a product, an event, or presentation. Our brains gravitate to challenges, contributions, and relevant tasks, and successful completion of the performance task encourages students to participate in this strategy.[12,p118] This skills-based pedagogy is a better way to learn because students are engaged in their learning and attain a better understanding of how to use knowledge and skill to solve real-life problems.[12,p142]

Cooperative grouping occurs during problem-based learning and is a key pedagogical skills-based strategy and increases on-task time and student achievement. Grouped students receive the performance task (prompt, rubric, and support information), and then plan and implement the authentic assessment, a demonstration of content and skill learned in the skills unit. Cooperative group learning activates the reward system in the brain and results in the release of dopamine.

Collaboration provides the opportunity for students to practice self-awareness and social awareness and feel important, influential, powerful, appreciated, and honored by their peers. This strategy enhances intrinsic motivation and results in learning more in smaller groups than in larger groups.

Feeling safe and valued as a result of cooperative learning, the student is motivated to achieve, interact, problem solve, and make decisions.[13,p57] Oxytocin is released during social bonding and activities, such as group learning, that develop trust. In order for these strategies to succeed, however, students learn the social and empathy skills necessary to function as a member of a group such as being an attentive listener, showing appreciation, not allowing put-downs, providing the right to pass during a group activity, and demonstrating mutual respect.[13,pp57–58]

The student brain is programmed to seek and find.[12,p148] Skills-based health/SEL education challenges the student, in a collaborative, safe, learning environment, to seek and find a resolution to an age-appropriate problem using the knowledge and skill learned in class. Proficiency is demonstrated by the ability to access, adapt, analyze, apply, assess, choose, compare and contrast, defend, demonstrate, determine, describe, differentiate, distinguish, empathize, encourage, examine, explain, evaluate, formulate, identify, implement, justify, list, locate, predict, propose, recognize, regulate emotions, take perspective, and work cooperatively. Teachers design performance tasks for different levels of cognition, in brain-safe classrooms where students are members of a positive learning community. They experience learning through trial and error and are supported by the effective feedback from formative assessments. Students are motivated by the enthusiasm of the teacher, a knowledgeable and skilled educator,[13,p149] who knows the value and power of skills-based health/SEL education.

The National Health Education Standards

The foundation of comprehensive skills-based health education is the *National Health Education Standards, Achieving Excellence (2nd ed.)* (**Figure 1.2**). The standards were revised and published in 2007 and embrace the knowledge and skills students need to acquire, maintain, and promote healthy behaviors. These standards provide a framework for curriculum, instruction, assessment, and accountability.

The first standard addresses concepts related to health promotion and disease prevention to enhance health. The standards do not, however, specify the content school districts include in a comprehensive PreK–12 health program but do provide districts with the flexibility to choose material from the common health education content areas (**Figure 1.3**) according to the needs of their students.

Standards 2–8 are skills: analyzing influences; accessing valid information, products, and services; using interpersonal communication; making decisions; setting goals; practicing healthy behaviors; and advocating for personal, family, and community health. They are sequenced to show progression from knowledge to the application of skills.

Performance indicators accompany each standard and clarify the functional health content (Standard 1) and skill (Standards 2–8) for each grade span of the standard (PreK–2, 3–5, 6–8, 9–12). The numbers that precede the performance indicator (**Figure 1.4**) signify the standard, the last year of the grade span, and the number of the performance indicator in the sequence. The performance indicator verbs inform assessment and instruction. The summative authentic assessment provides students the arena

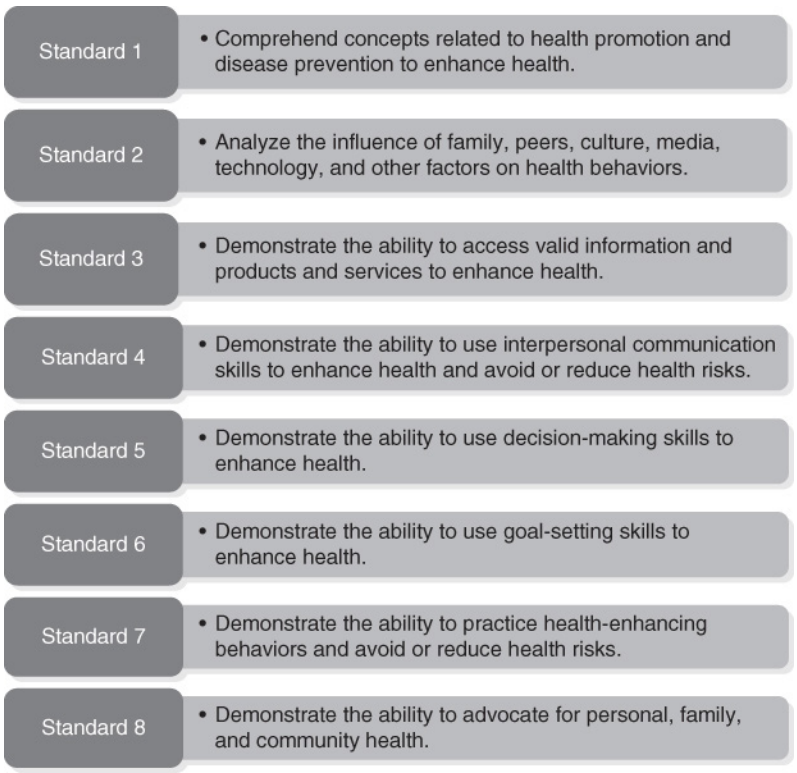


FIGURE 1.2 The National Health Education Standards

Data from Joint Committee on National Health Education Standards. (2007). *National Health Education Standards, Achieving Excellence*. (2nd ed.). Atlanta, GA: American Cancer Society.

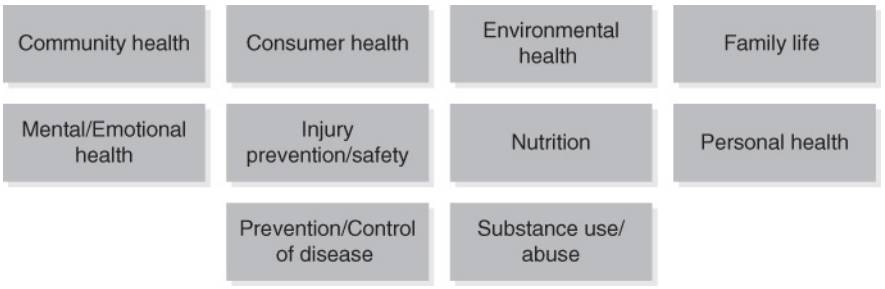


FIGURE 1.3 Common Health Education Content Areas
Data from Joint Committee on National Health Education Standards. (2007). *National Health Education Standards, Achieving Excellence*. (2nd ed.). Atlanta, GA: American Cancer Society.

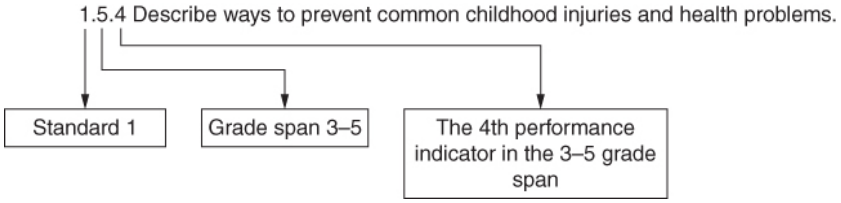


FIGURE 1.4 Performance Indicator Numbering System

to demonstrate knowledge and skill that is observable and measureable.[14,p152] To reach proficiency, a student demonstrates expertise in all the performance indicators for that grade span.

The performance indicators are developmentally appropriate for each grade span and include all six levels of Bloom's original taxonomy (**Figure 1.5**). In the 1990s, Lorin Anderson, a student of Bloom, revised the taxonomy and transformed the nouns of each level to verbs (remember, understand, apply, analyze, evaluate, and create) thereby making them active and compatible with the performance indicator verbs and the challenge of the performance task.

Using infused performance indicators as behavioral objectives results in lessons that challenge students to demonstrate content and skill learned as a result of instruction. Through the grade spans, students traverse higher levels of Bloom's taxonomy and are presented with increasingly more challenging performance tasks that include critical thinking and evaluative judgments.[14,p153]

The knowledge (Remember) level expects students to retrieve and remember information. When they take in new information (Understand), and use it, students demonstrate understanding and reach the comprehension level. The application level requires them to use (Apply) knowledge to solve problems without much prompting. On the analysis level, students deconstruct a complex problem into smaller parts (Analyze) in order to understand it better. To synthesize, students organize individual ideas or parts into a new

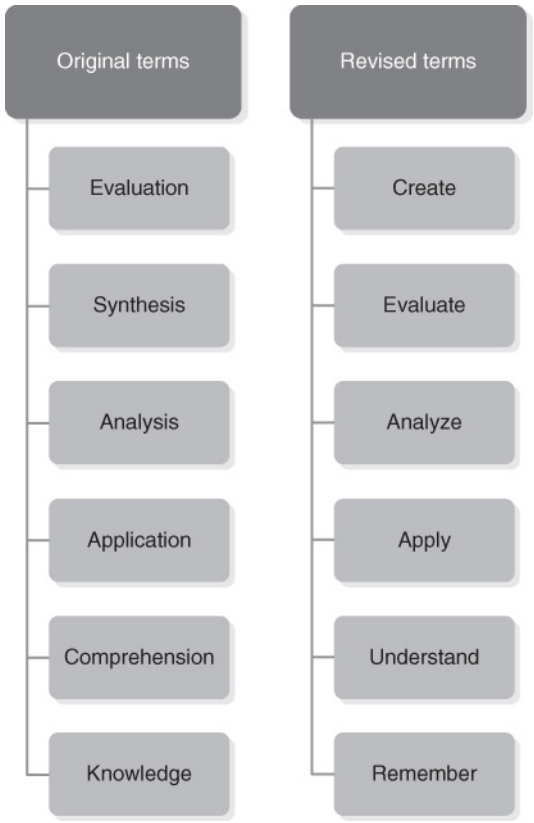


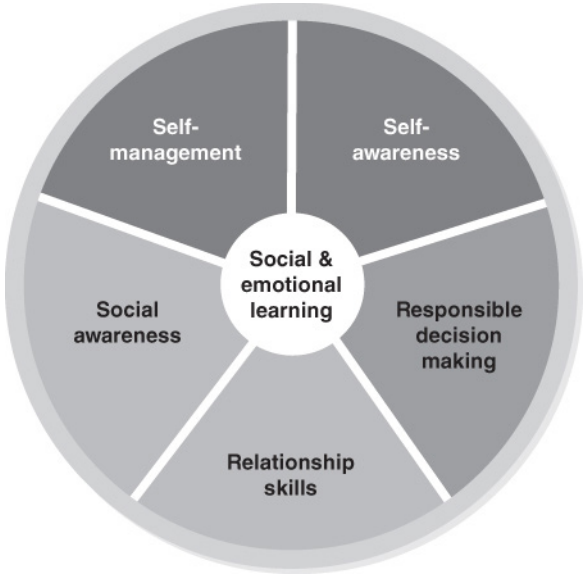
FIGURE 1.5 Bloom's Taxonomy: Old and Revised
Data from Original Terms New Terms. (2016, January 19). Retrieved from tic.iitm.ac.in/Blooms%20Tax.pdf

product (Create). They make judgments based on specific criteria or evidence on the evaluation level (Evaluate).[15]

As students gain knowledge in content and proficiency in skill from elementary to the middle and upper grades, they progress to more difficult tasks, such as examining, analyzing, predicting, comparing, and proposing. Even though elementary students are challenged with simpler tasks, they learn to achieve at higher levels with the appropriate instruction from a skilled health educator.

Social Emotional Learning Competencies

The five social and emotional learning competencies are very consistent with and support the National Health Education Standards. Together, these skills and competencies provide knowledge and skills to help youth achieve academic success and be prepared for the 21st century.



The Power of Coordination: Whole School, Whole Community, Whole Child Model

The effectiveness of school health education is increased when all stakeholders cooperate, collaborate, communicate, and coordinate to support the health of students, staff, school, families, and community. The WSCC Model provides a structure through which stakeholders work together to improve student learning and health by providing a student-centered environment where they are healthy, safe, engaged, supported, and challenged. WSCC has ten components: Health Education; Physical Education and Physical Activity; Nutrition Environment and Services; Health Services; Counseling, Psychological, and Social Services; Social and Emotional Climate; Physical Environment; Employee Wellness; Family Engagement; and Community Involvement. Representatives meet regularly to assess needs, design or implement policy, programs, and practice to meet those needs, then reflect on the efficacy.[16]

Healthy People 2020 Adolescent Health Objectives

Competency	Examples
Self-awareness—Accurately r**ecognize** how personal emotions, thoughts, and values influence behavior; accurately assess personal strengths and limitations with confidence and optimism.	Identifying emotions, accurate self-perception, recognizing strengths, self-confidence, self-efficacy.
Social awareness—Take perspective of and empathize with others from different backgrounds and cultures.	Perspective taking, empathy, appreciating diversity, respect for others.
Responsible decision making—Make constructive choices about personal behavior and social exchanges based on ethics, safety, and social norms. Include the evaluation of consequences of each choice and how the decision contributes to the well-being of self and others.	Identify the problem, analyze the situation, solve the problem, evaluate the choice, reflect on the choice, contemplate ethical responsibility.
Self-management—Successfully regulate personal emotions, thoughts, and behaviors in a variety of settings along with managing stress, controlling impulses, being self-motivated and being able to set and meet personal and academic goals.	Impulse control, stress management, self-discipline, self-motivation, goal-setting, organizational skills.
Relationship skills—Establish and maintain healthy and satisfying relationships with a variety of individuals and groups along with being able to communicate clearly, be a good listener, cooperate, resist inappropriate peer pressure, constructively negotiate conflict, and ask for help when needed.	Communication, social engagement, relationship building, teamwork.[8]

Reproduced from: U.S. Department of Health and Human Services. (2016, January 23). *Adolescent Health, Objectives*. Retrieved from HealthyPeople.gov: www.healthypeople.gov/2020/topics-objectives/topic/Adolescent-Health/objectives

FIGURE 1.6 Whole School, Whole Community, Whole Child Model

Data from Centers for Disease Control and Prevention. (2016, January 20). *The Whole School, Whole Community, Whole Child Model*. Retrieved from Centers for Disease Control and Prevention: www.cdc.gov/healthyyouth/WSCC/Pdf/WSCC_fact_sheet_508c.pdf.

The student is the center of the model, and all components work to enhance his or her health and well-being. The student is an active partner in learning and developing well-being, is actively involved in the school, and engaged by the school administration through social media, surveys, town meetings, and focus groups. Administrators seek the opinion of the student about school health policies, programs, and services, in a continuous cycle of communication and feedback. The student perceives himself or herself as an essential part of the school, a change agent, a proponent of school improvement, and a person who is able to achieve personal health and academic success.[17,p785,793]

To make the WSCC work efficiently, a school wellness team consisting of representatives from each component meets on a regular basis to assess student need, determine how to use resources, and coordinate and implement evidence-based policies, processes, and practices. Using the CDC School Health Index, the team assesses the current program.[18] The results identify program strengths and weaknesses and provide a platform to engage the stakeholders to design and implement improvement plans.[19,p755]

HEALTH EDUCATION

Comprehensive PreK–12 skills-based health education complies with state and national standards and is aligned with the characteristics of effective health education. Assessment, instruction, and curriculum are based on student need. Curriculum encompasses the physical, mental, emotional, and social dimensions of health and promotes content knowledge, healthy attitudes, and life skills. Planning, using the WSCC model, assures a consistency of health messages at home, and in the school and community.[15,p732] Assessment of student progress in the attainment of standards is continuous and reported.

Research support for health education:

- Academic grades for low-income minority students, aged 8–11, improved when they participated in an asthma self-management program that included health education and parent involvement. Another asthma self-management program that included health education for asthmatic children and their classmates, an orientation for school principals and counselors, and communication with and

education of custodians, caretakers, and clinicians resulted in students' demonstrating higher grades in science.[20,pp591–599]

- Elementary or high school students who participated in social skills training that also included teacher training improved their achievement. In a 6-year follow-up study of high school students who had received the training in elementary school, researchers found they had improved attendance and achieved higher scores on standardized tests than members of a control group. Students who received the highest level of training exceeded the control group for scores in language arts and math.[20,pp591–599]
- Ten months after participating in a 5-month Personal Growth course that taught social skills and included teacher training, students demonstrated an increase in their grade point average, school bonding, and perception of school performance as compared to a control group.[20,pp591–599]
- Academic success improved when social skills training included parents and community members and was incorporated into health education, breakfast programs, physical education, and mental and general health services.[20,pp591–599]
- Prevention programs that include knowledge, attitudes, values, and life skills report a decrease in incidences of HIV/AIDS.[1]
- Students engaging in violent behaviors have lower grades and test scores. Skills-based health education is designed to maintain or improve the behaviors of violent youth. Increasing student content knowledge and skill increases health literacy and impacts health and academic achievement.[21,p751]
- Improving communication and social skills (Standard 4) such as resisting social pressure to smoke, use alcohol and other drugs, or engage in behaviors that result in unintended pregnancy may improve the health of teens. Studies show that smoking has a negative effect on grades and the use of drugs and early intercourse are associated with lower school grades. Also, teen mothers are less likely to complete high school or attend college.[21,p752]

PHYSICAL EDUCATION AND PHYSICAL ACTIVITY

PreK–12 physical education is a planned, sequential curriculum that complies with state and national standards. It provides opportunities for students to learn functional knowledge and practice skills for a physically active life. A comprehensive physical education and physical activity program provides opportunities for students to be active and physically educated before, during, and after school, and in the community.[19,p734]

Research support for physical education:

- Project SPARK (Sports, Play, and Active Recreation for Kids), a PreK–12 program, provides evidence-based physical activity, nutrition programs, curriculum, staff development, follow-up support, and equipment. Researchers completed a rigorous evaluation of SPARK and found significant gains in reading performance. The academic functioning of participating students was not compromised, even though time for physical education was taken from the school day.[20,p597]
- Physical education programs that offered classes in fitness or skill training for 75 minutes each day resulted in no significant decrease in test scores and confirmed that physical education does not detract from academic achievement on standardized tests.[20,p597]
- Students participating in physical activity improved academic achievement including concentration and attention, higher test scores, and higher math scores.
- More participation in physical education class is associated with better grades, standardized test scores, and classroom behavior.
- Time spent in recess that encourages pro-social behavior is associated with improved cognitive performance and classroom behavior.
- Brief classroom breaks that include physical activity are associated with improved cognitive performance, classroom behavior, and educational outcomes including standardized test, reading, and math scores.
- Participation in extracurricular physical activity is associated with higher grade point averages, lower dropout rates, and fewer disciplinary problems.[21,p751]

NUTRITION ENVIRONMENT AND SERVICES

School nutrition services meet the standards for the National School Lunch and Breakfast Programs, consider the health and nutrition needs of all students, and ensure that competitive foods sold in the school meet the Smart Snacks in School standard. The nutrition program not only provides the food but also educates students about healthy eating by modeling the presentation of healthy foods and beverages, providing nutrition education, and displaying healthy food messages in the cafeteria and throughout the school.[19,p732]

Research support for nutrition environment and services:

- A pre-/posttest examining the food and nutrition services in the Pennsylvania and Maryland schools showed that African American and low-income students who participated in the school breakfast program for 4 months or longer showed a significant increase in math scores and a decrease in absence and tardiness rates.[20,p598]