HOOVER EDUCATION

2. A Survey of Whole-Child School Reforms

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Executive Summary

Whole-child education models are those that expand the ambit of schools beyond a traditional academic focus. While a range of whole-child models have been explored since at least the Progressive Era, use of these models has expanded greatly over the past twenty years.

Because nearly all children in the United States attend public schools, it can be a tempting place to provide near-universal access to programs and resources. However, for various reasons, some families and educators are wary of a more expansive role for schools in children's lives beyond academic training. I review several examples of whole-child reforms that have become popular over the past few decades: community schools, school-based health centers, wraparound service models, and social emotional learning curricula. After describing the general framework of each, I explore research into each model's effectiveness using standards of high-quality causal inference evidence defined by the US Department of Education.

While some models have proven effective at shifting child outcomes in certain settings, none have yet been proven—at large scale, using high-quality causal research methods—to be a silver bullet that can overcome the challenges many children face today in terms of improving academic outcomes. Though they may have other positive impacts on their own, without related investment in academic reforms, they are unlikely to be the panacea for the low academic performance that plagues children in the United States. Thus, at the end of this brief, I close with recommendations for policymakers to think carefully about implementation of these models in their own contexts.

- Whole-child education models are becoming better known in the United States.

- Their adoption in some public schools provides an opportunity to see which models contribute to academic success.

- However, they are a part of the topic of child welfare, not the entire picture.

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In the past couple of decades, there has been a renewed interest in the idea that schools should expand their ambit to address a wider range of student needs around health and well-being. Often this is described as a focus on development of the "whole child" rather than just the academic aspects of child development.

Of course, promotion of a wider ambit for schools beyond the academic sphere is at least a century old, as is the debate about whether it is optimal. The intellectual leaders of the Progressive Era, in the nineteenth century, sought to bring a broader focus to education systems than the traditional academic one. This included various ways of engaging the whole child, some of which are similar to the models covered here, particularly the social and emotional learning curricula and community school models that have skyrocketed in popularity in the past several years.

Similarly, the roots of whole-child reforms that are focused on improving children's physical health are deeply embedded in US education history. As early as 1850, states began requiring immunizations and sometimes hosted immunization clinics in schools, where there was easy direct access to children. Also, the beginning of what we now know as the standard school nurse model began in 1902 as a pilot program aiming to insert healthcare into schools in order to improve chronic absenteeism by managing easily treatable illnesses and focusing on prevention. Each of these foreshadowed the more recent creation and rapid expansion of school-based health centers, which insert healthcare providers directly into schools with the goal of improving academic and overall well-being.

Recent decades have seen a renewal in the popularity of whole-child models. To some extent, this renewed interest is partly a backlash to what many perceived as the laser focus of the No Child Left Behind era on student test score performance. The difficult periods of the Great Recession and the COVID-19 pandemic also contributed to this shifted focus. The recent version of this movement has also been helped by increased emphasis on the complex relationships between education, health, housing, and other social dimensions across a range of academic disciplines and policy spheres.

This whole-child movement in schools has taken many forms, some of which I describe in more detail below. Across all its forms, the theory of change driving whole-child reform has two main parts. First, many students struggle academically because their basic needs are not met. Second, supporting these basic needs directly by bringing healthcare and/or social service resources into the school itself will overcome the access barriers that some children face, particularly poor children, thereby increasing their ability to thrive academically and socially.

To some extent, this theory of change pervades the entire US education system. Almost all districts in the country provide some form of nonacademic care to students through the school nurse, school counselors, or expanded offerings like universal vision screening programs. And many provide extracurricular activities or partner with community organizations in a variety of ways. What differentiates the whole-child models of reform here from the standard public school environment is the broader range of services provided and the depth of engagement between the school and community partners.

Intuitively, the first part of this theory of change makes some sense. How can a child learn if they suffer from an ongoing undiagnosed disease or disorder that prevents them from attending school regularly, concentrating in class, or participating fully in the community around them? How can a child learn if they feel isolated in a community, are surrounded by violence, and lack strong support inside and outside of school?

There is little direct causal evidence to support this theory of change, and there are plenty of anecdotes about children thriving despite incredibly challenging experiences during childhood. Yet a majority of parents would agree that children thrive most when their basic needs are met. However, as with all aspects of childrearing, there is debate about which "needs" require fulfillment for children to thrive. Furthermore, there is debate about whether schools are the best provider of health and social services to support children.

For decades, people have debated whether schools are the most effective places to solve the deep-rooted societal problems, like poverty, that leave many children with their basic needs unmet. Some people see schools as the great equalizer, holding them uniquely responsible for the achievement and well-being of all students, regardless of their backgrounds or the social forces determining those backgrounds. Others argue that systemic poverty, isolation, violence, poor health, and other ills have such a strong role that schools cannot be responsible for overcoming them.

Because nearly all children in the United States attend public schools, it can be a useful place to provide nearly universal access to programs and resources. However, for various reasons, some families are wary of a more expansive role for schools in children's lives beyond academic training. Some have concerns about the differences between their own values and beliefs and those promoted in the school environment, as is the case with the recent backlash among social emotional learning programs. Others have concerns about whether school employees have the bandwidth and expertise to provide an expansive range of high-quality care; instead, they suggest that a focus on academic knowledge would allow school employees, like teachers, to be more impactful. Still others distrust the push for schools to focus on issues beyond academics because of concerns about greater intrusion into the private lives of families.

Below I review several examples of whole-child reforms that have become popular over the past few decades. After describing the general framework of each, I explore research into each model's effectiveness. Most have been described as effective by the literature, but this

assertion is generally based on research that is largely theoretical, comprises mixed methods, or is conducted either at a small scale or without the types of carefully constructed comparison groups that are essential for determining causal impacts. I focus on summarizing the subset of this literature that meets the Tier 1 or Tier 2 standard of the US Department of Education for strong or moderate evidence of effectiveness from either an experimental or a quasiexperimental design study (What Works Clearinghouse 2020).

Further, since many areas of research have shown patterns of effective programs in small studies that have limited effectiveness when taken to scale, I place particular emphasis on the relatively few studies that have analyzed the effectiveness of programs with large numbers of students across multiple school settings. While some have proven effective at shifting child outcomes in certain settings, none have yet been proven at scale, using high-quality causal research methods, to be a silver bullet that can overcome the challenges many children face today. Importantly, when looked at in total and given the scale of the existing research, the lack of conclusive evidence of a clear positive causal effect of these reforms on children's academic achievement casts doubt on the theory underlying these reforms. Though they may have other positive impacts, on their own and without attention to academic reforms they are unlikely to be the panacea for low academic performance that plagues children in the United States. Thus, at the end of this chapter, I close with recommendations for policymakers to think carefully about implementation of these models in their own contexts.

COMMUNITY SCHOOLS

The defining feature of a community school is the creation of a more comprehensive, deeper relationship between the school, its families, and the surrounding community than exists in the common public school framework. The theory motivating this design is that the strengthened relationships and related supports provided to children and families will allow children to thrive academically. Some also argue for the model's value in promoting the creation of a more engaged citizenry of the students, families, and neighbors of a community school.

There is no single definition of what a community school is—it is more a strategy than a particular model. In part, this is in acknowledgment that the needs and goals of individual schools and communities may vary, and so the design of the school and its partnerships should vary. In recent years, though, practitioners and researchers have theorized that the following four common core pillars of community schools may be important for their success (Maier et al. 2017):

1. Integrated student supports provided in partnership with social service agencies and health providers
2. Expanded learning time and opportunities—often operationalized as extended-day or year-round schooling—expanded access to extracurricular enrichment activities, or individualized academic support

3. Family and community engagement with shared decision-making responsibilities and expanded roles in onsite opportunities

4. Collaborative leadership and practice across participating groups, including district and school leadership, teachers, and community organizations, often with goals of data-driven assessment of operations

For more than a century, educators and politicians have touted the potential benefits of stronger engagement between schools and their surrounding communities. Like many education reforms, the use of a community school–type model is rooted in the progressive education movement. (John Dewey, in 1902, wrote an essay on the subject, titled "Schools as Social Center" [Dewey 1902].) Also, like other reforms, the community school movement has waxed and waned, often gaining in popularity in times of great economic and social change, such as the industrial revolution, the Great Depression, and the civil rights era. The most recent wave of expanded interest in the community school model likely began in the 1990s with the creation of popular national models and attention to the effects of living in poverty on children's educational progress. More recently, the proliferation of community schools has accelerated in response to the strong focus on academic outcomes of the No Child Left Behind Act of 2001 and with increased national attention to particular models.

Although there is no centralized tracking of community schools across the country, estimates suggest that, as of 2023, between 8,000 and 10,000 schools identified as community schools in the United States (Quinn and Blank 2020). As with the other types of whole-child reform discussed here, there has been a marked expansion in recent years. This includes both conversion of individual schools to a community school model and systemwide initiatives across multiple schools. For example, the Community School Initiative in New York City was introduced in 2014 and began with forty-five schools. Seven years later this number had increased by nearly 1,000 percent. As of 2023, there are 421 community schools in New York City.[1] This is more than the number of charter schools.

The availability of COVID-19 relief funds and the specific focus of those funds on supporting children's mental health has further increased interest in community schools. For example, in 2022, California announced a $3 billion investment in its Community Schools Partnership Program to provide up to seven years of funding to support the conversion of as many as four thousand Title I schools to a community school framework grounded in the pillars mentioned above (Fensterwald 2022).

Although not traditionally classified as community schools, the Promise Academy charter schools of the Harlem Children's Zone in New York City have many of the features of community schools. Started in 2004 and expanded in 2007, the Academy has an extended school day and school year and offers free medical, dental, and mental health services in the school to all children. The Academy provides additional support to families as needed and connects to more than twenty community programs in the Harlem Children's Zone that provide a variety of services and resources to children and families, such as extracurricular opportunities for children, health programs, and tax guidance programs.

Dobbie and Fryer (2011, 2015) examined the effectiveness of the Academy and related community services using multiple strategies, including the creation of comparison groups of students using those who were randomized into the Promise Academy and those who were randomized out. (This research therefore qualifies as moderate evidence in the classification schema laid out by the US Department of Education.) Dobbie and Fryer found that attending the Promise Academy led to reduced absences and increased test scores during elementary and middle school, as well as improvements in a variety of academic outcome measures such as high school completion. They also identified decreases in teen pregnancy for girls and incarceration for boys.

Crucially, the improvements for children in the Harlem Children's Zone accrued to children who enrolled in the Promise Academy but were not different based on whether the children had access to the community resources provided by the program. To investigate this, the authors compared the outcomes of lottery winners and lottery losers who lived within the zone and had access to the additional resources, to the outcomes of lottery winners and losers who lived outside the zone and did not have access to the additional resources. This suggests that it is the Promise Academy itself that was impactful in improving child outcomes, rather than the broader array of community services in the Harlem Children's Zone.

Similar studies have used methods of creating comparison groups of comparable students and schools to examine the effectiveness of community schools in other settings, such as Tulsa, Oklahoma, as well as Iowa, Maryland, Pennsylvania, and Washington State (Adams 2010; LaFrance Associates 2005a, 2005b, 2005c, 2005d). The results of these studies are mixed. There are positive effects of community school settings on academic and behavioral outcomes for children in some settings but not others. The range of effects could be driven by different characteristics of the community school architecture since there is some evidence that the most comprehensive interventions—those that include strong versions of each of the four core components listed above—show a stronger positive effect than those with only one of these dimensions or with only mild commitment to a particular dimension (Adams 2010). However, the differences could also be attributable to differences in design of the comparison groups and other dimensions of the studies, making it hard to generalize.

A recent study of the first set of schools in the New York City Community Schools Initiative is notable for its careful choice of schools for the comparison group and for the large number of community schools included (Covelli et al. 2022). The researchers made use of the decision rules about which schools would be among the first to become community schools in New York City to create a comparison group of schools that is arguably quite similar to the group of schools that became NYC Community Schools. They found that, in this initial group of forty-five community schools, chronic absenteeism fell immediately and test score performance increased within a few years.

This limited evidence is somewhat promising. We need additional studies of community school programs at scale to understand whether models that have worked in isolation in relatively small settings work more broadly. This is particularly true since the diffuse definition

of exactly what a community school is makes it hard to replicate successful models and bring them to scale across a broader range of schools. Evaluations thus far have focused on settings where school leaders and communities were initiating a new community-engaged schooling model on their own. Given that this model likely takes large investments by a range of leaders and stakeholders, results might be very different when schools are induced to adopt a vaguely defined community school model because of a funding incentive offered, say, by the state or federal government, particularly if available funding is not sustained and not as comprehensive as existing small-scale programs.

To date, research has identified some components of the model that are linked with more successful implementation of community schools. The four pillars outlined above are influential. Others have argued that a thorough initial strengths and needs assessment is essential, as are (1) connecting and coordinating across programs and services and (2) authentic community engagement (Quinn and Blank 2020). Some of the best-known models, which are considered by many to be successful, include specific staff, either at the school or at the state or district level, who coordinate across several schools and are dedicated to supporting the assessment and comprehensive coordination considered essential for community school success. Policymakers looking to explore a community school model may be able to learn a lot by connecting to or coordinating with these staff and other leaders who have successfully implemented this model.

Even supporters of the community school model emphasize that additional community resources are not, on their own, a panacea for improving student achievement, and they worry about the tension between using limited resources to provide strong school supports or the more "outside-of-school" supports that community schools are known for (Shapiro 2016). Policymakers interested in adopting a community school model would be best served by ensuring that the emphasis on community partnership does not come at the cost of investing in academic supports that have proven effective.

WRAPAROUND SERVICES

A cousin of the community school model is the wraparound services model (also called the comprehensive or integrated student support model). This model is focused on the first pillar of the community school model described above—the provision of integrated student support in partnership with social service agencies and health providers—without necessarily having the other components. In the most intensive form, wraparound services are schoolwide. Each student, regardless of their needs, is paired with a staff-support person to coordinate with families, teachers, health professionals, and community agencies in creating an individualized support plan with services tailored to the student. In this most intensive model, data on both the student and community partners is monitored and used to inform activities.

Historically, wraparound services were used to coordinate care for children with special needs, such as those with individualized education plans or those in the foster care system.

Recently, enthusiasm is spreading for the more intensive school-wide model described above. The rationale for expanding to the school-wide model is that a wider range of students could benefit from assistance "navigating the system" and that it will allow for children's needs to be identified early enough to provide preventive support rather than waiting until problems have reached a more difficult level.

There have been positive findings in evaluations of some wraparound school services programs. For example, City Connects is a program originally started in 2001 in the Boston Public Schools system in partnership with researchers at Boston College. The program embeds a coordinator into the school to evaluate the needs of all children. The coordinator then creates a support plan for each student that involves connecting them with a range of specific service providers depending on their needs. Using multiple different quasi-experimental evaluation methods, researchers found the City Connects program improves child outcomes such as absences and performance on achievement tests (City Connects 2016, 2020, 2022).

City Connects started in the 1990s as a collaboration between Boston Public Schools, researchers at Boston College, and community agencies to investigate ways to help children in Boston's public schools deal with factors outside the schools that were negatively impacting their success. After years of convening, engaging with the school and community partners, and planning, the first City Connects program debuted in six public schools in 2001.

City Connects involves six key factors considered important for its success (City Connects 2016):

1. School site coordinator (SSC): Each school has a coordinator who is trained as a counselor or social worker and is responsible for working with students, teachers, school staff, families, and community agencies to evaluate strengths and needs of students and to connect each student to a tailored set of in-school and out-of-school supports and programs.
2. Whole-class review: Each classroom teacher and SSC conduct a whole-class review to assess each student on four domains: academic, social/emotional/behavioral, health, and family. The review then involves identifying the appropriate supports and enrichment services and connecting each child and their family with providers of those services. It also involves tracking the use of the service and following up to ensure the appropriate fit.
3. Individual student review: Students determined to have intensive needs are assessed by a team of professionals including teachers, school psychologists, principals, nurses, and community agency staff led by the SSC. The aim is to develop specific measurable goals for the student and family.
4. Community agency partnership: Part of the SSC's role is to create a set of strong partnerships with community agencies, including an advisory board of citywide agency leaders and an advisory council of representatives working at the local level.

5. Connecting students to services, tracking, and following up: Using program-specific software, SSCs connect students to services and programs, track individual plans and engagement, and continue their interaction with students, families, and school staff to determine appropriate fit.
6. Service provision within the school: SSCs also provide some services, such as crisis intervention, in the school as needed.

The range of services it is possible to connect students with is extensive. It includes before-school and after-school programs, enrichment opportunities, health and wellness programs, social skills interventions, academic support or tutoring, family assistance, and family counseling. Each student's support plan is individually tailored to their strengths and needs. The SSC is integrated into the school and community and receives training and professional development through the City Connects program.

Over the years, the program has expanded to other school districts in Massachusetts, as well as to districts in Indiana, Ohio, and other parts of the country. Evaluations have demonstrated that the model has continued to succeed as it has scaled across communities, making this a promising model for policymakers and district leaders to consider.

Another wraparound services program with moderate evidence of effectiveness is Massachusetts Wraparound Zones (Gandhi et al. 2016). The researchers compared students in schools receiving wraparound programs with those in a carefully constructed comparison group of schools and looked for whether there were breaks in the pattern of differences in various outcomes over time with the onset of access to the wraparound services. While they found no differences in attendance, retention, or suspension, they did find significant improvements in standardized test score performance for children in elementary school and middle school.

There is something novel in this particular type of reform. Many tout the latest education reform—be it a new curriculum, new organizational structure, or something else—as *the* silver bullet that will cure all problems of the system for all children. The wraparound services model intervenes by providing to each student specialized services tailored to their needs and goals. Using data to provide a tailored program to each child and family helps remove barriers that exist, even in other whole-child models. Also, the model does not involve a change in curricular focus away from academic work and instead supplements the resources available to families to support the academic work.

As research on these promising potential models expands, it will be important to determine the key aspects of the model and whether the model is replicable. For example, are particular support services useful for students, and are particular service providers responsible for improved child outcomes? Can these programs be expanded successfully beyond Boston or Massachusetts? Are the differences in outcomes across studies related to differences in populations or to differences in the models themselves?

SCHOOL-BASED HEALTH CENTERS

Another model that has gained traction over the past few decades is one that more closely links healthcare providers with schools. In theory, directly linking schools with community primary care providers—or even embedding the providers within school buildings—will remove the geographic, administrative, and financial barriers many children face in receiving care. Their resulting improved health will lead to improved learning outcomes.

Although the first school-based health centers of the 1960s were focused primarily on family planning services and support for teenage parents, the role of school-based health centers has expanded greatly. Nearly all offer primary care through a nurse practitioner or physician that includes immunizations, diagnosis and treatment of acute illnesses and chronic conditions, referrals, and follow-ups. Some also offer dental, optical, and mental health care. Another common aspect of school-based health centers is population-level health education and primary prevention programming. All children enrolled in school-based health centers can receive these services upon parental consent.

According to a national survey of providers, the number of school-based health centers more than doubled from 1999 to 2017, increasing from 1,135 to 2,584 (Love et al. 2019). School-based health centers now provide services to more than ten thousand elementary, middle, and high schools across the country. Typically, these organizations are not funded by and are organizationally separate from school districts. Funding comes from a range of sources, including local, state, and federal grants; foundation support; and reimbursement for services provided. The proportion covering costs through reimbursement for services from public and private insurers has grown over time, such that now 90 percent of school-based health centers seek reimbursement from insurers (Price 2016).

There is a large body of literature promoting the efficacy of school-based health centers for improving children's health and academic outcomes. This includes prominent review articles, including those from Geierstanger et al. (2004), Knopf et al. (2016), Arenson et al. (2019), and Thomas et al. (2020). However, most of this literature does not meet the criteria for inclusion here because it lacks high-quality causal inference research design or is not conducted on school-based health centers at scale. The limits of this evidence are outlined in some of these review pieces and are clear even to the federal government. In a recent call for research proposals on school-based health centers, the National Institutes of Health summarized: "Although research evidence supports the *feasibility* of SBHCs to provide preventive and primary healthcare services to youth, rigorous research is lacking regarding their *effectiveness*" (National Institutes of Health 2022, emphasis added).

One exception is the research conducted by Westbrook et al. (2020), which explored the effects of school-based health centers across Colorado high schools on graduation rates. To isolate the causal relationship between school-based health center access and high school graduation rates, the authors compared graduation rates across schools that opened school-based health centers to those that did not, before and after the centers opened. They found

that school-based health center access increased graduation rates in these high schools, but the effects were only weakly statistically significant. In small samples, like the resulting data sample of 132 school-level data points, we should take caution generalizing weakly significant results. Thus, even this study exemplifies the need for a stronger research base for the claims of school-based health center effectiveness.

One of the challenges of school-based health centers is that the dependence on reimbursement from insurers for services makes them sustainable only in schools where there are many children who are eligible for Medicaid or the Children's Health Insurance Program. Thus, the model will not be able to support the health of the many poor children in other school settings. This dependence on charging for reimbursable services also shifts the emphasis away from preventive care or other programs that can have a great impact on children in favor of services that can be charged to insurers.

Even when school-based health centers are in operation, they face challenges reaching all students. For example, in New York City, only about 60 percent of students in schools with school-based health centers actually enrolled in the center.[2] Fewer still utilized the care provided by the center. In many school systems, the school-based health center replaces all other forms of school-provided physical and mental health services, such as those of the school nurse or other community health programs. When this happens, school-based health centers can only provide urgent first aid care to students who are not enrolled. The low enrollment rates of school-based health centers may mean some children actually lose access to healthcare services under the school-based healthcare model. Whether this is the case is an important open question, as few researchers have focused on whether students and families are more likely to participate in care in a traditional school nurse program than in a school-based health center. Policymakers interested in implementing school-based health center models should pay particular attention to ensuring that all children are enrolled and have access to the needed care in order to avoid any potential unintended consequences of adopting this new model.

SOCIAL AND EMOTIONAL LEARNING PROGRAMS

The Collaborative for Academic, Social, and Emotional Learning (CASEL) defines social and emotional learning as "the process through which all young people and adults acquire and apply the knowledge, skills, and attitudes to develop healthy identities, manage emotions and achieve personal and collective goals, feel and show empathy for others, establish and maintain supportive relationships, and make responsible and caring decisions."[3] The Collaborative defines competencies in five areas: self-awareness, self-management, social awareness, relationship skills, and responsible decision-making.

Like the other models in this chapter, social and emotional learning programs encompass a wide range of activities, sometimes in partnership with families and communities. Most commonly, a social and emotional learning program is a set of curricula adopted by a school to be

implemented by teachers school-wide or in particular grades (e.g., elementary school). This means the model is different from others considered here in two important ways. First, rather than healthcare and social services provided by professionals, as with school-based health centers, for example, most social emotional learning programs are in the hands of teachers who often have little training in mental, social, and behavioral health. This leaves open the quality of programming, particularly when programs are implemented at scale where we know fidelity often fades. Second, social emotional learning programs typically are not coupled with shifts in the length of the school day or other additional community resources. Therefore, time devoted to social and emotional learning curricula likely crowds out time spent on other learning activities.

Several common programs exist, such as Second Step, a classroom-based social skills program built on cognitive behavioral therapy; and Tools of the Mind, an early childhood curriculum focused on developing self-regulation and executive functioning. However, there is no single arbiter of what defines a program as social and emotional learning, let alone which programs are effective for improving children's academic outcomes or other aspects of their well-being.

The vast majority of schools have adopted some form of social emotional learning program or curricula, and the use of these programs has grown over time. In 2018, 34 percent of elementary school teachers and 60 percent of elementary school principals reported implementing a social and emotional learning program. By 2022, those numbers had climbed to 60 percent and 81 percent of elementary school teachers and principals, respectively. (Because these numbers focus on formal implementation of programs, they likely miss the many school environments where teachers and staff are adopting some components of social and emotional learning programs without utilizing formal programming.)

Much of the growth over this period was driven by the COVID-19 pandemic. Concerns about social isolation due to school closure and about the emotional impact of living through a crisis environment increased the emphasis on child health, and not just for children or in schools. Recent research using claims data for insured individuals has demonstrated that utilization of mental health care services is now 39 percent higher than before the pandemic (Cantor et al. 2023). Given this heightened focus on mental health in society, it makes sense that there would be renewed interest in the use of social emotional learning programs in schools.

Recent changes to the Every Student Succeeds Act opened the door for districts to use federal funds to support implementation of social and emotional learning programs. The reauthorization of the bill in 2015 allowed states and districts to use federal funding to support any program that meets the criteria for Tier 1 (strong), Tier II (moderate), or Tier III (promising) evidence. This opens the door for states and districts to use a wide range of evidence, of varying quality, to motivate spending on social and emotional learning programs. Even further, states and districts can also adopt programs that are only at Tier IV (demonstrating a rationale), as long as they build in evaluation systems to measure effectiveness as they go.

Publications by research and policy organizations have provided various "how-to" guides that make it easy for policymakers to choose programs that fit these criteria and include them in proposals for various funding streams from the federal government (Title I, Title II, and Title IV) (Grant et al. 2017). This has undoubtedly had a large impact on the use of these funds and, therefore, the proliferation of social and emotional learning programs.

As mentioned, to help school leaders determine the efficacy of social emotional learning programs, multiple organizations have produced reviews of existing evidence of their effectiveness (CASEL 2013, 2015; Durlak et al. 2015; Grant et al. 2017; Jones et al. 2017). However, much of this evidence does not meet the US Department of Education standards for strong or moderate evidence. For example, none of the studies summarized in Grant et al. (2017) provide strong or moderate evidence that any of the dozens of specific programs studied improve children's academic outcomes. There is some strong and moderate evidence of the effectiveness of these programs at improving children's inter- and intrapersonal skills, particularly in the short term immediately after program participation. However, it is still an open question as to whether these improvements in social skills are maintained for very long after an intervention and whether they fulfill the promise of improving children's ability to learn inside and outside the classroom.

A big concern among parents, professionals, and policymakers about social and emotional learning programs is that the term (and the way it is defined, for example, in the quote from CASEL above) is vague enough to be meaningless and to encompass a wide range of programs. Without clear definitions of program focus, a clear research base about the most important components, and a stronger research base about effective programs, almost any program can be sold—both literally and figuratively—to schools as important for investment. Recently, parents have begun objecting to programs billed as social and emotional learning programs, in part because these parents believe the programs have extended beyond traditional areas, like self-awareness and grit, into more controversial areas, like sex education and critical race theory. In this way, social and emotional learning programs are becoming a new front in the culture wars (Field 2022).

There is also the very real question of how to incorporate focus on social and emotional learning into what many consider an already full school day. Since few rigorous studies have shown positive effects of social and emotional learning programs on academic outcomes and because most of these programs are curricular interventions executed by teachers in the classroom, it is fair to assume that attention to these programs will crowd out attention to academic learning. That is a trade-off many parents and taxpayers are uncomfortable with, particularly given the large declines in children's achievement during the COVID-19 pandemic.

Moreover, many people who are in favor of social and emotional learning programs would also argue that teachers are already overburdened. Without proper training and support, it is difficult to imagine teachers effectively implementing curricula on a new dimension of cognitive development. Even with proper training and resources, these programs will necessarily shift focus away from areas of academic learning that are in great need of

attention—particularly now, post-pandemic. Asking teachers to master and incorporate a set of curricula on social and emotional learning skills on top of existing curricula seems to risk them being unable to do well in either area.

COMMON THEMES AND CONTROVERSIES IN WHOLE-CHILD MODELS

In reviewing the evidence on recent whole-child reforms, a few themes emerge. First, the theories motivating these reforms are at least a century old, as is the underlying structure of the models themselves. Under different names, some of these models, like the community school model, have been around for many decades. Second, many are focused on deep engagement with community partners to provide a more extensive and more comprehensive set of health and social services support in schools than the traditional model focused on academics. The exception is the social and emotional learning model, which more commonly operates with teachers as the provider of curricula focused on particular nonacademic skills. Third, all of these models either explicitly or implicitly assume that the school is the best vehicle or central conduction point for intervening to improve nonacademic outcomes.

A few controversies surround whole-child models, either as a group or for specific models. The most common controversy is the debate over whether schools are the appropriate places to focus on nonacademic outcomes and on the broader societal ills that so negatively impact child well-being. As I discussed at the beginning of this chapter, there are many potential concerns about locating this work in schools. One of the largest concerns is that, given scarce financial and bandwidth resources in public schools, these efforts will crowd out attention to academic outcomes and the academic reforms that research has proven are effective at improving child outcomes. Relatedly, others are concerned that schools do not have the expertise to venture beyond the traditional academic focus.

Social and emotional learning programs are notable for the growing controversy in the public and political spheres. Particularly since the pandemic, as the country has increased its focus on mental health, there has been incredible growth in the adoption of a wide range of curricula labeled as social and emotional learning. Because the curricula are adopted without expanding time in the classroom and are often taught by teachers without much, or any, background training, concerns exist that the social and emotional curricula are crowding out time spent on building academic skills without even the potential benefit that might accrue if the social and emotional skill building were in the hands of professionals trained in these areas.

TAKEAWAYS FOR POLICY

The emphasis on whole-child reforms in recent decades is understandable from a rhetorical perspective. Who among us would argue that they only care about one part of our children's

development? Or that they do not want to support children's development as productive citizens of society across a range of dimensions? And what parent who is trying to teach their child a new skill does not understand the value of concepts like grit and problem-solving skills?

However, the research evidence motivating the models of whole-child reform in schools is limited. To date, there is some promising evidence from a few programs in a few settings, but there is not enough to support any of these models' ability to improve children's educational outcomes at scale. There is also limited evidence on other outcomes of interest at scale. When examined in total, the lack of a more prominent relationship between improvements in social and behavioral outcomes and academic outcomes casts doubt on the underlying theory that school investments in a wider range of areas of child development are what is needed to enhance students' academic success.

One takeaway from this is that policymakers interested in improving their students' learning, particularly in the wake of the learning loss of the COVID-19 pandemic, should redouble their focus on academics by investing in tools that we know work, such as attracting and training a high-quality teaching workforce, extending the time children spend in high-quality learning environments, and math and reading curricula that demonstrate improvements.

For example, there is a growing body of high-quality causal evidence showing that teacher effectiveness can be improved. For example, teacher evaluation programs have improved teacher effectiveness (Taylor and Tyler 2012). Even low-cost peer-observation programs, which pair teachers to observe and provide feedback on each other's teaching without the incentives and extra costs of evaluation systems, have had positive effects on teacher performance (Burgess et al. 2021; Papay et al. 2020).

Of course, it is unlikely that any single reform will be a silver bullet that can improve education outcomes for all children. It may be the case that, in some districts, a whole-child model seems like the best available intervention. In these settings, care should be taken to determine the needs and goals of the school or district; clearly articulate these for the community; choose a whole-child model focused on the relevant outcomes with research evidence validating its effectiveness; provide adequate resources to support the implementation; and commit to a process of continual evaluation and a willingness to change directions or to abandon the model if it is not effective.

In this case, the most promising whole-child reform reviewed here is the wraparound services model, such as the City Connects program. In part, this is because the model is not a one-size-fits-all model that is trying to improve the outcomes of all children with an intervention in a particular area. Instead, it is a model of providing direct, data-driven, personally tailored support to each student using existing academic and broader resources. It has the benefits of increased access to resources for individual families and children that is a hallmark of proponents of whole-child reforms—but without the potential drawbacks of entirely restructuring the school organization or environment or shifting curricula wholesale for all children in ways that detract from time spent in academic environments.

Policymakers looking to invest in any of these reforms, either whole child or academic focused, should take a careful look at existing research. The US Department of Education's taxonomy of research quality is helpful, as is the What Works Clearinghouse it operates. However, the current level of quality required to motivate federal funding through the Every Student Succeeds Act is well below the level that a discerning policymaker or school leader should set before adopting a reform.

Finally, policymakers looking to initiate whole-child reforms should take care to complement those investments with investments focused on academics. This will avoid the possible pitfall of not maintaining emphasis on strong academic programming that even advocates of whole-child reforms raise concerns about and that is an important component of the overall effectiveness of whole-child reforms.

HESI PRACTITIONER COUNCIL RESPONSE

Essays in this series were reviewed by members of the Hoover Education Success Initiative (HESI) Practitioner Council. For more information about the Practitioner Council and HESI, visit us online at hoover.org/hesi.

Policymakers play a crucial role in shaping and implementing education reforms. When it comes to investing in education, policymakers should prioritize the establishment of a robust accountability mechanism. This mechanism should go beyond de minimis or adequate yearly progress and instead aim for a baseline standard for the quality of education that children receive within any model.

By incorporating explicit measurements and guidelines for accountability, policymakers can ensure that education reforms are grounded in evidence, have a significant impact, and can be sustained over time. This accountability system should encompass the establishment of clear benchmarks and targets for student outcomes, school performance, and overall educational quality. Through rigorous evaluation, policymakers can identify the reforms that yield the highest returns on investment and replicate them to drive positive change across educational institutions.

A comprehensive accountability mechanism should extend beyond academic performance to encompass other crucial aspects of education, such as well-rounded development and student well-being. By including factors like social emotional skills, creativity, and critical thinking in the accountability framework, policymakers can ensure that reforms go beyond a focus solely on test scores and promote the holistic growth of students.

Policymakers should involve all stakeholders, including educators, parents, and community members, in the development and implementation of reforms. This collaborative approach will ensure that reforms address the specific needs and challenges of the education system.

—Christina Laster, CEO of Bold Enterprises LLC

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A Nation at Risk + 40

The modern school-reform movement in the United States was set in motion by the release of the report *A Nation at Risk* in 1983. Countless education policy changes at the local, state, and national levels came as a result. *A Nation at Risk + 40* is a research initiative designed to better understand the impact of these efforts. Each author in this series has gone deep in a key area of school reform, exploring the following questions: *What kinds of reforms have been attempted and why? What is the evidence of their impact? What are the lessons for today's education policymakers?* As the nation's schools work to recover from the effects of the COVID-19 pandemic, this series not only describes the education-reform journey of the past forty years, it also provides timely and research-driven guidance for the future.

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