



## Collaborative for Academic, Social, and Emotional Learning

**Statement of Roger P. Weissberg, Ph.D.  
Professor of Psychology and Education, University of Illinois at Chicago  
President, Collaborative for Academic, Social, and Emotional Learning**

**Before the  
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Good morning, Chairman DeWine, Senator Kennedy, and members of the Subcommittee. Thank you for inviting me here today to comment from my 30-year perspective as a psychologist, prevention researcher, and practitioner addressing the challenges facing school and other community-based prevention programs as they work to prevent youth substance abuse.

I am Roger Weissberg, Professor of Psychology and Education at the University of Illinois at Chicago, where I direct a Prevention Research Training Program in Urban Children’s Mental Health and AIDS Prevention funded by the National Institute of Mental Health. I also serve as President of the Collaborative for Academic, Social, and Emotional Learning (CASEL), an organization dedicated to the development of children’s social-emotional competencies and the capacity of schools, parents, and communities to support that development. CASEL’s mission is to establish integrated, evidence-based social and emotional learning (SEL) as an essential part of preschool through high school education (see [www.CASEL.org](http://www.CASEL.org) for information on advances research and practice in this area).

Recently, I co-edited a Special Issue of the American Psychologist on “Prevention that Works for Children and Youth” (Weissberg & Kumpfer, 2003). The articles in the Special Issue are an outgrowth of an American Psychological Association Presidential Task Force on “Prevention: Promoting Strength, Resilience, and Health in Young People” that I co-chaired. The task force members concluded that prevention research has matured substantially in recent decades, synthesizing new knowledge and offering important findings to guide prevention practice and policy. Part of my testimony will highlight some common features of effective prevention programming identified by scholars representing diverse perspectives. I am pleased to emphasize that there is great overlap between our views and the principles emphasized in the new Strategic Prevention Framework to advance community-based programs for substance abuse prevention and mental health promotion announced by the Substance Abuse and Mental Health Services Administration (SAMHSA).

In Part I of this testimony, I briefly introduce findings about trends in adolescent substance use and other risky behaviors and comment on the implications of these findings for coordinated prevention and youth-development programming. In Part II, I review results from recent large-scale studies and reviews on effective school-based prevention programs. Part III presents some of the challenges and difficulties that schools face in administering school-based prevention programs. In Part IV, I share with you some of the work CASEL is doing to reduce the gap between research and practice. In the last part, I comment on SAMHSA's "Strategic Prevention Framework" as a powerful tool towards collaboration and coordination among multiple prevention programs.

### **Trends in Adolescent Substance Use and Other Risky Health Behaviors**

The news regarding recent national trends in adolescent substance use is mixed. Perhaps the simplest set of headlines is "During the past 12 years, tobacco and alcohol use has declined; marijuana, cocaine, and illegal steroid use has increased; and, overall, too many students engage in all forms of substance use." To support this summary, I highlight some findings recently reported by the Centers for Disease Control and Prevention (CDC) from the 2003 Youth Risk Behavior Surveillance System ([www.cdc.gov/yrbss](http://www.cdc.gov/yrbss)). The National Youth Risk Behavior Survey is conducted every two years during the spring semester and provides data gathered from students in grades 9-12 in public and private schools throughout the United States. The chart below summarizes changes in percentages of self-reported substance use between 1991 and 2003.

<b>Behavior</b>	<b>1991</b>	<b>2003</b>
Lifetime cigarette use	70.1	58.4
Current cigarette use (last 30 days)	27.5	21.9
Lifetime alcohol use	81.6	74.9
Current alcohol use (last 30 days)	50.8	44.9
Episodic heavy drinking(last 30 days)	31.3	28.3
Lifetime marijuana use	31.3	40.2
Lifetime cocaine use	5.9	8.7
Lifetime illegal steroid use	2.7	6.1

Defying some commonly held stereotypes, substance use crosses geographic and economic boundaries. For example, studies comparing substance use between adolescents from affluent suburban versus low-income urban families show that high rates of teens from affluent families use substances (Luthar & Becker, 2002; Levine & Coupey, 2003). Such findings speak to the importance of universal (i.e., targeting all children) rather than selective approaches to prevention. Targeting only selective groups of children and youth in our prevention efforts may result in ignoring substantial numbers of children and youth who are in urgent need of prevention programs. Some may argue that broadly targeted prevention programming may not be appropriate for at-risk groups. However, research findings suggest that as long as we provide programs with fidelity, that is, implement them in a way that is faithful to the original program design, most programs are equally beneficial for all students (Griffin, Botvin, Nichols, & Doyle, 2002). Furthermore, Caulkins and his colleagues (2002) recently examined whether the benefits of a model school-based prevention program exceed its costs. According to their best

estimates, they concluded that society would currently realize quantifiable benefits of \$840 from a student’s participation compared with a program cost of \$150 per participating student, a saving of almost \$6 for every \$1 invested.

It may sound as though I am making an argument that early and effective substance abuse prevention for young people should be our highest priority. But, actually, I will argue that a broader perspective is needed. Preventing substance abuse is a worthy endeavor, but it is a limited goal. It is indisputable that young people who are not drug abusers may still lack the resources to become healthy adults, caring family members, responsible neighbors, productive workers, and contributing citizens (Pittman, Irby, Tolman, Yohalem, & Ferber, 2001). In addition to having drug-free sons and daughters, parents across the United States want children who:

- are intellectually reflective and committed to lifelong learning;
- interact with others in socially skilled and respectful ways;
- practice positive, safe, and healthy behaviors;
- contribute ethically and responsibly to their peer group, family, school, and community; and
- possess basic competencies, work habits, and values as a foundation for meaningful employment and engaged citizenship.

Although the prevalence of substance use calls for action, there is also reason for concern about high rates of related adolescent risk behaviors in domains such as violence, sexual behavior, depression, and suicide. Consider the following percentages of student involvement in problem behaviors from the 2003 CDC Youth Risk Behavior Surveillance System:

<b>Behavior</b>	<b>2003</b>
Threatened or injured with a weapon on school property (last 12 months)	9.2
Engaged in a physical fight on school property (last 12 months)	12.8
Currently sexually active (last 3 months)	34.3
Had 4 or more sex partners (lifetime)	14.4
Felt so hopeless almost every day two weeks or more in a row that they stopped doing some usual activities (last 12 months)	28.6
Made a suicide plan (last 12 months)	16.5
Attempted suicide (last 12 months)	8.5

When we look at the broader picture of adolescent functioning, it is clear that, beyond substance use, significant percentages of young people experience mental health problems, engage in other risky behaviors, and lack social-emotional competencies. The 1999 Surgeon General’s report on mental health indicated that 20% of children and adolescents experience the symptoms of a mental disorder during the course of a year, and that 75-80% of these children do not receive appropriate services (U.S. Department of Health and Human Services, 1999). Dryfoos (1997) estimated that 30% of 14 to 17 year-olds engage in multiple high-risk behaviors, and that another 35%, considered to be at medium risk, are involved with one or two problem behaviors. Approximately 35% have little or no involvement with problem behaviors, but even these young people require strong and consistent support to avoid becoming involved.

Such a constellation of multiple high-risk behaviors points to the importance of moving beyond the problem-focused approach and especially beyond targeting only one problem behavior at a time. Ripple and Zigler (2003) argued that such approaches fail to take into consideration the complicated etiology of individual target problems and the significant overlap of multiple problems. The design of prevention programs should be guided by the theoretical knowledge on risk and protective factors commonly underlying multiple problem behaviors. Furthermore, programs should not merely aim at reducing risk conditions; they also should explicitly promote personal and environmental assets that will decrease problem behaviors and, more important, serve as foundations for healthy development (Greenberg et al., 2003; Kumpfer & Alvarado, 2003; Wandersman & Florin, 2003).

In assessing the functioning of young people and families, I draw three major conclusions that have relevance for prevention policy and practice. First, a significant proportion of children will fail to grow into contributing, successful adults unless there are major changes in the ways they are taught and nurtured. Second, families and schools must work together more systematically and effectively to enhance the social-emotional competence, character, health, and academic learning of all children. Finally, new kinds of community resources and arrangements are needed to support the positive development of young people into responsible, healthy, productive workers and citizens.

### **Principles of Effectiveness Based on Meta-Analyses and Large-Scale Reviews of Prevention Programs**

The No Child Left Behind Act has prompted heightened awareness of educational accountability as well as the need for evidence-based programs to improve student performance. Federal and state government agencies are mandating that only programs proven to be effective should receive public funds. Due to significant advances in prevention science, there have been increasing efforts to identify effective prevention programs and the characteristics that underlie such programs (Nation et al., 2003).

A number of institutions, both public and private, including the Centers for Disease Control and Prevention, the Center for Substance Abuse Prevention, the Office of Juvenile Justice and Delinquency Prevention, the U.S. Department of Education, and CASEL have put forth lists of model programs. However, there have been growing concerns about the gap between scientific knowledge about prevention programs and actual practice (Wandersman & Florin, 2003). Therefore, with the intention to inform practitioners about the availability and characteristics of effective programs, several researchers have conducted reviews and meta-analyses of prevention programs. These studies have yielded noteworthy principles of successful prevention programming (Catalano et al., 2002; Durlak, 1998; Eccles & Appleton, 2002; Greenberg, Domitrovich & Bumbarger, 2001; Kumpfer & Alvarado, 2003; Nation et al., 2003; Tobler, 2000; Wilson, Gottfredson, & Najaka, 2001).

In their meta-analysis of 207 universal prevention programs published between 1978 and 1998, Tobler et al. (2000) found that programs that only emphasized information and lacked an interactive approach were minimally effective. Among three types of programs categorized under interactive approaches—interpersonal skills training programs, comprehensive life skills training programs, and school-wide restructuring programs—system-wide restructuring showed the strongest impact. As researchers have consistently pointed out, thoughtful school-based prevention and youth development interventions should enhance students' personal and social assets and at the same time improve the quality of the environments in which students are

educated (Catalano et al., 2002; Eccles & Appleton, 2002; Greenberg et al., 2003). Given that peer social influences are the most salient determinant of substance use, no one will doubt the crucial role that refusal skills (the ability to “say no” and mean it) play in preventing teens from using tobacco, alcohol, and other substances. However, skills training alone is not sufficient. Considering that many youth involved in substance use lack a sense of connectedness to school and family, instruction of skills and knowledge should take place in tandem with changes in school-wide culture that help children feel more engaged, safe, and supported.

Weissberg, Kumpfer, and Seligman (2003) highlighted six characteristics of effective prevention programming across school, family, and community levels for young people:

- Uses a research-based risk and protective factor framework that involves families, peers, schools, and communities as partners in coordinated programming that targets multiple outcomes;
- Is long-term, age-specific, and culturally appropriate;
- Fosters development of individuals who are healthy and fully engaged by teaching them to apply social-emotional skills and ethical values in daily life;
- Aims to establish policies, institutional practices, and environmental supports that nurture optimal development;
- Selects, trains, and supports interpersonally skilled staff to implement programming effectively; and
- Incorporates and adapts evidence-based programming to meet local community needs through strategic planning, ongoing evaluation, and continuous improvement.

Despite advances in scientific knowledge about ways to make prevention programs effective, there still is wide gap between research and practice—what we know and what we do. In the case of school-based prevention programs, many schools still do not use programs of proven effectiveness (Gottfredson & Gottfredson, 2001). Even when schools select research-based programs, the majority of them report that they do not implement those programs with fidelity. Bolstering the quality of schools so that they work effectively with families to foster both the social-emotional development and academic performance of all students must be the top priority of any comprehensive prevention strategy for young people (Osher, Dwyer, & Jackson, 2002).

### **Barriers to Successful Implementation of School-Based Prevention Programs**

Several observations can help to explain the disparity between research and practice. Taken together, they represent a set of barriers to the successful implementation of beneficial school-based prevention programs.

First, there is widespread fragmentation and lack of coordination among prevention programs. In most cases, schools are flooded with programs covering such topics as character education, substance abuse prevention, and HIV/AIDS awareness, with no effort to coordinate what are in fact closely interrelated realms. No matter how many prevention programs schools have, those programs are not likely to achieve their intended effects as long as they are introduced in a piece-meal and uncoordinated manner.

A second challenge is the lack of administrator-teacher support and professional development opportunities. Bombarding principals and teachers who are already overburdened by academic duties with a succession of new programs with minimum support and guidance is likely to raise

educators' resistance and ultimately result in ineffective program results. As seen in the work of Osher et al. (2002) and Adelman and Taylor (2000), for a prevention program to achieve maximum impact, the entire school community should embrace the program's mission and goals, thereby changing whole school culture. However, without the ownership of the school community, active leadership of administrators, and high-quality implementation by teachers and student-support staff, the program is not likely to be successful.

A third challenge is the lack of an accountability system. I have already noted that the majority of the programs are not implemented with fidelity. The problem is exacerbated by the absence of accountability systems through which both the implementation and the impact of a prevention program is assessed and shared publicly in an ongoing fashion. Therefore, to achieve faithful and successful implementation of prevention programs, we should adopt accountability systems for children's social-emotional development and health with the same vigor as we do for their academic performance.

### **The Social and Emotional Learning Framework: Bridging the Gap Between Science and Practice**

In 1994 a group of educators, school-based prevention researchers, and child advocates came together to address the ineffective nature of so many prevention and health promotion efforts. The result was the formation of the Collaborative for Academic, Social, and Emotional Learning (CASEL). Since its inception, CASEL has been working toward the goal of establishing social and emotional learning (SEL) as an essential element of education from preschool through high school. SEL is the process of acquiring the skills to recognize and manage emotions, demonstrate caring and concern for others, make responsible decisions, establish positive relationships, and handle challenging situations effectively. SEL is fundamental to children's social and emotional development, health and mental well-being, ethical development, citizenship, motivation to achieve, and academic learning.

Developmentally and culturally appropriate SEL-focused classroom instruction in the context of a safe, caring, well-managed, and participatory school environment enables young people to learn, practice, and apply SEL skills. It also enhances students' connection to school through caring, engaging classroom and school practices. Learning social and emotional skills is similar to learning other academic skills in that the effect of initial learning is enhanced over time to address the increasingly complex situations children face. SEL outcomes are best accomplished through effective classroom instruction; student engagement in positive activities in and out of the classroom; and broad student, parent, and community involvement in program planning, implementation, and evaluation. Ideally, planned, systematic SEL instruction should begin in preschool and continue through high school. We at CASEL believe that the rationale for SEL can serve as a powerful framework to facilitate coordination and integration of multiple fragmented prevention efforts (Greenberg et al., 2003) and thus address more effectively some of the most pressing problems facing prevention and health promotion programs today.

There is growing evidence that school-based SEL programming can successfully enhance students' academic performance as well as reduce substance use and address other problem behaviors (Greenberg et al., 2003; Zins, Weissberg, Wang, & Walberg, 2004). In spite of the fact that most schools' mission statements embrace the notion of the whole child, most schools do not make systematic efforts to institutionalize promotion of social and emotional competencies and creation of environments supporting their development.

CASEL believes that schools should explicitly address children's social and emotional development as an educational priority. We are conducting a variety of activities to help educators and prevention professionals create and sustain more effective approaches to prevention programming. These activities include:

- Disseminating scientific knowledge about the conceptual framework for SEL and evidence-based SEL programs through CASEL's publications, web site, and monthly electronic newsletters;
- Providing support and technical assistance for the pre-service and in-service training of teachers and administrators to ensure fidelity and sustainability of school-based SEL prevention programs;
- Promoting school-family-community partnerships; and
- Developing and facilitating local, state, and national networks of educational leaders who are concerned about effective prevention and positive youth development programming

At the state level in Illinois, our Governor recently signed the Children's Mental Health Act of 2003 (Public Act 93-0495). Section 15 (Mental Health and School) requires the following:

- The Illinois State Board of Education shall develop and implement a plan to incorporate social and emotional development standards as part of the Illinois Learning Standards for the purpose of enhancing and measuring children's school readiness and ability to achieve academic success.
- Every Illinois school district shall develop a policy for incorporating social and emotional development into the district's educational program. The policy shall address teaching and assessing social and emotional skills and protocols for responding to children with social, emotional, or mental health problems, or a combination of such problems, that impact learning ability.

CASEL is currently working with the Illinois State Board of Education and the Illinois Children's Mental Health Partnership to implement this legislation. The Illinois effort can serve as a national model for fostering educational systems that focus on student competencies that serve as foundations for successful academic performance, health, character, and citizenship.

At the national level, CASEL trains school building-level and school district-wide coordinators who support the implementation, evaluation, and continuous improvement of evidence-based school safety and substance use prevention programs. Specifically, we, as a team with three other groups (the American Institutes for Research, the Education Development Center, and the National Association of School Psychologists) provide training and technical assistance to the National and Middle School Prevention Coordinators under the Office of Safe and Drug-Free Schools in the U.S. Department of Education. The coordinators play a critically important role in their schools and districts by ensuring successful implementation of evidence-based programs. Their roles include: (1) integrating and coordinating multiple programs, (2) conducting needs assessments and establishing baseline data related to prevention and youth-development programming, (3) conducting implementation and outcome assessments, and (4) overseeing and facilitating prevention-related school staff development.

We applaud the Office of Safe and Drug-Free Schools for its effective leadership in conceptualizing and advancing efforts to train and support Safe and Drug-Free School Coordinators. Given the crucial role that they play in successful implementation of programs and the host of tasks for which the coordinators are responsible, more funding should be provided for training the coordinators and selecting and hiring more individuals to join in this important endeavor. For school-based prevention to succeed, it is crucial that districts and schools have staff members who are explicitly responsible for assuring the selection, effective implementation, coordination, evaluation, and continuous improvement of evidence-based programming.

Another important avenue for informing and supporting educators to implement research-based SEL programming is through the Regional Education Laboratories. CASEL is effectively collaborating with the Mid-Atlantic Regional Educational Laboratory for Student Success at Temple University to disseminate information and provide supports to thousands of educators who implement school-family prevention programming (CASEL, 2003; Zins et al., 2004).

### **Toward Further Collaboration and Coordination: The SAMHSA Strategic Prevention Framework**

In recent years, SAMHSA has provided groundbreaking and high-quality national leadership in translating rigorous science into effective practice. For example, through its Model Programs initiative, Training and Technical Assistance Centers, and informative publications, SAMHSA has focused on making sure that the highest quality, evidence-based programs are provided effectively and broadly to American children and families. Given the common risk and protective factors for substance abuse and mental health problems, it is good to see increased coordination between CSAP and CMHS so that their science-based interventions focus simultaneously on the fundamental and common factors that influence both types of outcomes. The best payoff from these efforts will come from programming that begins in early and middle childhood and works with schools, families, and communities to create integrated systems of prevention and treatment in which prevention is seen as the front line of defense to reduce the number of new cases as well as an important offensive strategy to enhance the competence of all young people.

SAMHSA has recently announced that it will provide \$45 million to support states in implementing the new "Strategic Prevention Framework (SPF)" to prevent substance abuse and promote mental health. The Framework is based on the belief that effective prevention programs must (1) involve individuals, families, and entire communities, (2) acknowledge the importance of health promotion as well as problem prevention, (3) emphasize common risk and protective factors among multiple problems, and (4) have accountability systems through which program implementation and impact are monitored in an ongoing fashion.

The SPF recognizes the lack of collaboration and coordination among multiple prevention efforts and the absence in too many cases of a comprehensive theoretical framework. I applaud SAMHSA for creating this comprehensive framework. It has tremendous potential to, in SAMHSA's own words, "bring together multiple funding streams from multiple sources to create the true cross-program and cross-system approach that health promotion and disease prevention demand."

The newly proposed SAMHSA Framework will facilitate collaboration among different prevention programs in multiple settings that include schools, families, and communities, a crucial component for effective prevention strategies. SAMHSA's strategic planning represents an exciting set of directions, but their prevention initiatives require new and substantial funds if we are to reduce significantly the number of young people who develop substance abuse and mental health problems. I urge you to provide more funding for SAMHSA's prevention efforts. In addition, I hope that you will encourage stronger interagency linkages between federal agencies - such as the U. S. Department of Education, SAMHSHA, and the National Institutes of Health - both to improve practice and to understand factors that influence high quality dissemination and utilization of effective prevention programs and policies.

Once again, thank you, Mr. Chairman and Senator Kennedy for the opportunity to present this testimony and for holding this timely hearing. I would be glad to answer any questions the subcommittee may have.