The Whole School, Whole Community, Whole Child Model: An Opportunity for School Psychologists to Show Leadership

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Over the past few decades, the reciprocal and interactive nature of student health and academic outcomes has been well established (Basch, 2010; Institute of Medicine, 2015). A multitude of research has demonstrated how both common student health issues (e.g., asthma, poor vision) and poor health-related behaviors (e.g., lack of physical activity, poor nutrition) can severely inhibit student academic success (Basch, 2010, 2011a, 2011b). For example, youth with health-related problems have lower educational (a) achievement (Case, Fertig, & Paxson, 2005; Eide, Showalter, & Goldhaber, 2010), (b) attendance, (c) connectedness, and (d) engagement (Michael, Merlo, Basch, Wentzel, & Wechsler, 2015). Alternatively, research demonstrates that when students' health needs are met, they attain higher academic achievement (Bradley & Green, 2013; Michael et al., 2015). Despite acknowledgement of these reciprocal influences between health and learning, education reform has continued to narrowly focus on academic achievement without adequately addressing underlying student health issues (Michael et al., 2015), representing a missed opportunity for public health and education efforts. This article describes the Whole School, Whole Community, Whole Child model addressing the health and learning needs of all students, and encourages school psychologists to seize the opportunity to lead efforts in its implementation.

A Brief History of Coordinated School Health

With an understanding of the benefits of collaboration and connection across domains of student functioning, both the Centers for Disease Control (CDC) and the Association for Supervision and Curriculum Development (ASCD) have previously and separately advanced models which focus on addressing health within education. In 1987, the CDC published the Coordinated School Health (CSH) model, which has served as the primary model for school-health collaboration ever since (Lewallen, Hunt, Potts- Datema, Zaza, & Giles, 2015). This model included important aspects of physical, social, nutritional, and psychological health across eight interrelated components (health education, health services, nutritional services, physical education, counseling and support services, healthy school environment, family/community involvement, and health promotion for staff), but it failed to gain widespread educational support because educators viewed it as a health initiative; it was not perceived to fit well into the academic-achievement-oriented educational context (ASCD & CDC, 2014; Michael et al., 2015). In 2007, the ASCD launched the Whole Child Initiative, a model of school–health collaboration designed to shift mindsets about education away from a narrow focus on student academic achievement to a broader view encompassing students' comprehensive needs by fostering collaboration across contexts (ASCD & CDC, 2014). This model, however, was perceived

as solely an education initiative, and did not adequately connect schools to the health community (ASCD & CDC, 2014; Michael et al., 2015). Recognizing the limited impact of these models and the fundamental need for collaboration among education and health agencies to improve youth outcomes, the CDC and ASCD worked together with experts in health, public health, education, and school health to develop the Whole School, Whole Community, Whole Child (WSCC) model, which launched in 2014.

The Revised Model: Whole School, Whole Community, Whole Child

The WSCC model incorporates the components of CSH and takes an ecological approach in which the *whole school* draws resources from the *whole community*, to serve the *whole child*, thereby providing a model to address the "symbiotic relationship between learning and health" (ASCD & CDC, 2014, p. 6). The WSCC model (see http://www.cdc.gov/healthyyouth/wscc for a graphical representation), expands the eight-component CSH model to 10 components by breaking two original components into four components. Specifically, the healthy and safe school environments component in the CSH model was divided into the two distinct yet encompassing components of (a) social and emotional climate and (b) physical environment in the WSCC model, putting an increased emphasis on the importance of these interconnected factors within schools. Additionally, the family/community involvement component in the CSH model was divided in the WSCC model into the two distinct components of (a) family engagement and (b) community involvement, highlighting the importance of individuals within each of these domains. See Table 1 for a summary.

Table 1 Components and Brief Descriptions in a Whole School, Whole Community, Whole Child Model

COMPONENT	DESCRIPTION	RESEARCH SUPPORT
Community Involvement	Community involvement refers to collaboration between school and various community agencies such as groups, organizations, and businesses. The development of a symbiotic relationship between school systems and these agencies through partnerships and joint project participation can foster the sharing of resources, enhance student opportunities, and catalyze student learning and health.	Research indicates that the sharing resources between schools and various community agents (e.g., social service agencies, health clinics, colleges and universities) improves student academic achievement, providing students with valuable opportunities to both learn about and access health related services (Epstein, [2011]; Michael et al., [2015]).
Family Engagement	Family engagement in the form of family–school partnership is essential in supporting	Family engagement has been associated with a decrease in the likelihood of

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	student learning and health needs. Schools and families possess the shared responsibility of ensuring the healthy development of children and can be more effective in these tasks through meaningful collaboration.	cigarette and alcohol use, of early pregnancy, of being physically inactive, and of being emotionally distressed. Family engagement has also been linked to increased attendance, higher academic achievement, better social skills, improved classroom behavior, and increased likelihood of high school graduation (CDC, 2012).
Health Education	Health education represents the continuum of formal and informal learning opportunities that students are exposed to across settings with the intentions of promoting healthy decision making. Health education reflects high-quality instruction that focuses on learning, adopting, and encouraging healthy behaviors within context–appropriate universal and individualized settings.	Research suggests that health education can decrease risk of alcohol and other drug use, decrease risk of teen pregnancy, and decrease school absences and dropout risk. Health education has also been associated with improved student behavior and student academic performance (Murray, Low, Hollis, Cross, & Davis, 2007).
Physical Environment	The physical environment represents both the internal aspects of the school and the characteristics of the surrounding land areas. A healthy school environment should address any physical, chemical, or criminal-based risks that threaten a safe and productive learning environment.	Physical environment characteristics such as poor ventilation; inconsistent air Temperature; and biological and chemical agencies within the air, water, or soil have been shown to impact student academic achievement by causing lethargy, decreasing student concentration, and by triggering asthma and allergic reactions (Environmental Protection Agency, 2012; Filardo & Vincent, 2010).
Social and Emotional Climate	Social and emotional climate refers to the unique psychological and social aspects of a school and how these influence student engagement, relationship building, and learning. A positively focused school climate promotes a safe and supporting learning environment and encourages student health, growth, and development.	Positive social and emotional climate has been associated with a decrease in student substance abuse, early sexual initiation, violence, and unintentional injury. Additionally, climate has been shown to have a positive impact on student absenteeism, attendance, maintaining appropriate grade level, classroom behavior, and school attrition

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		(Thapa, Cohon, Guffey, & Higgins-D'Alessandro, [2013]).
Nutrition Environment and Services	The nutrition environment in schools represents a variety of school areas, including the cafeteria, vending machines, concession stands, and school stores, and serves as a learning platform for students. In these settings, students are exposed to multiple food/beverage choices and information regarding nutrition and healthy consumption practices, all of which must meet federal standards and accommodate students with distinct nutritional needs.	Schools that emphasize a healthy nutritional environment increase student health by focusing on the consumption of essential food groups (e.g., fruit, vegetables) and hydration. Additionally, nutritional services that provide heathier foods, and access to breakfast and drinking water, have been shown to increase student cognitive performance, academic performance, standardized test scores, and to reduce absenteeism (Edmonds & Jeffes, [2009]; Kempton et al., [2011]).
Health Services	School health services work to address both immediate health concerns and chronic health issues within schools, concurrently promoting health wellness and prevention strategies. Additionally, health services work closely with parents and community healthcare providers to increase health education and better manage health related issues.	Research suggests that schools with strong health services help to improve student health and academic outcomes by decreasing time spent outside the classroom and school environment. Many common health ailments such as asthma, diabetes, epilepsy, and sickle cell anemia are related to increased absenteeism and poor academic behaviors (e.g., lower cognitive functioning, decreased attention), providing an important niche for the development of appropriate health services (Basch, [2011a]; Kucera & Sullivan, [2011]; Michael et al., [2015]; Murray et al., [2007]; Taras & Potts-Datema, [2005]).
Counseling, Psychological, and Social Services	Counseling, psychological, and social services include a broad range of mental, behavioral, and social–emotional health prevention and intervention supports for students within the educational setting. The primary objective of these services is to accurately identify and sufficiently address student barriers to learning, using a team of	Counseling, psychological and social services within schools have been shown to increase student attendance, positive classroom behavior, test scores, and GPA, and to decrease suspension rates (Becker, Brandt, Stephan, & Chorpita, [2013]; Borders & Drury, [1992]; Wells, Barlow, & Stewart-Brown, [2003]).

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	educational professionals and support staff (including school psychologists) to provide students with direct and indirect services. Collaboration with families and community providers to coordinate necessary student support is essential.	
Physical Education and Physical Activity	Physical education and physical activity are important components that must be built into school environments in order to most effectively assist students in maintaining healthy and active lifestyle habits through childhood and into adulthood. Successful programs address both student learning and active practice in a planned and comprehensive manner.	Participation in physical activity is associated with improved academic outcomes related to increased cognitive performance and more adaptive classroom behavior (Castelli et al., [2014]; Fedewa & Ahn, [2011]; Michael et al., [2015]; Murray et al., [2007]; Raspberry et al., [2011]).
Employee Wellness	Fostering employee wellness directly benefits the health of teachers and may subsequently Impact both student learning of healthy behaviors and the fulfillment of individualized student needs. Effective employee wellness programs contain a variety of programs, policies, benefits, and supports and work in conjunction with personalized health agencies to establish both prevention and intervention based health initiatives.	Research regarding school employee wellness indicates that employees with unhealthy patterns of behavior and with health issues are less productive and effective in their work which, in turn, negatively impacts student outcomes (Eaton, Marx, & Bowie, [2007]).

Adapted from Centers for Disease Control and Prevention's Components of the *Whole School, Whole Community, Whole Child* (available at http://www.cdc.gov/healthyschools/wscc/components.htm).

As part of the ecological approach of the WSCC initiative, the model includes an emphasis on developing and coordinating local policies, processes, and practices to move the model into action. Moreover, the WSCC model advocates that all stakeholders (a) start with a common understanding about the interrelationship between learning and health; (b) work collaboratively to develop joint policies, processes, and practices; and (c) use available knowledge about the interrelationship between learning and health as guideposts over time when adjusting or adapting policies, processes, and practices to promote students' positive learning and health outcomes. This collaborative emphasis is aligned with research demonstrating that models that (a) reflect the importance of the multifaceted relationships between and among influential groups (individuals,

families, schools, communities) and (b) work to unify these groups within a coordinated system have a more significant impact on student health and learning (Epstein, 2011).

The WSCC model, with 10 research-based components and a focus on collaboratively developed and executed policies, processes, and practices, directs attention in both health and education to the child rather than to an academic subject or service location. By calling for the establishment of mutually beneficial relationships through increased coordination and collaboration among schools, families, healthcare agencies, community organizations, and other influential entities, the WSCC model transforms the way we think about both education and healthcare. Adopting, integrating, and effectively implementing the WSCC model will be a significant challenge for schools, requiring both a thorough understanding of the interrelated components and their dynamic leadership. School psychologists are established school leaders with the fundamental skills to take on this task.

Seizing the Opportunity to Lead Wscc Efforts

School psychologists are vital leaders in a variety of psychological and educational domains (NASP, 2010). Their comprehensive skills across data-based decision making, consultation and collaboration, diversity, evaluation, and student- and systems- level services align with core themes within the WSCC model, making coordinated health another natural domain for school psychologists to provide leadership. School psychologists are strong advocates for social justice and can use their knowledge and skills to advocate for adoption, integration, and implementation of the WSCC model to improve the well-being of all students (NASP, 2010). Furthermore, school psychologists can harness their assessment, evaluation, systemslevel intervention, family and community collaboration, and data-based decision making skills to (a) identify the priority health needs of their student population, (b) identify community assets and resources, and (c) develop collaborations with healthcare agencies and community organizations (NASP, 2010; Rooney, Videto, & Birch, 2015). Finally, school psychologists can use their consultation, assessment, and program evaluation skills to (a) develop measureable goals and objectives for WSCC implementation, (b) identify strengths and weaknesses, (c) use data to inform program adjustments and revisions, and (d) communicate outcomes to stakeholders (NASP, 2010; Rooney et al., 2015).

School psychologists regularly apply their wide-ranging skills across a variety of roles and responsibilities, which gives them the advantage of regularly viewing the school system from multiple perspectives. In this sense, school psychologists are able to take the perspective of students trying to learn, classroom teachers with multiple competing demands, administrators responsible for communicating a vision of student success and managing resources to achieve that vision, families wanting their children to develop into happy and successful adults, and community agencies and healthcare providers working to improve outcomes for local youth. Capitalizing on these differing vantage points, school psychologists can successfully integrate WSCC within and across systems. In this way, an important role is to serve as dynamic change agents through effective integration of health and education sectors.

Conclusion

School psychologists are lifelong learners who embrace continual professional growth (NASP, 2010). In this spirit, professional development designed to link existing skills within increased focus on key domains to facilitate implementation of the WSCC model is a worthy goal. For example, although current school psychologist training focuses on how to engage in a variety of situations in the school context, there has been less directed focus on collaboration with professionals across other contexts serving student health. Additional expertise on how to lead interprofessional collaborative efforts would assist school psychologists in increasing engagement and integration across all contexts serving student learning and health. With an increased understanding of how to initiate, develop, sustain, and grow collaborative practice among schools, families, and communities, school psychologists will be better positioned to assist with the “how” behind the WSCC model, thus further working to improve the lives of all students.

Over the past few decades, the link between education and health has been established. Increased attention to dissemination of these findings combined with the additive positive benefits from school, family, and community collaboration on student outcomes has resulted in the need for a comprehensive model to change the way in which education-health is considered. The WSCC model has answered this call, focusing on 10 components that have been shown to have a significant impact on student outcomes while simultaneously promoting unified coordination across important groups. These ideals relate directly to the wide range of responsibilities held by school psychologists, which include student advocacy, evidence-based practice, and collaboration and consultation. As professionals skilled in these domains, school psychologists have the ability to be influential leaders in the integration of health and education through use of the WSCC model.

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