Basic Life Skills Promotion: A Philanthropic Intervention to Improve Health and Reduce Poverty

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by

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In the last planning paper in this series, the overlapping concepts of basic capabilities and mediating factors were introduced to describe certain human development characteristics that form the foundation for higher levels of functioning and well-being. When I turned my attention to searching for examples of programmatic strategies aimed at improving basic capabilities and mediating factors, I had only limited success finding them using either of those terms. Continuing to look for programs that focused on specific basic capabilities, I found a gold mine of interventions that concentrated on development of *life skills* (the preferred term) and *executive function skills* (another term that covers a subset to life skills). "Life skills," is simply another way of conceptualizing basic capabilities and mediating factors. The emphasis on *skills* (i.e., the learned ability to accomplish a task with an expected outcome) as the intervention makes perfect sense: it implicitly highlights knowledge transfer of a capability that is based on a theory of action and empirical evidence. In other words, behaviors that have been proven to produce desired results. So in this paper, the emphasis will be on life skills, what they are, how they have been used and by whom, and what the evidence suggests that we may expect from using them. To set the scene, the paper will begin with a discussion of a novel framework for thinking about health, salutogenesis, and an account of international efforts to change thinking about health promotion.

Salutogenesis

Aaron Antonovsky introduced the word "salutogenesis" to the world almost 35 years ago, a combination of the Latin word *salus* meaning health and the Greek word *genesis* meaning origin. Springing from his studies of health, stress, and coping, salutogenesis is primarily concerned with what creates and sustains health rather than with explaining the causes of diseases and how to cure them (the pathogenic approach). In other words, instead of focusing on risk factors for disease, it looks for factors that promote health. It is an asset-based approach.

Antonovsky began his exploration of what creates health by examining why some people stay healthy after being exposed to hazardous influences and others succumb to illness. He concluded that the health of a person depends upon one's ability to cope with persistent stressors and the resources they can turn to for support. He referred to these assets as *general resistance resources (GRRs)*. Antonovsky argued that the repeated successful use of GRRs to manage stress results in an attitude that, over time, is "in itself the essential tool for coping." He referred to this new attitude as the *sense of coherence (SOC),* which is the centerpiece of salutogenesis theory, uniting cognitive, behavioral, and motivational factors. SOC is the ability to make sense of situations (comprehensibility); to use the available resources to respond to them (manageability);

and to feel that these responses are meaningful and make sense (meaningfulness). When confronted with a stressor, a person with a strong SOC, according to Antonovsky, will:

- Wish to be motivated to cope (meaningfulness)
- Believe that the challenge is understood (comprehensibility)
- Believe that the resources to cope are available (manageability).

Antonovsky envisioned human life as existing along a continuum between the pathogenic ("dis-ease" in his term) and the salutogenic ("ease"). Each of us at any given time is somewhere along the continuum. When confronted by a stressor, one's sense of coherence, or lack of it, moves her either closer to ease or to dis-ease. This notion of a continuum of pathogenesis and salutogenesis begins to unravel the traditional medicine-public health dichotomy that is often described by a river metaphor. In this metaphor, health education and disease prevention are upstream activities and medical care and treatment of disease are downstream activities. The former activities prevent people from falling into the river and the later activities fish out people who have fallen into the river, saving them from suffering and death. Among public health professionals (and some enlightened physicians) there is a decided bias in favor of upstream services. Antonovsky claims that none of us are on the banks of the river; we are all in the river, moving either upstream or downstream to greater ease or dis-ease. "We are all, always, in the dangerous river of life," he wrote. "The twin question is: How dangerous is *our* river? How well can we swim?"

The rivers of many residents of Wyandotte County are quite perilous indeed. Our duty is to help make them more effective swimmers.

The Ottawa Charter for Health Promotion

The first International Conference on Health Promotion sponsored by the World Health Organization was held in Ottawa, Ontario (Canada) November 17-21, 1986. It brought together a group of influential researchers, policy-makers, and public health practitioners from around the world to help set a framework for health promotion. Out of it came the Ottawa Charter, often recognized as a foundational document of health promotion. The definition of "health promotion" in the Ottawa Charter altered thinking about health promotion in ways that are still being felt today:

> Health promotion is the process of *enabling people to increase control* over, and to improve, their health. To reach a state of complete physical, mental, and social well-being, an individual or group *must be able to identify and realize aspirations, to satisfy needs, and to change or cope with the environment.* Health is therefore, seen as a *resource for everyday life*, not the objective of living. Health is a positive concept emphasizing *social and personal resources*, as well as physical capacities. Therefore, health promotion is *not just the responsibility of the health sector*, but goes beyond healthy life-styles to well-being (emphasis added).

The Charter went on to identify three basic strategies for health promotion (advocate, enable, and mediate) and to identify six health promotion priority action areas (build healthy public policy, create supportive environments, strengthen community actions, develop personal skills, reorient health services, and move into the future), thus setting the framework for much of the health promotion work accomplished in the past 28 years. While all of the strategies and priority actions will improve population health broadly, the development of personal skills holds particular promise for vulnerable populations. The section of the Ottawa Charter on the development of personal skills reads:

> Health promotion supports personal and social development through providing information, education for health, and *enhancing life skills*. By doing so, it increases the options available to people to *exercise more control over their own health and over their own environments*, and to make choices conducive to health.
>
> Enabling people to learn throughout life, to prepare themselves for all of its stages, and to *cope with chronic illnesses and injuries* is essential. This has to be facilitated in school, home, work, and community settings. Action is required through educational, professional, commercial, and voluntary bodies, and within the institutions themselves (emphasis added).

As influential as the authors of the Ottawa Charter were in advancing the ideas that health promotion needs to extend beyond simply disease prevention and that the participation of individuals in the promotion of their own health is essential, they were also reacting to many of the ideas outside of the biomedical and public health sectors that were newly emerging at the time. One of those influences, noted by an individual who worked on drafting the Charter, was salutogenesis. (Another was *A New Perspective on the Health of Canadians,* a 1974 report by then Canadian Minister of Health, Marc Lalonde. Many claim that the Lalonde Report was the first governmental report in the Western world to propose the concepts later embodied as the social determinants of health. The 1986 WHO conference in Ottawa was co-sponsored by Health and Welfare Canada and the Canadian Public Health Association.)

The Ottawa conference spawned other international conferences on health promotion (in 1988, 1991, 1997, 2000, 2005, 2009, and 2013). The Charter also provided fodder for other international health meetings. One meeting sponsored by the Department of Mental Health of the World Health Organization, entitled "Partners in Life Skills Education," was held in Geneva, Switzerland April 6-7, 1998. The gathering was a United Nations Inter-Agency meeting of leaders and experts from five UN agencies, commissions, funds and programs. In organizing the meeting, the Ottawa Charter for Health Promotion was specifically mentioned and an excerpt from the Ottawa Charter on development of personal skills was printed in the summary of conclusions that memorialized the inter-agency meeting.

Basic life skills domains that are relevant across cultures were identified in the concluding summary:

1. Decision making and problem-solving
2. Creative thinking and critical thinking
3. Communication and interpersonal skills
4. Self-awareness and empathy
5. Coping with emotions and coping with stress

The summary stresses the complementary relationship of life skills training and health promotion, stating, "To be effective, the teaching of life skills [should be] coupled with the teaching of health information and the promotion of positive (health promoting and pro-social) attitudes and values."

A clear consensus emerged from those attending the meeting that *livelihood skills,* such as money management and entrepreneurial skills, are not life skills, but the teaching of livelihood skills can be designed to complement life skills education. As we will see below, many organizations that engage in life skills training also rely heavily on livelihood skills instruction.

Clearly, both the World Health Organization and other United Nations agencies have embraced the belief that life skills (or in Antonovsky's view, general resistance resources) have a formative role to play in health and health maintenance. The emphasis on life skills as a necessary first step in health promotion suggests that more resources should be dedicated to that area. Although Antonovsky died before he was able to turn his attention to other areas (he died unexpectedly in 1992), it is highly likely that his sense of coherence concept might apply to poverty as well as to health.

Life Skills Promotion

Michael Harrington published a highly influential study of poverty in 1962 called *The Other America*, which some suggest led to President Lyndon Johnson's War on Poverty, declared in a State of the Union address on January 8, 1964. In that book, Harrington discussed the culture of poverty in the United States, saying (in language that may not be used today): "People who are much too sensitive to demand of cripples that they run races ask of the poor that they get up and act just like everyone else in society." He went on to observe that, "It takes a certain level of aspiration before one can take advantage of opportunities that are clearly offered." Harrington suggested that many of the poor do not act "like everyone else" because they suffer certain "cultural" deficits that impair their ability to function in life on equitable terms with more advantaged populations. The inability to aspire is but one deficit that he and others have singled out in relation to poverty. Moral and political philosopher Fabienne Peter has written, "The social conditions into which one is born have a profound impact on what she or he can achieve

and aspires to achieve."[1] Life skills training is a way of redressing this imbalance by providing low-income individuals with the resources that enable them to achieve their optimal health.

So, what are life skills, and more specifically, exactly what comprises the life skills set? Answers vary, but on the whole there is more agreement than disagreement (see Figure 1). Almost everyone agrees that life skills are psychosocial, that is, concerned with psychological development in the context of the social environment. More specifically, they deal with the cognitive, behavioral, and emotional ways we understand the world we live in and navigate our way through it. In other words, life skills are the constructive ways we think, act, and feel; they enable us to overcome challenges in our lives and to realize our potential. Life skills are the stuff from which resilience is built.

Figure 1
Life Skills Definitions

Life skills are abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life. (World Health Organization)

Life skills are a large body of psychosocial and interpersonal skills that can help people make informed decisions, communicate effectively, and develop coping and self-management skills that may help them lead a healthy and productive life. (UNICEF, United Nations Children's Fund)

Life skills are a comprehensive set of universal cognitive and non-cognitive skills and abilities, connecting behavior, attitudes, and knowledge, which youth can develop and retain throughout their lives. Life skills increase young people's well-being and help them to develop into active and productive members of their communities. (World Bank)

Executive function and self-regulation skills are the mental processes that enable us to plan, focus attention, remember instructions, and juggle multiple tasks successfully. (Center on the Developing Child, Harvard University)

[1] The Harrington and Peter quotations predate the influential contribution of anthropologist Arjun Appadurai to the literature of poverty. In 2004, Appadurai wrote a chapter on "The Capacity to Aspire: Culture and the Terms of Recognition" for *Culture and Public Action,* a book published by the World Bank on culture and international development. In it, Appadurai asked why culture matters to poverty and went on to answer his own question: "The answer is that it is in culture that ideas of the future, as much as of those about the past, are embedded and nurtured. Thus, in strengthening the capacity to aspire, conceived as a cultural capacity, especially among the poor, the future-oriented logic of development could find a natural ally, and the poor could find the resources required to contest and alter the conditions of their own poverty." In 2013 two papers took up this theme, one, "Poverty and Aspirations Failure" by economists at the University of Warwick (UK), buttressed with page after page of economic equations, and the other, "Aspiration Failure: A Poverty Trap for Indigenous Children in Peru?" a Working Paper published by Young Lives. In 2014, the World Bank newsletter *Inequality in Focus* contained a story titled "Aspiration Traps: When Poverty Stifles Hope." These examples point to the growing acceptance of the relationship of cultural attitudes, values, beliefs, and knowledge to poverty. The ability to aspire is only one of several facets of culture that can affect poverty.

Depending on the setting and the goals to be achieved, the list of specific life skills can vary considerably. Nevertheless, out of this expanding list of skills a Maslovian-like hierarchy emerges, resting upon a set of *basic* life skills that must be acquired first before other life skills can be pursued. In 1997, the Programme on Mental Health of the WHO identified "a core set of skills that are at the heart of skills-based initiatives for the promotion of health and well-being." They are summarized and defined in Figure 2.

Figure 2
Core Life Skills

Decision making helps us deal constructively with opportunities and problems in our lives; it focuses not only on the decision-making process but also on the assessment of the future consequences of the choices made.

Problem solving enables us to deal constructively with problems in our lives. Significant problems that are not resolved can cause stress and contribute to physical strain.

Creative thinking contributes to both decision making and problem solving by enabling us to explore available alternatives and various consequences of our actions. It helps us to look beyond our direct experience and to respond adaptively and with flexibility to the situations of our daily lives.

Critical thinking is the ability to analyze information and experience in an objective manner. It helps us to recognize and assess factors that influence our attitudes and behaviors and those of others.

Effective communication means that we are able to express ourselves, verbally and non-verbally in ways that are appropriate to our culture and situation. Assertiveness is included in effective communication, i.e., expressing feelings and needs directly to another person, while maintaining respect for others and keeping emotions under control.

Interpersonal relationship skills help us to relate in positive ways to the people with whom we interact, family, friends, acquaintances, and strangers.

Self-awareness includes the recognition of ourselves, and our character, strengths, weaknesses, desires, and dislikes. Developing self-awareness can help us recognize when we are stressed. Self-awareness is closely associated with the concept of self-esteem.

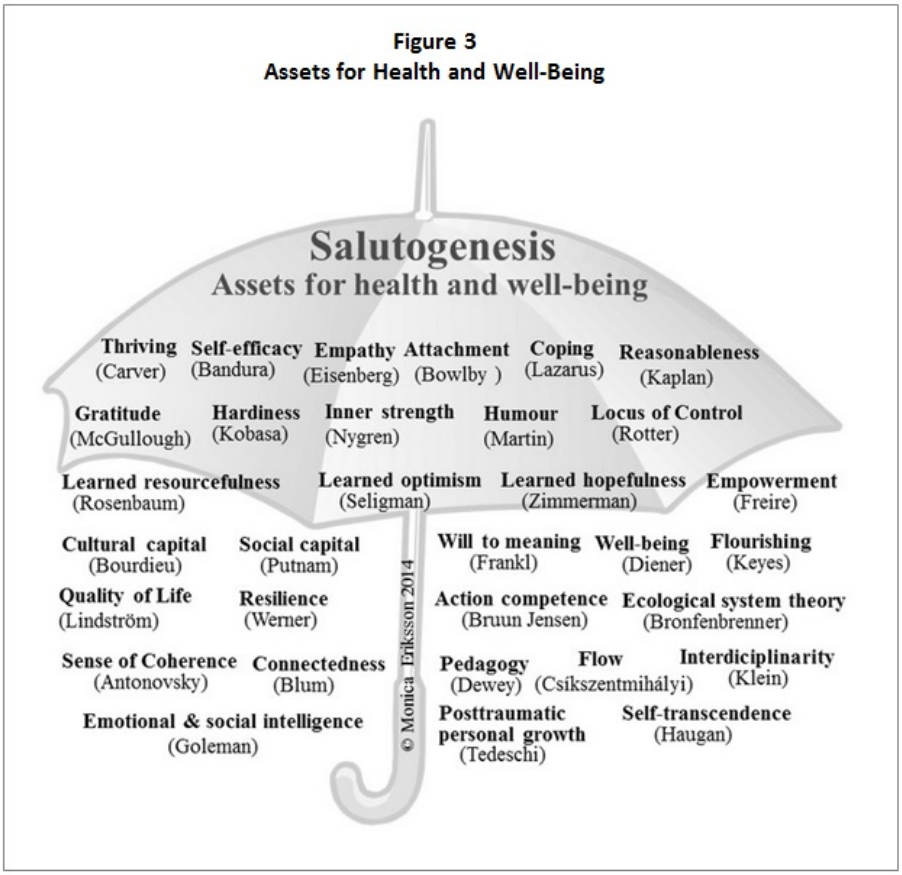
Empathy is the ability to imagine what life is like for another person, even if that person's situation is not familiar to you. Empathy can help improve our social interactions.

Coping with emotions involves recognizing emotions in ourselves and others, being aware of how emotions influence behavior, and being able to respond to the emotions appropriately.

Coping with stress concerns recognizing the sources of stress in our lives, recognizing how it affects us, and acting in ways that help control our levels of stress, either by taking actions to reduce the source of the stress or by learning how to relax.

Two notable absences to this list of core life skills are self-efficacy and locus of control. A sense of self-efficacy is necessary to any behavior change. An individual must believe in her ability to change a situation before she will take action. Research shows that worry, which leads to anxiety and stress, is correlated with perceived self-efficacy. Individuals who believe that they are not competent to change their situations, have greater self-doubt and apprehension. Self-efficacy, in part, is determined by one's locus-of-control beliefs, that is, the degree to which one believes that she controls the events that affect her. Other assets/resources that promote health and well-being may not rise to the level of basic life skills, but they are nevertheless important. Figure 3 reproduces a graphic which appears on the Website for the Center on Salutogenesis at University West (Trollhättan, Sweden). The figure shows the many theories, principles, and constructs that fall under the Salutogenesis umbrella. In parenthesis under each of these is the name of its originator or primary proponent.

Figure 3
Assets for Health and Well-Being



Basic life skills can be taught. Typically, they are taught to young children through the process of socialization, beginning in the home. Because some basic life skills may be less fully developed in some families or micro-cultures (such as neighborhoods), it is possible that some children may not acquire some of the basic life skills. In some areas, schools and other civil society organizations and institutions have reached out to children and adolescents and taught them basic life skills in other settings. Still, it is possible to reach adulthood without ever acquiring these skills. Providing life skills training to adults is a form of remedial education.

Basic Life Skills Training

Target Populations for Basic Life Skills Training: Basic life skills training is widely used in health education curricula around the globe. Skills-based health education for younger elementary school children focuses on general health topics such as the understanding of the concept of health, the value of health, the relationship of personal behavior to health, and the value of healthy lifestyles and behaviors. Basic life skills training is woven into this didactic content. As children move into adolescence, skills-based health education becomes more focused on specific health topics, such as healthy nutrition and violence prevention for younger children, and avoidance of alcohol, tobacco, and drugs and sexual and reproductive health for adolescents. The life skills taught (or reinforced) among adolescents varies by age and lesson content.

A number of programs are available to support basic life skills instruction to pre-school and kindergarten students. Even in these programs some health content – such as nutrition and cleanliness – is taught.

Some aspects of life skills training have also been incorporated into some job training programs. Life skills are viewed as complements that enhance the effectiveness of the vocational goals taught. Programs that combine vocational and life skills training have tended to focus on younger individuals, but as suggested above, some amount of remedial education for adults might be appropriate to either 1) make up for earlier learning deficits or 2) reinforce the relationship of life skills to employment.

Life skills training is also routinely made available to developmentally disabled individuals and persons recovering from a serious mental illness to improve their functioning, assist them in managing their conditions, and help assure their safety. The Idaho Department of Health and Welfare reimburses for life skills services to "promote the skills necessary for clients to maintain a drug and alcohol free lifestyle." The approved list of IDH&W Life Skills Standards and Service Limits contains life skills subjects that go well beyond basic life skills, but the approved providers and online resources contain programs that teach or reinforce some of the basic life skills.

In some cases, life skills training is moving into new territory. The Kamloops (British Columbia) Homeless Action Plan contains a Skills Development Project (2013) documented in a 44-page report (complete with a logic model depicting how program inputs and activities will achieve its planned outputs and outcomes). The Washington State Department of Social and Health Services (and possibly other states as well) includes some life skills or "soft skills" – a widely used term that means non-cognitive basic life skills – in their job training programs (e.g., self-awareness, attitude, stress and anger management, and communications skills). These services can also be provided independently of job training, recognizing their importance to everyday life and employment generally.

Life Skills Training and Poverty at the Federal Level: Testifying before the Senate Finance Committee about poverty on June 5, 2012, Ron Haskins, a senior fellow at the Brookings Institution and co-director of its Center on Children and Families and senior consultant at the Annie E. Casey Foundation[2], said the following:

> I want to emphasize the importance of individual initiative in reducing poverty and promoting economic success. My Brookings colleague Isabel Sawhill and I have spent years emphasizing the importance of individual responsibility in reducing poverty and increasing opportunity. One of our arguments... is that young people can virtually assure that they and their families will avoid poverty if they follow three elementary rules for success – complete at least a high school education, work full time, and wait until age 21 and get married before having a baby. Based on an analysis of Census data, people who followed *all three* of these rules had only a 2 percent chance of being in poverty and a 72 percent chance of joining the middle class (defined as above $55,000 in 2010). These numbers were almost precisely reversed for people who violated all three rules, elevating their chance of being poor to 77 percent and reducing their chance of making the middle class to 4 percent. Individual effort and good decisions about the big events in life are more important than government programs. Call it blaming the victim if you like, but decisions made by individuals are paramount in the fight to reduce poverty and increase opportunity in America. *The nation's struggle to expand opportunity will continue to be an uphill battle if young people do not learn to make better decisions about their future.* (Emphasis added.)

Apropos Michael Harrington's suggestions that we expect the poor to "act like everybody else," the ability to make good decisions requires that the poor have access – like everybody else – to cultural tools, such as basic life skills. Before we can improve decisions, we must first improve the process of decision-making and its cognitive and behavioral correlates.

In 2014, Gene Falk and Karen Spar of the Congressional Research Service issued a report titled "Poverty: Major Themes in Past Debates and Current Proposals." In it they state that strategies to address poverty fall into three general categories focusing either on income, service, or employment. Each of the strategies reflects a different theory of the causes of poverty. As a practical matter, over the years, many of the past legislative efforts have combined the three strategies. In discussing the *services strategy* they wrote:

[2] The Annie E. Casey Foundation and its sister organization, Casey Family Programs, have an interest in life skills training, although both organizations think of life skills somewhat more expansively. The Annie E. Casey Foundation funded an excellent paper by the Crittenton Women's Union on "Using Brain Science to Design New Pathways Out of Poverty" (2014), and Casey Family Programs designed and makes available free of charge a tool, the Casey Life Skills Assessment (ACL), for determining the behaviors and competencies youth need to achieve their long term goals (see http://lifeskills.casey.org/).

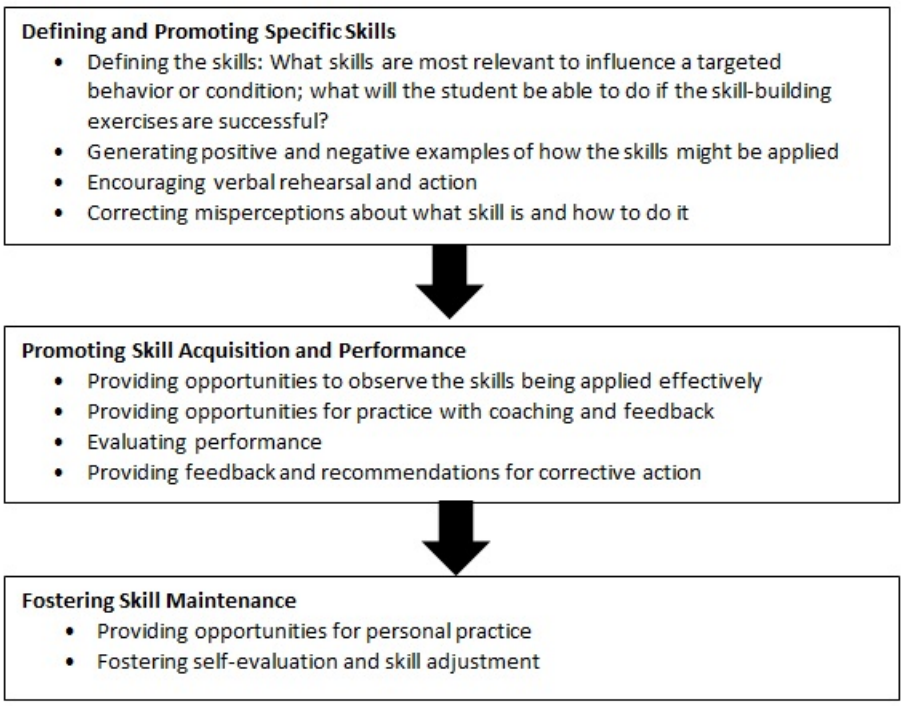
> This strategy attempts to address poverty by providing a service designed to change or prevent certain behaviors and to improve an individual's ability to function in the economy. Services are intended not only to alleviate the effects of low income, but to address the root causes of poverty. They are based on a specific "diagnosis" of the cause of an individual's poverty. For example, if poverty is caused by low levels of educational attainment or skills, education or job training programs can address this deficiency through services designed to raise an individual's "human capital." If poverty is caused by lack of "soft skills," life skills classes can address this concern through training on the basics of functioning in the workplace.

Although life skills training does not appear to be in any of the current anti-poverty proposals languishing in Congress, it was employed to varying degrees during President Johnson's War on Poverty[3] and again in the welfare reform experiments of the 1980s and 1990s. Program evaluations have not shown these services to be successful, but they have been embedded in other programs which might have muted their effects; their impacts are difficult to measure; and they often can be measured only after a sufficient amount of time has passed for the impacts to register. Also, the metrics of success for these evaluations are inclined to stress short-term legislative outcomes. When offered, the service strategy programs have been funded at levels far below those programs embodying income and employment strategies. Life skills training programs typically are not established as entitlements and demand for services tends to exceed supply.

Teaching Basic Life Skills: Use of the word "teach" to describe basic life skills learning is perhaps a misnomer: some educators stress that, at any age, "life skills are built, not taught." By this, they mean that "life skills need to be practiced to be learned" and "the process of learning life skills is as important as learning its content." Interactive teaching methods which allow the students to learn concepts, observe the concepts being modeled, practice skills, and receive feedback to improve performance have been found to be effective in basic life skills training. According to the WHO, "retention of behaviours [sic] can be enhanced when people mentally rehearse or actually perform modelled behavior patterns." Participatory teaching methods include small group and class discussion, demonstration and guided practice, debates, role playing, storytelling, educational games and simulations, and guest speakers. Figure 4 presents a model of the stages of life skills development.

[3] President Ronald Reagan more than once said, "In the sixties we waged a war on poverty, and poverty won." The evidence suggests otherwise. Certainly, poverty still exists, so it was not completely vanquished, but the War on Poverty was remarkably successful while it lasted. According to testimony before the U.S. House of Representatives Committee on the Budget on January 28, 2014: "Using the official poverty rate, *poverty declined about 30 percent within five years* of President Johnson's declaration of his War in 1964, but there has been little progress since the 1960s (except among the elderly). For the last two decades, poverty has averaged well above the 12.1 percent achieved when Johnson left office in 1969." (Emphasis added.) A 30 percent reduction in poverty in five years suggests that the elimination of poverty for most people in the United States is not an unachievable goal.

Figure 4
Stages of Life Skills Development



Source: Mangrulkar, Whitman, & Posner, Pan American Health Organization (2001) and WHO (2003)

Basic Life Skills Program Planning

A case can clearly be made that the lack of basic life skills, stemming from a multitude of causes, has a substantial impact on poverty and poor health. A further case can be made that poverty and poor health are mutually reinforcing. Therefore, basic life skills training may make a real and sustainable contribution to poverty reduction, improved health, or both. Planning for the introduction of a new program to promote basic life skills training should focus on 1) the approach to be used, 2) an assessment of need for specific services, 3) an inventory of local providers of life skills training, and 4) the population and geographic targets for services.

Approach: In the last paper in this series, it was suggested that children were the highest priority for basic life skills training, but that they were difficult to reach in a timely way. Because of this, mothers were identified as the possible prime target because "mothers will clearly benefit from basic capability development programs and pass the benefits (and later the lessons) of these programs on to their children." In a December 2013 research report, The National Human

Services Assembly promoted a similar idea and expanded upon it.[4] They called it a *two-generation approach.* According to NHSA:

> To break the cycle of poverty, many human service organizations use two-generation approaches with "young families" (that is, families with children in which the parent is an [out-of-school and out-of-work] young person ages 15-24 years). One hallmark of these two-generation approaches is the use of strategies that address the developmental needs of the young parents, their children, and the families as a whole.

Programs embracing this approach serve childen and parents individually and also as a family unit. They seek to "re-engage young parents in education and/or work; nurture parent-child bonds; improve children's well-being; and connect families with economic, social, and other supports." Independent evaluations by the Aspen Institute and the Urban Institute "demonstrate" that the two-generation approach can disrupt the cycle of poverty. Using this approach to train low-income people in life skills has considerable appeal. It concurrently reaches the two sub-populations, mothers (and fathers when present) and children, that were previously identified as the ones most likely to have the biggest impact on disrupting intergenerational poverty in Wyandotte County. Life skills training will improve the ability of low-income children and adults to manage stress, and when combined with some level of health education and coaching, will improve perinatal care of mothers and health behaviors more generally for adults and adolescents. Together they will increase the probability of more poor people being able to achieve Ron Haskins' three rules for success.

Assessment: An assessment of the life skills of various groups in Wyandotte County is necessary for two reasons. First it helps identify life-skill deficits among low-income residents, and second, it helps identify the prevalence of the problem, if one exists. Both of these assessments should take place for the various target audiences: differences are likely to exist between age groups and possibly between racial and ethnic groups. It might also be useful to include a small number of more affluent residents in the assessment as a control group. This will take the life skills training approach out of the realm of mere speculation and shore it up with Wyandotte County-specific empirical evidence. Evidence from the assessment will be used to design programs (i.e., what populations to reach out to and what services to offer) but the assessment can also be used to establish screening criteria for participation and establish baseline measurements for subsequent process evaluations.

Because most basic life skills are psychosocial concepts, a number of reliable and valid psychometric instruments are available for measuring them. For example, instruments are

[4] The National Human Services Assembly is an association of more than 80 of the nation's leading non-profit human service providers (e.g., National Urban League, Salvation Army, United Way, YWCA USA, Goodwill Industries, Catholic Charities USA, and Jewish Vocational Services), founded in 1923 and whose vision is "a just and caring nation that seriously and effectively addresses human development and the health and human service needs of its citizens." The research study and report cited was funded by the Annie E. Casey Foundation.

available for assessing preceived stress, depression, self-reported health, coping strategies, self-esteem, self-efficacy, locus of control, optimism/pessimism, social support, subjective social status, and adverse child events. This is not a complete list. Some instruments, such as the Casey Life Skills Assessment, combine several of these scales into a longer instrument. These data could also be combined with socioeconomic data from respondents. Some of these instruments can be used at no cost. They provide very strong tools that should be used in the assessment of need.

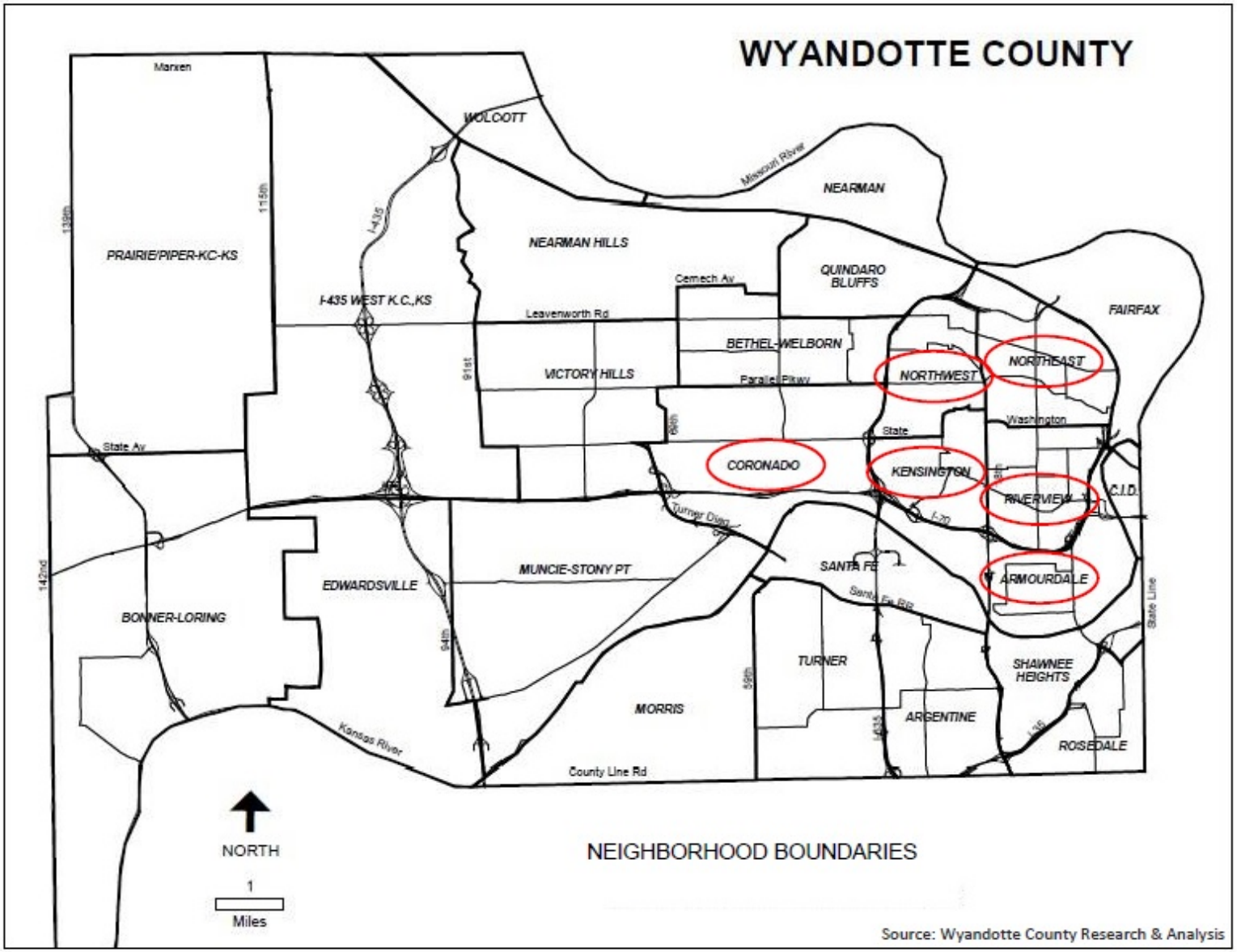
Providers: The assessment should also consider the number of providers in the area who provide basic life skills training. This aspect of the assessment is undertaken to assure that there are enough providers to meet the need and to identify the scope and quality of existing services. An inventory of providers is also necessary because it will form the pool of potential grantees if the assessment leads to a life skills training program. Most of the organizations that will appear on the inventory will be organizations that have never applied for or received a grant from a health care conversion foundation. Not only will it be necessary for you to find them, but once you do find them, it will be necessary for you to introduce yourself to them. Given the pyschosocial nature of the work they do, it should not be hard to sell them on the idea that basic life skills affect health and poverty. Still, some of them may only see life skills deficits as a mental health issue. Although most of the providers are likely to be human service providers or mental health professionals, safety net clinics should not be overlooked. Some may provide some services currently and would be willing to expand services. They also might partner with another provider to offer services in their setting, for example, one organization might provide life skills training and the other integrated health education.

The inventory has to be geographically bound. Wyandotte County may not have a sufficient supply of providers to satisfy its own need. If the supply should fall short, consideration will have to be given to how far from Wyandotte County the boundary lines should be drawn. Providers do not have to live in Wyandotte County, but all services should be provided in Wyandotte County, preferably in the neighborhoods where the target populations live.

Target Populations: The people at greatest risk for intergenerational poverty (and those who are victims of it) live in high-poverty neighborhoods. An analysis of census data for Wyandotte County identifies six neighborhoods as high-risk: Armourdale, Coronado, Kensington, Northeast, Northwest, and Riverview. The approximately 55,000 people who live in these neighborhoods (35 percent of the total population of the county) are the target population (see Figure 5).

Although these six neighborhoods have much in common, there are differences among them that have implications for program planning. Table 1 presents comparative demographic data for the six neighborhoods. The population range of the six is substantial. One, Armourdale, is small with approximately 2,400 residents, and one, Riverview, is large with approximately 18,100 residents. The other four are about equal in size, averaging approximately 8,500 residents. The

Figure 5
High-Risk Neighborhoods in Wyandotte County



Source: Wyandotte County Research & Analysis

Table 1
High-Risk Neighborhoods in Wyandotte County, 2008 – 2012 American Community Survey

	Wyandotte County	Armourdale	Coronado	Kensington	Northeast	Northwest	Riverview
Total population	157,274	2,442	8,112	8,802	8,466	9,445	18,107
Population percent under 18 years	28.3	32.9	35.1	34.9	32.1	29.2	32.5
Percent White (non-Hispanic)	43.4	31.5	30.7	23.6	5.7	7.7	20.8
Percent Black (non-Hispanic)	25.2	0.0	43.5	12.5	65.7	59.8	14.0
Percent Asian (non-Hispanic)	2.6	1.2	5.0	1.1	1.5	2.8	4.8
Percent two or more races (non-Hispanic)	1.9	1.0	1.7	2.1	1.9	2.2	2.3
Percent other races (non-Hispanic)	0.8	0.8	1.5	2.8	0.9	0.0	0.5
Percent Hispanic or Latino (of any race)	26.1	65.5	17.6	57.9	24.3	27.5	57.6
Per capita income	$19,216	$11,245	$14,586	$13,390	$10,704	$15,073	$11,964
Median household income	$39,163	$28,787	$32,581	$35,914	$19,929	$34,183	$26,918
Income in past 12 months < poverty level:							
All	23.4	37.4	30.7	31.3	45.3	28.8	37.1
Under 5 years	37.2	47.9	50.4	48.1	67.9	25.5	46.9
5 to 17 years	33.8	59.8	39.2	41.8	55.1	44.5	45.2
18 to 64 years	20.0	30.1	25.8	25.5	42.1	25.1	33.5
65 years & older	11.6	19.8	13.5	10.5	27.4	12.2	27.6
Educational Attainment:							
Percent less than high school graduate	21.5	47.8	22.2	41.2	26.0	28.6	41.4
Percent high school graduate (equivalent)	34.0	30.2	32.1	30.5	41.3	36.0	31.7
Percent some college, no degree	22.3	11.9	26.3	13.7	21.5	22.8	15.9
Percent associate's degree	6.8	6.9	5.7	4.2	4.9	5.8	3.6
Percent bachelor's degree or higher	15.4	3.2	13.7	10.4	6.3	6.8	7.4
Unemployment rate	13.0	16.5	14.3	12.8	27.6	21.0	15.1
Median owner-occupied housing value	$96,000	$43,300	$91,654	$74,319	$40,184	$55,488	$65,924
Percent renter occupied units	38.8	45.8	51.2	41.0	44.0	42.1	55.5
Percent vacant units	14.2	19.9	13.9	18.6	22.0	30.7	16.9

percentage of the population represented by children in each of the neighborhoods is greater than the rate for the entire county. Approximately one-third of all residents in these neighborhoods are children.

Three of the neighborhoods have Hispanic majorities; two have Black or African-American majorities; and one neighborhood (Coronado) is mixed: 43.5 percent Black, 30.7 percent non-Hispanic White, and 17.6 percent Hispanic. In the Black majority neighborhoods, approximately 25 percent of the population is Hispanic; in the majority Hispanic neighborhoods approximately 12 percent is African-American. In the three majority Hispanic neighborhoods, the second most populous racial-ethnic cohort is non-Hispanic Whites.

All of the neighborhoods are poor. Northeast has the highest poverty rate (45.3 percent) of the six neighborhoods, but it shares a western border with Northwest which has the lowest poverty rate (28.8 percent) of the six. The poverty rate for all of Wyandotte County is 23.4. The poverty rate for children under 5 years of age (the most formative period of their growth) hovers around 50 percent for four neighborhoods and one of the six has a poverty rate of 67.9 percent for children less than 5 years of age. Only one neighborhood, Northwest, has a poverty rate that is lower (25.5 percent) than the county rate (37.2 percent) for young children.

As would be expected from the poverty rates, per capita income and median household income is below the average for the county. Northeast is especially low and the ratio of per capita income to median household income for the neighborhood *suggests* that Northeast has a higher number of single-individual households than the other five target neighborhoods.

Educational attainment for adults is especially low in the majority Hispanic neighborhoods. More than 40 percent of the adults in each of these three neighborhoods did not graduate from high school.

There is a higher percentage of renters in these six neighborhoods than in the county as a whole, and the median value of owner-occupied houses is significantly lower in five of the six neighborhoods; the house value in the Coronado neighborhood is still lower than county average, but it is much closer to it than the other neighborhoods are. Finally the number of vacant properties is higher than the county average in five of the six target neighborhoods. The rate of vacant properties for the Northwest neighborhood is more than twice the rate for the county as a whole. Once again, the Coronado neighborhood has the lowest percentage of vacant properties of the six target neighborhoods, and its percentage is slightly less than the county average.

These similarities and differences may affect the way that potential grantees approach life skills training in the neighborhoods.

Summary

This is the final paper in a series of three papers that sought to 1) describe the nature and extent of poverty in Wyandotte County; 2) discuss how social conditions can trigger harmful biologic processes in the body, and identify a set of psychosocial skills that can moderate or eliminate the negative health consequences of poverty; and 3) suggest that basic life skills training provides the poor who do not possess these skills with resources that allow them to improve and manage their health across the life course. Two notions are central to these three papers. First, poverty and poor health are opposite sides of the same coin: poverty can cause poor health and poor health can cause poverty, but wherever the starting point is, a cyclical pattern begins to develop. Breaking the cycle requires that attention be paid to both poverty and health. Second, not everyone who is poor suffers equally from poor health. Certainly, some of the differences between those who are healthy and can compete in life with fewer encumbrances and those who are impaired by poor health can be attributed to one's genetic endowment. But another primary contributor is a set of skills that positively affect one's vision of the world and oneself; one's resilience in the face of adversity; and one's ability to make good decisions in real-time and to plan (i.e., anticipatory decision-making) for the future. Those poor individuals who are not genetically "superior" but are still healthy, may have learned some of these skills at an early age within families or other social circles and in higher quality pre- and elementary schools. The good news for those not fortunate enough to have learned these lessons before is that these skills can still be learned later in life.

Although these papers have focused on poverty and poor health, the aim of life skills training is not to eliminate either of them. These problems are too large for a single solution. The goal of life skills training is to provide poor individuals with the resources or tools *to move themselves closer* to "ease" – health and well-being – and away from "dis-ease."

Although this is the final paper, it is just the beginning of planning. The first issue is, of course, whether you want to move forward with a program that focuses on life skills training. In making that evaluation, consider that many people will think that it is not possible for anybody to have reached adulthood without having acquired basic life skills. They may think that a training program is unnecessary, and that higher order skills such as money management and job training are the place to start. Psychologists would likely disagree; they often encounter individuals or groups whose mastery of basic life skills is imperfect. Psychologists, however, do not often play prominent roles in policymaking. Perhaps that is why the foundation of basic life skills training is so seldom laid.

A good deal of the last two papers used examples and data drawn from international contexts. There are several reasons for this. First, examples and data from American programs are scarce. Second, the domestic urban poor have many similarities to the poor of developing countries. Frequently, social justice advocates in the United States characterize our health indicators for the poor – especially those concerned with birth outcomes – as "positively third-world." So they

are. Third, individual efforts to improve human development and health worldwide led by two U.N.-affiliated organizations, the World Bank and the World Health Organization, use life skills training. And finally, many countries across the world see public health differently than we do, because they have single-payer health systems. They invest heavily in population health solutions to reduce the numbers of people who have to enter the health care system. The national governments in these countries pay the bill for both population health and health care, but they know that health care is much more expensive and that it provides only marginal benefit to overall health. Out of this calculus, public health is accorded substantially more respect in these countries than it is in the U.S. More importantly, these population health interventions work: just look at any international comparisons of population health indicators. Typically, the U.S. leads only in per capita spending on health.

In making the decision to move forward with a life skills training program there is also a question of whether this one discrete piece will have the impact we think is possible. If it is indeed a necessary-but-not-sufficient foundational activity, what resources exist to form the next tier of services? Are they adequate? If they are, what systems can be put in place to improve a "warm hand-off" to them? Obviously, the performance of higher level programs will improve substantially if more of their clients/students come to them prepared to succeed.