



NASW SPECIALTY PRACTICE SECTIONS
SUMMER ■ 2018

SSW
SCHOOL SOCIAL WORK

SECTION CONNECTION

Letter from the Chair

Another school shooting! There have been more than 24 school shootings thus far in 2018. This averages out to roughly one incident per week of gun violence injuring or killing someone in school. The Pew Research Center recently surveyed adolescents between the ages of 13 and 17 as well as parents of teenagers (Graff, 2018). The findings indicated that 57 percent of adolescents were very concerned about the possibility of a shooting taking place at their school, and 63 percent of parents of adolescents shared those concerns. Zhang, Musu-Gillette, and Oudekerk (2018) reported similar findings and confirmed that school violence is a major fear in the United States.

School social workers are leaders in creating safe schools and preventing school violence. Welcoming and supportive school learning environments are essential for students to be successful (Espelage, Polanin, & Low, 2014). Key practices require schools to intentionally focus on strengthening relationships between teachers and students, implement school-wide approaches that teach and reinforce prosocial behaviors, provide high-quality social-emotional-behavioral skill instruction to all students, and offer a compendium of mental health supports in schools (Lindsey, 2016). Having a sufficient number of school social workers, school psychologists, and school counselors is critical to ensuring that all students have access to high-quality school-based mental health services.

Astor & Benbenishty (2018) gave clear directions for schools on how to reduce school violence by cultivating environments that are conducive to learning and where students and staff are safe. Their approach highlighted effective school practices, such as:

- Use data to monitor and map incidents of school violence;
- Provide ways for teachers, students, and parents to share ideas about school safety;
- Increase physical and emotional safety through data mapping and monitoring; and
- Incorporate social-emotional learning curricula to promote self-awareness, decision-making, and interpersonal relationship skills.

Schools that implement most or all of these recommendations will discover things they are doing to create positive school climates. They can use the approach to identify needs and resources to empower students, families, and teachers—thus creating safe schools and supporting children's mental health.

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A CLOSER LOOK AT CLINICIANS in a Multi-Tiered System of Supports

ALI HEARN, MSW, LCSW

The role of school-based clinicians (that is, school social workers, school psychologists, school counselors, etc.) in a Multi-Tiered System of Supports (MTSS) framework is an area of growing importance for educational professionals. Reshaping the function of this clinician allows schools to more effectively meet the social-emotional needs of *all* students. Student social-emotional needs are evolving, as is the need to refine the skill sets of teachers who support them. Turning school-based clinicians into leaders is critical to create a systematized and sustainable approach to service delivery and lasting outcomes for our youth.

THE NEED TO SYSTEMATIZE SERVICE DELIVERY

Across the country, schools enroll hundreds, sometimes thousands, of students and typically have a small number of clinicians to provide support. These limited resources underscore the need to systemize the way schools offer support, so all youth can be served effectively. Transforming clinicians from being the sole providers of social-emotional support to being social-emotional leaders will be key to achieving long-term sustainable outcomes and will ultimately help create a system in which all youth receive the exact level of support that meets their needs.

THE REDEFINED ROLE

Many school-based clinicians are already used to being consultants, coordinators of supports, and facilitators of interventions. When considering what a redefined role looks like, it will be necessary to examine how a clinician's time is allocated. One model to consider is:

- Providing coaching, teaching, and consultation with school-wide systems at **Tier 1** (e.g., consulting with the team that

develops the student handbook, conferring with the team that analyzes school-wide data, training all staff on function-based thinking and classroom management);
- Coaching and coordinating systems and interventions at **Tier 2** (e.g., becoming a Tier 2 coach, developing the curriculum for social/academic skill instruction groups, coordinating and training groups of mentors); and
- Coaching and facilitating individualized teams and working with individuals directly at **Tier 3** (e.g., leading a functional behavior assessment and behavior intervention planning team, facilitating a person-centered planning process with a youth, coaching one teacher directly on effective classroom management strategies).

This paradigm shift allows clinicians to guide the overall development and installation of systems and processes for youth with lower-level needs, rather than be the sole provider of those supports. These youth are often the ones with whom clinicians end up spending the bulk of their minutes, often because of systems being in place; the lack of ability (or comfort) of all staff to help provide basic levels of social-emotional support; subjective decision making, leading to misidentification of students needing direct clinical support; or simply because the squeaky wheel gets the grease. The redefined role creates more time for clinicians to directly support youth with the highest levels of need. It is crucial that each function is covered and less important that the title of the clinician matches the job function. In other words, it's more important that a Functional Behavior Assessment (FBA) is completed; it's less important who performs it (a social worker, a psychologist, etc.). Systems in the school will be strengthened if the staff is clear about processes and procedures that relate to the role of the clinician.

For this paradigm shift to unfold, administrators must lay the foundation for the clinician to be the social-emotional leader. This is done by clearly defining the role and being transparent about how the coming changes will affect relevant stakeholders. Administrator understanding, and support will be an important part of how the role of the clinician changes with regard to addressing crises. Although the situation is often not discussed, when there is a perceived crisis in a school building, administrators expect school personnel to do what they are most accustomed to and feel most comfortable with—rather than doing what is the most effective. This can look like classroom teachers or administrators calling clinicians on loudspeakers, over walkie-talkies, or on phones when clinicians are out of the building and imploring them to return quickly. Sometimes this urgency is warranted, but often it is not. This instant response mechanism serves many parties in the process well. For example, teachers and/or administrators receive help and support, a student's function of his/her behavior is often met, the school has responded with the highest level of behavioral resources possible (the clinician), and clinicians get to experience a sense of responsibility, fulfillment, and accomplishment for solving the problem. However, this way of functioning is not efficient or effective for our youth. Instead, we need a preventative approach that teaches staff and students skills to prevent future occurrences.

The redefined role of the clinician will (a) empower clinicians to be leaders of this preventative work, (b) help all staff feel truly equipped to support youth social-emotional needs more effectively, and (c) help create systems for accurate identification of youth in need of higher levels of support and of mechanisms for appropriate levels of service delivery. Ultimately, more youth will receive effective support sooner.

GETTING STARTED

As a first step, clinicians can prepare themselves with the strategies, tools, and information necessary to provide training to all staff. This will include training administration, other support staff, and key stakeholders on universal social-emotional support topics: trauma, restorative practices, function-based thinking, classroom management, and other mental health diagnoses and concerns. Once a universal knowledge base has been provided, other adults in the building, including classroom teachers, will be armed with tools and skill sets to teach basic social-emotional skills in the classroom. Students who receive this foundational level of support will be less likely to need higher levels of support directly from a clinician. It is critical for all staff to understand, via ongoing professional development, that in terms of achieving positive social and academic outcomes for our youth, teaching social-emotional skills is as important as teaching reading, math, or science. Ideally, teachers will embed direct instruction of social-emotional skills within a strong academic curriculum.

Even at the Tier 2 level, educational professionals other than clinicians can effectively deliver social skills instruction (essentially reteaching the social skills previously taught at Tier 1) through small groups, mentoring, and so on. Diagnoses and the delivery of therapeutic services to youth will continue to fall under the role of the clinician. This model allows for clinicians (who typically possess the greatest level of behavioral expertise) to effectively support youth with the highest levels of social-emotional needs while helping to build the capacity for early preventative supports to be provided at the lower tiers for youth with lower-level needs. The overall goal is more youth supported earlier in the process and more clinician time allocated to youth with higher-level needs.

SUMMARY

Typically, there is no greater resource regarding behavioral expertise in schools than clinicians. These resources need to be protected and conserved for supporting our youth with the highest levels of need as they help to build the capacity of the entire staff to support lower-level needs; this model develops a strong school culture and climate. Clinicians can be effective leaders in helping the staff envision the model of supporting all youth effectively in the building, and administrators have an imperative role in bringing the vision to fruition.

It is critical that all key stakeholders are clear on the role of the clinicians, the part all staff play in supporting the social-emotional growth of all youth, and the processes for how higher levels of support are accessed through an MTSS framework. The responsibility for the culture and climate of our schools belongs to everyone. The culture and climate can be greatly improved by the leadership of our clinicians, who can help expand the toolboxes of everyone who touches the life of a child. Our youth are counting on it!

Ali Hearn, MSW, LCSW, is a technical assistance director with the Midwest, Positive Behavioral Interventions and Supports, (PBIS) Network, in Illinois. She can be contacted at ali.hearn@midwestpbis.org.

SAVE THE DATE

TREATMENT AND MANAGEMENT OF OPIOID ADDICTION

DATE: **Tuesday, July 31, 2018 - 1 – 2:30 pm (ET)**

PRESENTERS: **Maurice S. Fisher, Sr., PhD, LCSW, LSATP**

David Geho, LSATP, LMHP

This webinar is designed to review the current state of opioid addiction in America and explain some of the best psychosocial clinical practices. Social workers will learn how to use harm reductive methods to help reduce the addicted person's negative risk to self and society.

To register visit https://naswinstitute.inreachce.com/ and put the title in the search box.

The self study version will be online within a week of the original webinar.

TEACHING MINDFULNESS SKILLS to Youth

KRISTINA SARGENT, LISW
JONATHAN B. SINGER, PHD, LCSW

You've heard the word "mindfulness." You've seen the announcements for "mindfulness" workshops in the back of your favorite mental health publication. The term may arouse images of peaceful human silhouettes sitting cross-legged against the backdrop of an exotic setting sun. Perhaps others may think of a combination of freshly burning incense, flickering candles, and beckoning gongs. You might think of mindfulness as the latest mental health fad, but mindfulness is not a trendy therapy. It is an approach to life that has been around for centuries—no beach sunset or incense required! Unlike many treatments we learn in school or on the job, mindfulness can be taught and learned by people across the lifespan. What I have found most useful about the practice of mindfulness is that it offers inner peace and inner safety despite outer life circumstances.

WHAT IS MINDFULNESS?

Put simply, mindfulness is awareness in the present moment. If you are noticing your thoughts, feelings, bodily sensations, and the surrounding environment in the moment—instead of getting caught up in the thoughts and worries of past and future—then you are practicing mindfulness. Becoming aware of your own breath, observing the room for a certain color, truly listening to a sound, and intentionally tasting to experience food in a new, focused way are all forms of mindfulness. Mindfulness is the practice of noticing, without judgment, thoughts and worries that pop up in the moment and letting them go.

MINDFULNESS AND YOUTH

Although most books and programs that teach mindfulness are designed for adults, developmental psychologist Lawrence Steinberg (2014) argues that childhood and adolescence are the ideal stages of life in which to teach mindfulness. While the adult brain's neural pathways have been established, children's and adolescents' brains are highly malleable (which neuroscientists call "plastic"). Every time youth learn something new, they are etching neural pathways into their brains. The more those pathways are used, the stronger they become. In contrast, when adults learn something new, they modify existing neural pathways. For these reasons, Steinberg considers mindfulness a cornerstone of healthy adolescent development. Awareness is the foundation of all life experiences and skills. When children increase their awareness in the present moment, they can increase attentiveness skills, better regulate their emotions, make safer choices, and notice and attend to others' emotions. When children are present enough to notice others' emotions, they can develop or enhance skills in empathy, kindness, compassion, forgiveness, and appropriate social skills.

INCORPORATING MINDFULNESS PRACTICE INTO YOUR WORK WITH CHILDREN, ADOLESCENTS, AND YOUNG ADULTS

Step one: Start practicing.

There is no better way to teach this skill than to know it and practice it yourself. Not only will you be aware of the challenges associated with mindfulness, but also you will become more present and aware as a result of your practice. We are better providers when we are truly present in the moment with our clients, approaching them from a sense of offering rather than a sense of fixing or controlling, and noticing and letting go what we need to in our own lives (our own worries, fears, perceived failures, etc.). Ten minutes a day of sitting down and practicing a guided meditation or simply focusing on our breath is so helpful!

Step two: Teaching mindfulness skills.

1. Don't forget to breathe! It might seem strange that we have to remember to breathe. After all, the average adult takes approximately 22,000 breaths per day (Wikipedia, 2016). But it is precisely because we take so many breaths that we turn on our automatic pilot to breathe, literally. Breathing is regulated by our autonomic nervous system (ANS). Luckily, breathing is the only part of the ANS that we can control. Conscious breathing can help us to calm down when our ANS is hyping us up, or it can bring energy and awareness when our ANS is shutting us down. Conscious breathing is often seen as the starting point for mindfulness. Right now, as you're reading about breathing,

you've probably become aware of your breathing. Do you notice the rise and fall of your body? What about the coolness of air entering versus the warmth as it leaves? You've taken control of your breathing, but it might not be very intentional. In fact, it probably seems very artificial and forced. But noticing your breath is the first step in conscious breathing.

2. Teach conscious breathing: Instruct your client to "breathe in through your nose as if you are smelling a flower and breathe out your mouth onto the palm of your hand." If your kids can't relate to flowers, you can substitute the smell with something they like (for example, pizza). Breathing into the hand allows kids to experience the warmth of their breath as it leaves their bodies. Teaching children deep breathing by using illustrations and tangible objects also adds an extra sensory component and fun twist. Examples include breathing on pinwheels (you can even have a game of who can make their pinwheel move for a longer period of time, thus encouraging slower, more focused breathing), breathing on a tissue while holding the corner to keep it in mid-air, and using a Hoberman expanding sphere (one of those expanding geometrical spheres) to guide deep inhales and slow exhales. You can even pretend these expanding spheres are the child's lungs to illustrate breathing in to fill the entire lungs (belly breathing). Glitter bottles can be used to teach children how their minds can become less cluttered and settled as they focus on their breathing (shaking the glitter bottle, then breathing while watching the glitter settle).

3. Learn to stay in the present moment. Even though very young children live in the present because they lack the capacity for past or future orientation, adults can help them identify their basic senses and when their senses are activated in everyday life. After the capacity for past and future orientation has been developed, older children and adolescents can learn to stay in the present via the concept of grounding or anchoring. You can print coloring pages of anchors from the Internet and have teens write or draw their own grounding techniques (things that help them feel more present in the moment). This could be anything from conscious breathing to looking around the room for a certain color, to imagining you are putting your worries into balloons and watching them float away in your mind as you choose to let them go.

4. Practice mindful listening. Children of all ages can practice mindful listening with a chime. Simply hit the chime and have the child or teen focus and indicate when he or she can no longer hear the fading sound. If you want to provide a bit more structure, give the child a small object (penny, pebble, etc.) and have them imagine a stoplight. When the chime starts, the pebble is on green. As the chime fades, they move to yellow (when the chime sounds softer), to red (when the chime has completely stopped). Focusing on what they are hearing, seeing, and doing is the essence of mindfulness. It's amazing to see how calm and relaxed children are during and after this activity!

Step three: Practice, practice, practice—until it becomes your practice.

Integrating mindfulness into your therapy with children, adolescents, and young adults will take time. We hope that these suggestions inspire you to try it out. And if you try and it fails miserably, then you'll get an opportunity to practice radical acceptance, to let the judgment go, and to know that next time might be different.

Kristina Sargent, LISW, is a child and family therapist practicing in Cincinnati, Ohio. She is the author and illustrator of the children's picture book on mindfulness *Ursula Unwinds Her Anger* to help children learn such skills as breathing mindfully, acknowledging feelings and letting them go, and slowing down to notice how others are feeling (empathy). You can find more mindfulness skills, tips, and interventions on her blog ArtofSocialWork.com.

Jonathan B. Singer, PhD, LCSW, is associate professor of social work at Loyola University Chicago, founder and host of the Social Work Podcast, and chair of NASW's Child, Adolescent, and Young Adult Specialty Practice Section. He is the author of *Suicide in Schools: A Practitioner's Guide to Multi-level Prevention, Assessment, Intervention, and Postvention.*

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RESOURCES

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Call for Social Work Practitioner Submissions

NASW invites current social work practitioners to submit brief articles for our specialty practice publications. Topics must be relevant to one or more of the following specialized areas:

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- Child Welfare
- Children, Adolescents, and Young Adults
- Health
- Mental Health
- Private Practice
- School Social Work
- Social and Economic Justice & Peace
- Social Work and the Courts

For submission details and author guidelines, go to SocialWorkers.org/Sections. If you need more information, email sections@naswdc.org.

Did You Know?

School social workers can lead the development of strategic plans that prepare other school personnel to respond adequately during the times of chaos and crisis. For more details read:

NASW Practice Perspective
The School Social Worker in Crisis Situations: The Right Skills, The Right Professional
socialworkers.org/LinkClick.aspx?fileticket=aY3BPrNYUew%3d&portalid=0

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