COLLABORATIVE STRATEGIES FOR BUILDING SCHOOL MENTAL HEALTH

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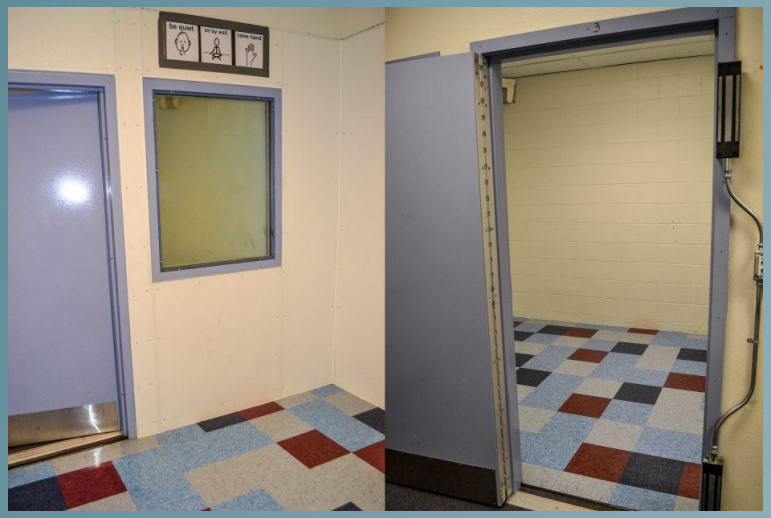
OBJECTIVES

- *Participants will be able to describe key features of a community of practice*
- *Participants will be able to discuss the benefits of a community of practice in expanding or improving school-based mental health services*
- *Participants will be able to identify specific tools and resources that could be developed by communities of practice to enhance school-based mental health services*

A PROBLEM BASED EXAMPLE



- *You work in a county that sends an increasing number of students out to alternative school placements.*
- *Many of the students have documented disabilities.*
- *Some students return to their homeschool only to go back to the alternative school for a permanent placement.*
- *Some of your colleagues in the county also identify this situation as a problem.*
- *No one feels like they have enough of what it takes to change it alone.*

COMMUNITY OF PRACTICE

HOW TO START A MOVEMENT

- *In Derek Sivers 2010 TED Talk on Leadership, he describes how one starts a movement.*
- *Sivers describes a lone concert goer dancing (as if no one is watching) on the venue's lawn.*

https://www.youtube.com/watch?v=J5pFf27OtPM

WHAT IS COMMUNITY OF PRACTICE (COP)?

"Groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis."

Wenger, E., McDermott, R., & Snyder, W. M. (2002). Cultivating communities of practice: A guide to managing knowledge. Boston: Harvard Business School Press

- *You decide that the only thing that's going to change this surge of alternative school placements is if you become the "lone nut".*
- *You identify a few other colleagues who might be able to join your movement and you approach them.*

WHAT DOES IT TAKE TO BE AN EFFECTIVE MEMBER OF A COMMUNITY OF PRACTICE

- *Willingness to:*
  - *Be the "second or third nut"*
  - *Problem solve and remain solution-oriented*
  - *Collaborate*
  - *Do!*

- *In some cases, the more the better! Even the quiet ones can support the movement by increasing your total number activists.*

A PROBLEM BASED EXAMPLE: CONTINUED

- *You enlist:*
  - *A psychiatrist*
  - *2 school counselors*
  - *2 school occupational therapists*
  - *3 school psychologists*
  - *3 community mental health workers*
  - *4 parents*
  - *Several teachers and school social workers*

COMMUNITY OF PRACTICE INDICATORS

- *Joint Enterprise*
- *Diverse Membership*
- *Participatory Framework*
- *Mutuality/Sense of Community*
- *Sharing and exchanging of knowledge*
- *Reflection*
- *Reproduction cycle/continuity*
- *Action Orientation*
- *Construction of New Knowledge*
- *Dissemination of Knowledge*

Winton, P. & Ferris, M. (2008) Communities of Practice Indicators Worksheet. Retrieved on July 20, 2015 from http://fpg.unc.edu/sites/fpg.unc.edu/files/resources/curricula/NPDCI-Communities-of-Practice-Indicators-Worksheet-12-1-08.pdf

PRINCIPLES OF A COMMUNITY OF PRACTICE

- *Design for evolution*
- *Open dialogue*
- *Invitations including different levels of participation*
- *Development of public and private spaces*
- *Focus on value*
- *Combination of familiarity and excitement*
- *Rhythm*

Wenger, McDermott, & Snyder (2002)

Five Stages of Communities of Practice

Wenger, McDermott, and Snyder (2002, page 69) identified the following five stages of CoPs:

1. Potential The basic elements exist: a social network, an important topic, perceived value from developing the network, and the sharing of knowledge.

2. Coalescing Energy is generated to develop the community, build trust among its members, and identify what knowledge should be shared.

3. Maturing The CoP's focus, role, and boundaries are clarified, and gaps in knowledge may become more apparent as it expands.

4. Stewardship The focus is on action and maintaining momentum, sometimes by adding new members, and working to keep the community's practice on the "cutting edge."

5. Transformation Since CoPs depend on the commitment and passion of its members, a point may arrive where a community's work is done. It may go dormant and revive when a new issue emerges to stimulate participation. Sometimes a CoP will split into new communities or merge with others.

National Center for Dissemination of Disability Research (NCDDR) (2005) Communities of practice: A strategy for sharing and building knowledge *Focus* Technical Brief Number 11 Retrieved on July 7, 2015 from http://ktdrr.org/ktlibrary/articles_pubs/ncddrwork/focus/focus11/Focus11.pdf

A PROBLEM BASED EXAMPLE: THE EVOLUTION

- *The Alternative School Placement (ASP) group met 2 times in 12 weeks and communicated via email. The group determined that the following actions were needed:*
  - *A parent/student guide for understanding rights specific to temporary alternative school placement*
  - *Education to the county's special ed administrative staff on Manifestation Determination, as well as LRE and how temporary alternative school placements fit*
- *The ASP considered further actions related to:*
  - *Inviting alternative school workers to join the group*
  - *The examination of school policies related to weapons and illegal substances (e.g., drugs and alcohol) and possibly making recommendations regarding these policies*
  - *The examination of school PBIS/PBS systems and possibly making recommendations regarding these systems*

A Snapshot Comparison

Communities of practice, formal work groups, teams, and informal networks are useful in complementary ways. Below is a summary of their characteristics.

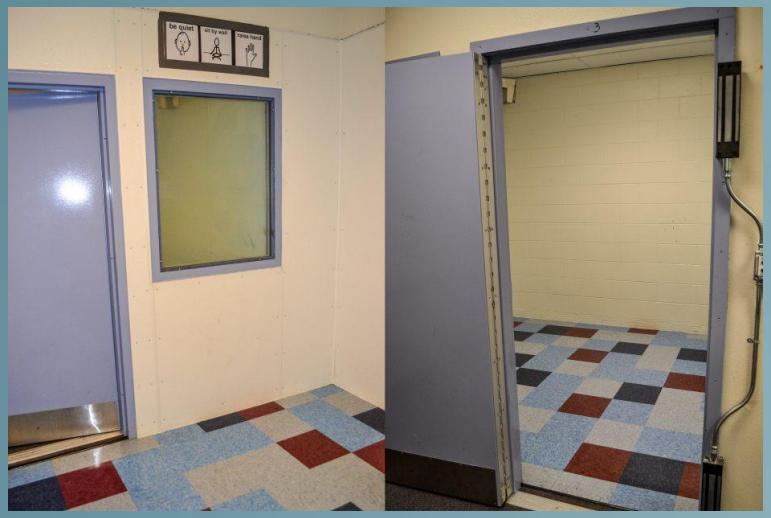
	What's the purpose?	Who belongs?	What holds it together?	How long does it last?
Community of practice	To develop members' capabilities; to build and exchange knowledge	Members who select themselves	Passion, commitment, and identification with the group's expertise	As long as there is interest in maintaining the group
Formal work group	To deliver a product or service	Everyone who reports to the group's manager	Job requirements and common goals	Until the next reorganization
Project team	To accomplish a specified task	Employees assigned by senior management	The project's milestones and goals	Until the project has been completed
Informal network	To collect and pass on business information	Friends and business acquaintances	Mutual needs	As long as people have a reason to connect

Wenger, E., McDermott, R., & Snyder, W. M. (2002). Cultivating communities of practice: A guide to managing knowledge. Boston: Harvard Business School Press

WHAT A COP IS NOT

- *A journal club formed by a school to study the evidence around alternative school placement and present the findings at a faculty meeting.*
- *A colleague who asks another colleague to help find an alternative school placement for a specific student.*
- *A group of mental health workers who are required by their boss to take alternative school placement data and report it.*
- *An individual who is conducting a research project related to truancy.*
- *A group of school personnel who participate on their school's Problem Solving Team and identify supports for students with social emotional needs.*
- *A community member who meets with the principal to discuss afterschool programming for at-risk youth.*

A PROBLEM BASED EXAMPLE: RESOLUTION



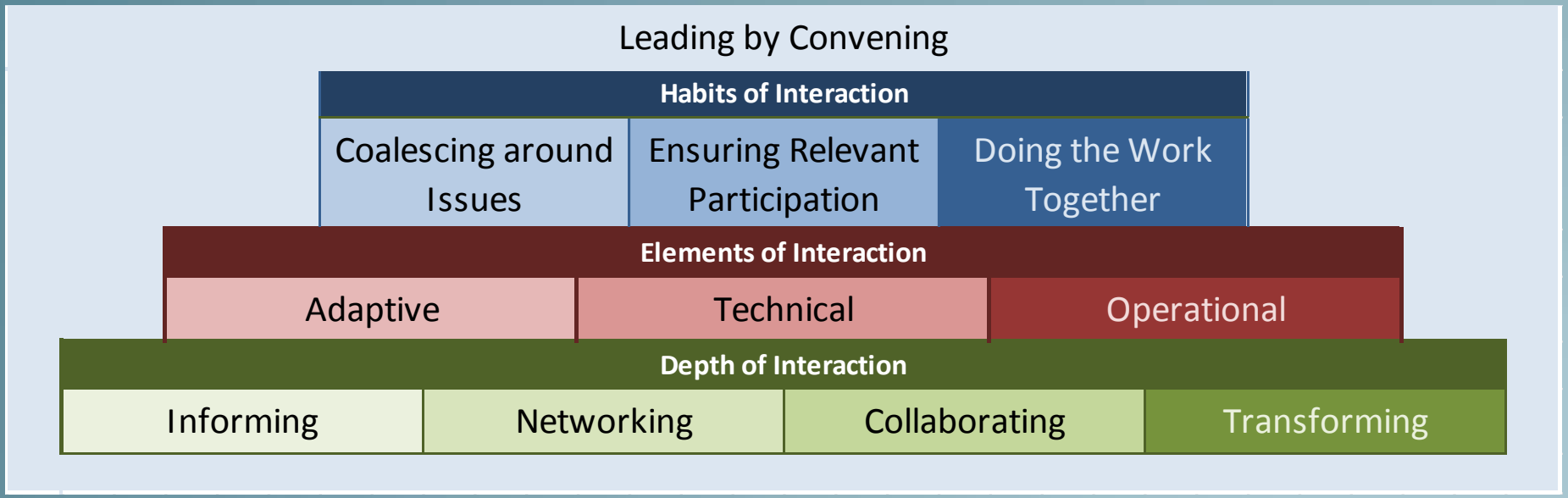
- *The Alternative School CoP:*
  - *developed a parent/student guide for understanding rights specific to temporary alternative school placement*
  - *Provided an inservice to the county's special ed administrative staff on Manifestation Determination, as well as LRE and how temporary alternative school placements fit*
  - *Invited new members from the alternative schools*
  - *Developed a list of other priorities to continue their work next quarter*

IDEA Partnership

www.ideapartnership.org
www.sharedwork.org

IDEA Partnership

OUR APPROACH TO CONVENING



Empowering Leadership in Others:

leading by convening

CONTENTS

AOTA Pediatric Workgroups: Community of Practice

Pediatric Occupational Therapy Practitioners convene by teleconferencing to conduct *shared work* on key focus areas. Our goal is to promote best practices. Questions? Contact Sandy Schefkind at sschefkind@aota.org

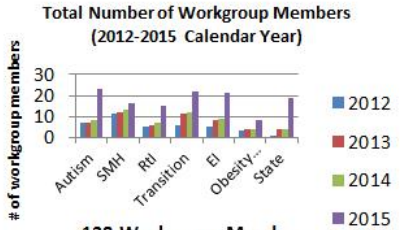
What is a community of practice (CoP)?

"Groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis." (Wenger, McDermott, & Snyder, 2002, p. 4)

What are the Community Members Accomplishing?

- Developing, reviewing 59 resources so far
- Networking and building relationships

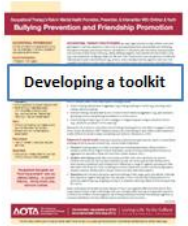
Wenger, E., McDermott, R., & Snyder, W. M. (2002). *Cultivating communities of practice: A guide to managing knowledge.* Boston: Harvard Business School Press



138 Workgroup Members

What's New?
Illinois is piloting a State OT CoP

School Mental Health



Transition

Response to Intervention

State Leaders

Early Childhood

Autism

Childhood Obesity and Health Promotion

www.aota.org/AboutAOTA/Get-Involved/Leadership
See the AOTA page of the IDEA Partnership web site
www.sharedwork.org

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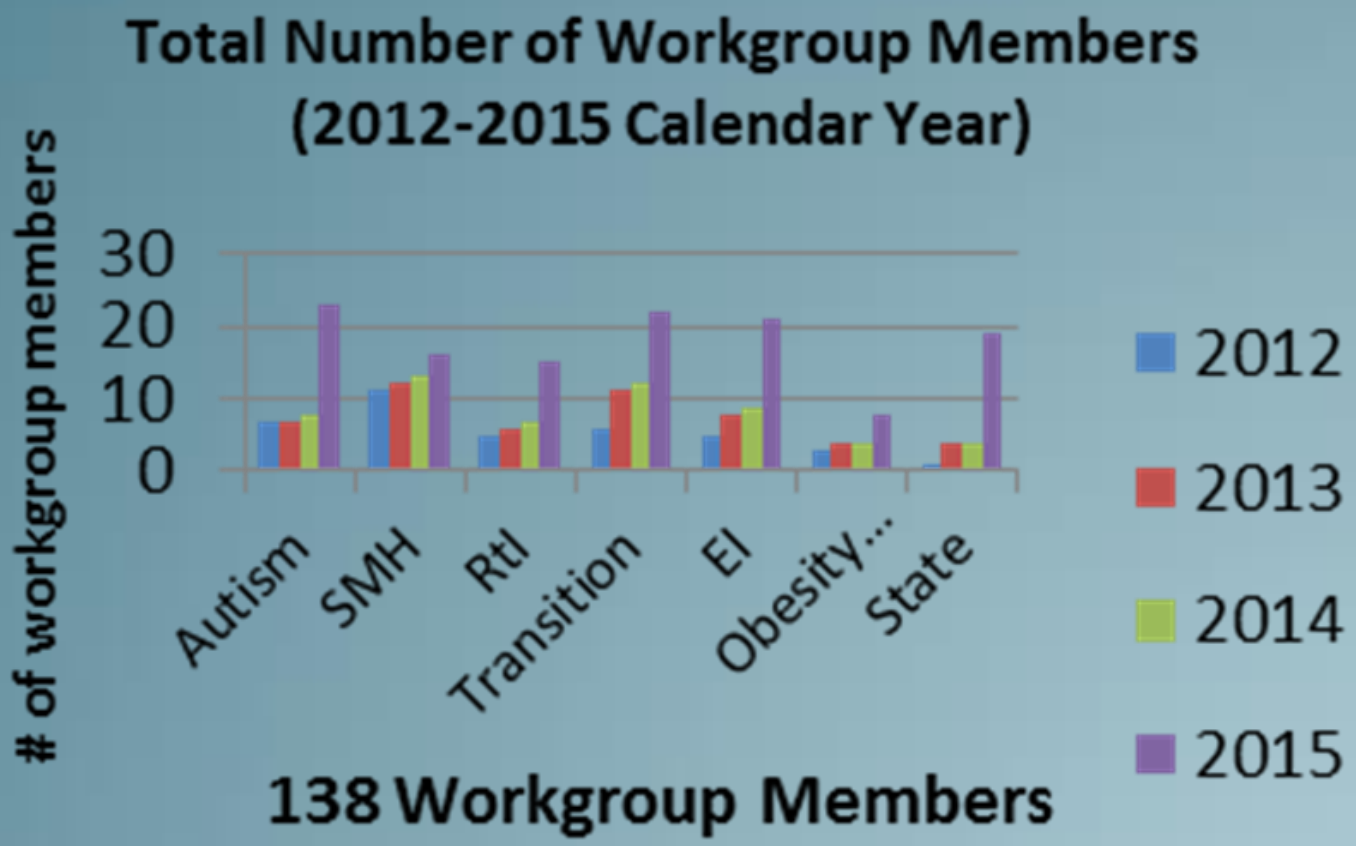
AOTA Workgroups



AOTA
School Mental Health Workgroup

- Developing resources:
  - SMH toolkit of 12 information sheets
  - FAQ and fact sheet
- Conducting Conference presentations
- Convening regularly
- Building identity

Occupational Therapy's Role in Mental Health Promotion, Prevention, & Intervention With Children & Youth

Social and Emotional Learning (SEL)

OCCUPATIONAL PERFORMANCE

Social and emotional competencies (see Table 1) are required for successful participation in almost all areas of occupational performance. Examples include:

Social Participation

- develop appropriate relationships with others
- resolve conflicts
- resist inappropriate social pressure

ADLs

- understand social expectations and manners during eating
- recognize appropriate dress for the context
- use good judgment in personal safety and care

Education

- participate in social groups
- respond appropriately to criticism and feedback
- understand social expectations
- maintain academic performance despite frustrations

Work

- develop skills for obtaining and maintaining work
- set and make progress toward personal work goals

Play and Leisure

- cooperate during play and leisure activities
- develop relationships based on mutual interests
- regulate emotions during competitive games

IADLs

- set and make progress towards personal financial and transition goals
- recognize and use family, school, and community resources

OCCUPATIONAL THERAPY PRACTITIONERS use meaningful activities to help children and youth participate in what they need and or want to do in order to promote physical and mental health and well-being. Occupational therapy practitioners focus on participation in the following areas: education, play and leisure, social situations, activities of daily living (ADLs: e.g., eating, dressing, hygiene), instrumental activities of daily living (IADLs: e.g., meal preparation, shopping), sleep and rest, and work. These are the usual occupations of childhood. Task analysis is used to identify factors (e.g., sensory, motor, social and emotional, cognitive) that may limit or facilitate successful participation across various settings, such as school, home, and community. Activities and accommodations are used in intervention to promote successful performance in these settings.

SOCIAL AND EMOTIONAL LEARNING (SEL) is defined as a process for helping children gain critical skills for life effectiveness, such as developing positive relationships, behaving ethically, and handling challenging situations effectively (Zins et al., 2007). Specifically, strategies that foster SEL help children to recognize and manage emotions, think about their feelings and how they should act, and regulate behavior based on thoughtful decision making.

Table 1: Below is a list of the five SEL competencies, adapted from the Collaborative For Academic, Social and Emotional Learning (CASEL)

SEL Framework:	
Self Awareness	identify one's emotions, thoughts, interests, and values: understand how internal characteristics influence actions: maintain a sense of self-confidence and self-efficacy
Self Management	regulate emotions, thoughts, and behaviors across contexts: cope with stress and manage impulses: set goals
Social Awareness	understand subtle social and cultural norms and rules of engagement: take others' perspectives: respect and empathize with others
Relationship Skills	establish and maintain relationships with others: resist inappropriate social pressure: work cooperatively: prevent and resolve interpersonal conflict: seek help when needed
Responsible Decision Making	accurately identify and evaluate problems: make decisions based on ethical and social norms: consider context in decisions: contribute to well-being on school and community

According to CASEL, research shows that embedding SEL strategies within school curricula promotes improved behavior, academic performance, and social skills (Wilson, Gottfredson, & Najaka, 2001: Greenberg, et al., 2003: Durlak, Weissberg, Dymnicki, Taylor, & Schellinger, 2011). SEL skills directly influence academic, social, home, and work participation. As a national leader in the field, CASEL focuses on the development of high-quality, evidence-based SEL as a necessary part of preschool through high school education. For example, in 2004, SEL standards were developed in Illinois along with a plan to incorporate them into each districts' educational program.

With research to support its effectiveness, it is important for occupational therapy practitioners to: 1) become knowledgeable about SEL and its implementation (e.g. read CASEL training materials): 2) determine if the local school district or state has adopted SEL standards or a SEL curriculum, obtain information about such initiatives, and assist in implementation: 3) identify school committees that may address SEL programming and volunteer to become a member: 4) embed SEL strategies into occupational therapy services (group, individual, and consultative): and 5) collaborate with other disciplines who may be conducting skills training to enable opportunities for generalization and practice in natural contexts such as the classroom, cafeteria, and on the playground.

continued

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This information was developed by Lauren Foster, OTD, OTR/L, with contributions from AOTA's 2013 School Mental Health Work Group.

Living Life To Its Fullest OCCUPATIONAL THERAPY

This information sheet is part of a School Mental Health Toolkit at http://www.aota.org/Practice/Children-Youth/Mental%20Health/School-Mental-Health.aspx

Occupational Therapy's Role in Mental Health Promotion, Prevention, & Intervention With Children & Youth

Anxiety Disorders

OCCUPATIONAL PERFORMANCE

Children who experience anxiety disorders may be challenged in the following areas of occupation:

Social Participation

- May avoid social situations due to fear of being in an unfamiliar setting, embarrassing themselves, or having a panic attack
- May "flee" when uncomfortable
- Can appear irritable and unapproachable to other children
- May choose to withdraw as a way to manage symptoms
- Overall discomfort interferes with enjoyment of social activities

ADLs

- Excessive worry, poor concentration, slowed information processing, and fatigue can disrupt daily routines and the ability to carry out bathing, toileting, dressing, and eating tasks
- May demonstrate poor initiation and low motivation

Education

- Potential for social isolation at recess and in the cafeteria
- Difficulty concentrating and processing information can interfere with activity engagement, ability to understand and follow instructions, and completion of assignments
- May lose train of thought due to intrusion of worrisome thoughts
- Generally avoids speaking up in class or calling attention to self

Work

- May avoid work settings where there is a need to interact with the public and/or the environment is busy and unpredictable

Play/Leisure

- Tendency to engage in familiar occupations, either alone or with a good friend
- May find it hard to relax and enjoy themselves

Sleep/Rest

- Can be disrupted due to worry, which leads to daytime fatigue

OCCUPATIONAL THERAPY PRACTITIONERS use meaningful activities to help children and youth participate in what they need and or want to do in order to promote physical and mental health and well-being. Occupational therapy practitioners focus on participation in the following areas: education, play and leisure, social participation, activities of daily living (ADLs; e.g., eating, dressing, hygiene), instrumental activities of daily living (IADLs; e.g., meal preparation, shopping), sleep and rest, and work. These are the usual occupations of childhood. Task analysis is used to identify factors (e.g., sensory, motor, social–emotional, cognitive) that may limit successful participation across various settings, such as school, home, and community. Activities and accommodations are used in intervention to promote successful performance in these settings.

About Anxiety

Everyone experiences anxiety as a response to stress from time to time, even children. Mild anxiety can help a young person cope with a difficult or challenging situation, such as taking an exam, by channeling that anxiety into positive behaviors, e.g., reviewing course material ahead of time in order to prepare for the exam. However, when anxiety is constantly present and appears to be an irrational fear of familiar activities or situations, then it is no longer a coping mechanism but rather a disabling condition (National Institute of Mental Health (NIMH, n.d.).

Anxiety Disorders

These disorders often begin in childhood as early as 6 years of age, or in adolescence, and can interfere significantly with the performance of everyday occupations (NIMH, n.d.). The *Diagnostic and Statistical Manual of Mental Disorders* (DSM- IV-TR) identifies 5 types of anxiety disorders: obsessive compulsive disorder (OCD), posttraumatic stress disorder (PTSD), social or specific phobias, panic disorder, and generalized anxiety disorder. Common symptoms are:

1. excessive, unexplained worry
2. difficulty managing the worry
3. restlessness or unexplained nervous energy
4. tiring easily
5. difficulty concentrating or loss of thoughts ("mind going blank")
6. irritability
7. muscle tension
8. sleep disturbances

DID YOU KNOW THAT?

"1 in 10 young people may suffer from an anxiety disorder."

—Minnesota Association for Children's Mental Health

Brain imaging can now demonstrate the biology of anxiety disorders (NIMH, n.d.). These types of studies have revealed atypical brain activity in children with anxiety disorders (e.g., not being able to differentiate between threatening versus non-threatening situations), as well as brain circuitry changes during adolescence which make females more prone than males to developing mood and anxiety disorders. Research is also helping determine effective treatment methods other than prescribed medications, such as family-based cognitive behavioral therapy and social skills training (Bonder, 2010).

How do Anxiety Disorders Impact Participation?

Anxiety symptoms can interfere with a child's ability to engage in school activities, chosen occupations, and social opportunities. Fear of failure, concern about having a panic attack, or fear of embarrassment can lead to a child's lack of participation even though he or she may want to be engaged. These experiences can lead to social isolation and result in poor occupational performance in all life skill areas.

How Do Anxiety Disorders Impact Emotional Health?

Decreased participation in social situations and occupations can exacerbate feelings of low self-esteem, distort a child's self-image, and disrupt habits, routines, and roles. Overall quality of life and well-being are affected because of the underlying symptoms.

continued

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Occupational Therapy's Role in Mental Health Promotion, Prevention, & Intervention With Children & Youth

Inclusion of Children With Disabilities

For detailed information about the Americans with Disabilities Act (ADA) and Part B of the Individuals with Disabilities Act (IDEA), please go to http://idea.ed.gov/explore/home.

OCCUPATIONAL PERFORMANCE

Occupational therapy practitioners enhance occupational performance for children with disabilities by encouraging participation in inclusive environments by:

Social participation

- Helping students develop social relationships through peer interaction and modeling
- Ensuring that students participate with peers in educational and community experiences
- Increasing students' leisure skills to enhance enjoyment

Activities of Daily Living

- Promoting self-help skills (e.g., dressing, eating) in the natural environment
- Incorporating peer modeling of social expectations and positive behaviors into curricula

Education

- Encouraging students to participate with their peers in academic and nonacademic settings (e.g., playground, cafeteria, art room, music class, and gym)
- Increasing access to community-based educational programs, such as museums and parks

Work

- Developing early work skills such as time management and organization within the school setting (e.g., library, school store)

Play and Leisure

- Assisting students with developing play and leisure skills with all peers during recess, after school, and in the community

OCCUPATIONAL THERAPY PRACTITIONERS use meaningful activities to help children and youth participate in what they need and/or want to do in order to promote physical and mental health and well-being. Occupational therapy practitioners focus on participation in the following areas: education, play and leisure, social interaction, activities of daily living (e.g., eating, dressing, hygiene), instrumental activities of daily living (e.g., meal preparation, shopping), sleep and rest, and work. These are the usual occupations of childhood. Task analysis is used to identify factors (e.g., sensory, motor, social-emotional, cognitive) that may limit successful participation across various settings, such as at school, at home, and in the community. Activities and accommodations are used in intervention to promote successful performance in these settings.

Occupational therapy practitioners promote integrated services in all contexts and environments where children are learning, playing, and growing.

ABOUT INCLUSION

Inclusion refers to integrating students with disabilities with their peers into a variety of general education and community settings. Inclusion is a social justice issue—all children and youth with disabilities have a right to live, learn, play, and work alongside their typical peers.

- Schools: In school settings, inclusion is the law. The Individuals with Disabilities Education Act (IDEA) mandates the *least restrictive environment*, meaning students with disabilities receive their education, including related services, with their typical peers to the maximum extent possible. The Individualized Education Program (IEP) team must first consider general education as possibly meeting the student's needs before considering a more restrictive setting.
- Community: Inclusion in the community refers to equal access to all facilities and services. The Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act of 1973 prohibit discrimination on the basis of disability by recipients of federal financial assistance.

ABOUT INTEGRATED SERVICES

In order to help support successful inclusion of children and youth with disabilities in general education and community contexts, it is critical that occupational therapy practitioners skillfully integrate services. *Integrated service delivery* involves providing occupational therapy in the child's or youth's natural environments (e.g., bus, classroom, playground, cafeteria, recreational settings), emphasizing nonintrusive methods and common goals (Bazyk, Goodman, Michaud, Papp, & Hawkins, 2009). Theories of motor control and motor learning indicate that practicing meaningful occupations in natural settings is most effective for learning new skills (O'Brien & Lewin, 2008). All parties benefit from integrated services. In schools, occupational therapy practitioners learn about the curriculum, teacher preferences, and the unique culture of the classroom (Bazyk & Cahill, 2014). Teachers, paraeducators, and other service providers have opportunities to learn how to embed occupational therapy intervention strategies when OT is provided in the natural context. Specifically, students with disabilities benefit from teachers' increased ability to implement therapy strategies throughout the day (Silverman, 2011). Lastly, there is enhanced educational continuity for students with special needs who are not pulled out of the classroom for related services (Bazyk & Cahill, 2014).

Continued on page 2.

Universal design is a concept that was developed in the 1970s by the late architect Ron Mace and his colleagues at North Carolina State University. Universal design, composed of seven principles, refers to the design of services, products, and environments that are usable by the widest range of individuals possible, regardless of age, ability, social status, or preference.

AOTA The American Occupational Therapy Association, Inc.

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Occupational Therapy's Role in Mental Health Promotion, Prevention, & Intervention With Children & Youth

Recess Promotion

OCCUPATIONAL THERAPY PRACTITIONERS' (OTs') role in the school setting is to promote student academic achievement and social participation. They support students' occupational performance in the following areas: education, play, leisure, social participation, activities of daily living (e.g., eating, dressing, hygiene), sleep and rest, and work. Task analysis is used to identify factors (e.g., sensory, motor, social–emotional, cognitive) that may limit successful participation. Practitioners promote a student's strengths and abilities throughout all school routines and environments, including recess and playground time.

Recess defined: *active, free play with peers.*

Recess is an important part of each school day and an opportune time for OTs to implement innovative programs to address a variety of issues related to school performance. Although many areas of function can be addressed during recess, play and social participation are the most natural areas for OTs to target. Recess is an important time for students to develop important performance skills in the areas of emotional regulation and communication and social skills.

The problem: School districts are cutting the amount of time devoted to recess in order to increase the amount of instruction time. A study by the Center on Education Policy found that 20% of districts **recently reduced recess by 50 minutes per week** in order to dedicate more time to academics (Ramstetter, Murray, & Garner, 2010).

Benefits of recess

- Increased opportunity for engagement in social participation, improved physical and emotional health, development of leisure and play to counteract the imbalance between sedentary and physical activity, and preparation of the body and mind for attentiveness and engagement in the classroom.
- Recess is a time to "recharge [students'] bodies and minds" (Robert Wood Johnson Foundation, 2010, p. 4). Play in any form is a stress reliever from the world of more and more academic instruction and benchmark testing (Miller & Almon, 2009).
- Better classroom behaviors are found in classrooms receiving at least one 15-minute recess break each day (Barros, Silver, & Stein, 2009).
- Attention to classroom tasks is improved after recess time (Holmes, Pellegrini, & Schmidt, 2006).

Professional Recommendations

- The Centers for Disease Control and Prevention (2000) recommend that elementary school children participate in recess at regularly scheduled periods during the school day. Recess should be supervised by trained adults who can encourage physical activity, enforce rules, and prevent bullying. Appealing equipment and materials should be provided.
- The National Association for Sport and Physical Education (NASPE: 2004) recommends elementary school children have unstructured play time in order to increase physical activity and encourage enjoyment of movement. Recess should not replace physical education and should not be withheld as punishment. NASPE also suggests recess be supervised by qualified adults to facilitate conflict resolution and enforce safety rules.
- The National Association of Early Childhood Specialists in State Departments (2002) of Education recognizes recess as an "essential component of education" and recognizes the restorative effect of recess for students with attention disorders (Ramstetter et al., 2010).

continued

WHY SHOULD OTS CARE ABOUT RECESS?

- Only **36%** of children meet doctor's recommendations for daily physical activity.
- Recess represents about half the available time for children to dedicate to physical activity.
- Recess may be removed because of behavior problems. OTs can help prevent this by helping recess staff learn how to structure recess to promote positive behavior and reduce problem behaviors.
- Funding for structured play often goes to after-school programs and physical education. Recess is an untapped resource and OTs have both the skills to develop new programs and the responsibility to advocate for the importance of play (Robert Wood Johnson Foundation, 2007).

The Challenges of Keeping Recess: limited equipment or supplies; unsafe conditions; disorganization; discipline problems; bullying; lack of awareness of play benefits.

A 2010 study showed that urban schools and schools with 75% of students receiving free lunch have LESS recess time than rural & suburban schools. (Ramstetter et al., 2010)

References

National Center for Dissemination of Disability Research (NCDDR) (2005) Communities of practice: A strategy for sharing and building knowledge *Focus* Technical Brief Number 11 Retrieved on July 7, 2015 From http://ktdrr.org/ktlibrary/articles_pubs/ncddrwork/focus/focus11/Focus11.pdf

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