Figuring out the Missing MTSS Puzzle Piece: Tier 2 Mental Health Supports

National Center for School Mental Health Conference 2019
Kelly Whitaker, PhD, Education, Training, & Research (ETR) Associates
Erin MacDougall, PhD, Public Health Seattle & King County
Ashley Mayworm, PhD, Loyola University Chicago
Stephanie Moore, PhD, Johns Hopkins University
Eric Bruns, PhD, University of Washington, SMART Center
Aaron Lyon, PhD, University of Washington, SMART Center
Sharon Hoover, University of Maryland, Baltimore
Outline

**Paper 1: Revising a model of care framework to advance the use of Tier 2 evidence-based mental health supports**

Presenters: Kelly Whitaker, Erin MacDougall, Aaron Lyon

**Paper 2: Linking Screening to Tier 2 Interventions**

Presenters: Stephanie Moore, Ashley Mayworm

**Paper 3: Adapting BRISC (a Tier 2 intervention) for School Social Workers**

Presenters: Kelly Whitaker, Ashley Mayworm, Eric Bruns
Paper 1: Revising a model of care framework for a system of school-based health centers to advance the use of Tier 2 evidence-based mental health supports
Overview

Evidence-based School mental health services through school-based health centers (SBHCs)

Improving Access & Quality of School Mental Health Services aligned with school MTSS

Developing intervention strategies & implementation supports
Seattle & King County School-based Health Centers

• Partnership between School Districts in King County & Public Health of Seattle & King County 1990-present
• 30+ SBHCs in high, middle, and elementary schools
• Funded by local public funding
• Staffed by 8 health care agencies
Seattle & King County School-based Health Centers

- Integrated primary care and mental health services in schools
  - Collaborating with school social, emotional, behavioral health needs and supports
- More than 8,000 students served and 40,000 visits annually
UW SMART & PHSKC Partnership

Using an evidence-based and public health prevention framework to implement school mental health center services

- **2005**: Robert Wood Johnson Grant: Training & Consultation
- **2007-2010**: Evidence-Based Clinical Consultation Program
- **2010-2014**: Model of Care Work Group
- **2014-2015**: Evaluation of Standardized Assessment Use
- **2017-present**: Health Information Technology for Routine Outcome Monitoring

**Revision of the Model of Care: Focus on MTSS-B Tier 2 Services**
- Time-limited
- Goal clarity
- Evidence-based
- Group services
Access to Mental Health Care

More than 18 million children and adolescents experience behavioral health problems

- 1 in 5 adolescents has a diagnosable disorder
- Only 36% of youth receive treatment
Access to Mental Health Care

Youth of color are significantly less likely to access and receive high-quality mental health care than their white peers despite similar levels of need for services (Garland et al., 2005; Alegria et al., 2006)
School-based Mental Health

- provides up to 70% of all behavioral health services  
  (Merikangas et al., 2011)

- improves service access for underserved youth  
  (Kataoka et al., 2007; Lyon et al., 2013)
Goal: Improve Access & Quality of SBHC MH

- **Conduct literature review** of best practices for with a focus on brief, goal/problem focused individualized and group therapies and standardized and idiographic assessments
- **Distill findings** of the literature review and provide recommendations for evidence-based care using a measurement-based approach in school-based health centers, with a focus on Tier 2 interventions
- **Develop intervention strategies and implementation supports** for providers
Methods: Literature Review

• Identified Tier 2 Evidence Based Practices (EBPs)

• Literature on EBPs was searched in google scholar, PWEBS database, UW libraries (PubMed, PsychINFO) and bibliographies from the articles

• Search Terms: School-based mental health interventions; Tier 2 school-based interventions; Tier 2 evidence-based group interventions; school focused; evidence-based therapy; evidence-based interventions for anxiety, depression, attention, trauma, suicide, aggression, behavioral acting out; common elements; and common elements for anxiety, depression, attention, trauma, suicide.

• Synthesized and reviewed results with the SMART team iteratively
Evidence-based Practice: Concerns

- EBP Manuals are often too rigid (e.g., fixed content, intensity, length)
  - Clinicians are more likely to adopt treatments with flexibility to address severity, complexity, and co-morbidity
- EBPs mostly address a singular presenting problem
- EBPs have been mostly tested with Caucasian samples
- EBPs can be difficult to implement
  - Don’t fit with school context, too many sessions (15-20), difficult for clinicians with limited EBP experience
Common Elements

- generic treatment components (e.g., exposure, psychoeducation, relaxation, etc.) that cut across distinct treatment protocols for common child and adolescent mental health problems (e.g., depression, anxiety, trauma, behavior disorders) (Chorpita, Daleiden, & Weisz, 2005; Garland, Bickman, & Chorpita, 2010; Lyon, Charlesworth-Attie, Vander Stoep, & McCauley, 2011)
- are represented in well-established interventions such as CBT approaches.
Common Elements: Approach

- Brevity and learnability
- Addresses needs of caseload and comorbidity
- Flexibility and Flux
- Stand-alone elements and skills
- Informed by practitioner and researcher feedback

(Weisz, Bearman, Santucci, & Jensen-Doss, 2016)
Common Elements: Benefits

- extending the reach of mental health services
- addressing comorbidity and supporting child and adolescent mental and behavioral health
- more acceptability among clinicians
- Improved outcomes
"By stripping some of our best treatments down to the essence, we can allow them to be fleshed out again at the point of service by practitioners with local expertise who are embedded in the local context (Chorpita et al., 2011, p. 495)."
Recommendations

Implement Brief Modular Interventions
by focusing on brief interventions, to increase access and equity

Collaborate with Community Mental Health Providers
to focus on time-limited Tier 2 interventions, relationships should be developed with community-based mental health agencies with the capacity to serve students with more intensive mental health needs

Increase buy-in
Explore agencies contextual & practice constraints to determine acceptability and feasibility of implementing new model of care
Gather stakeholder feedback on revised Model of Care

Strengthen Provider Capacity
Develop supports and accountability systems to support agency and practitioner uptake of the revised model of care

Integration
SMH clinicians should be integrated with and inform overall school programming related to student social emotional and behavioral health
Preliminary Intervention components

Identification of Common Elements from Emerging Interventions

Key strategies from FIRST:

- Feeling Calm
- Increasing Motivation
- Repairing Thoughts
- Solving Problems
- Trying the Opposite

(Weisz, Bearman, Santucci, & Jensen-Doss, 2016)
## Selected Common Elements

<table>
<thead>
<tr>
<th>Practice Element</th>
<th>Definition</th>
<th>Presenting problems</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychoeducation</td>
<td>Reviewing information about treatment, its relation to the presenting</td>
<td>Anxiety, Depression, Disruptive disorders</td>
</tr>
<tr>
<td></td>
<td>problem, or service delivery</td>
<td></td>
</tr>
<tr>
<td>Problem solving</td>
<td>Using techniques (e.g., brainstorming, choosing a solution, evaluating</td>
<td>Anxiety, depression, Disruptive disorders</td>
</tr>
<tr>
<td></td>
<td>results) designed to solve targeted problems</td>
<td></td>
</tr>
<tr>
<td>Assessment</td>
<td>Gathering information about the client’s strengths and needs, such as by</td>
<td>Anxiety, Depression, disruptive disorders</td>
</tr>
<tr>
<td></td>
<td>interviews, questionnaires, observations</td>
<td></td>
</tr>
<tr>
<td>Feeling calm</td>
<td>This is self-calming and relaxation techniques for reducing short-term</td>
<td>Trauma, Attention and hyperactivity behaviors, Anxiety, Delinquency and disruptive</td>
</tr>
<tr>
<td></td>
<td>situational tension and the accompanying emotional arousal</td>
<td>behavior</td>
</tr>
<tr>
<td>Trying the opposite</td>
<td>Engaging in activities that directly counter the behavioral problem.</td>
<td>Anxiety, Depression, Delinquency and disruptive behavior</td>
</tr>
<tr>
<td>Repairing thoughts</td>
<td>Identifying and changing biased or distorted cognitions.</td>
<td>Anxiety, Attention and hyperactivity behaviors, Autism Spectrum Disorders, Depression, Trauma, Eating disorders</td>
</tr>
</tbody>
</table>
Overview of BRISC

<table>
<thead>
<tr>
<th>Brief-Intervention for School Clinicians (BRISC)</th>
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</thead>
<tbody>
<tr>
<td>Structured / systematic identification of treatment targets</td>
</tr>
<tr>
<td>Focused on skill building / problem solving</td>
</tr>
<tr>
<td>All intervention elements are evidence-based</td>
</tr>
<tr>
<td>Utilizes structured processes and standardized tools for progress monitoring</td>
</tr>
<tr>
<td>Uses motivation strategies, terms tailored for youth (“Stress,” “Game plan,” “Problem solving”)</td>
</tr>
<tr>
<td>Common element</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Anxiety</td>
</tr>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Relationship issues</td>
</tr>
<tr>
<td>School problems</td>
</tr>
<tr>
<td>Anger/Externalizing</td>
</tr>
<tr>
<td>Trauma</td>
</tr>
</tbody>
</table>
BRISC helps SMH provider:

• **Engage** with student by asking about their immediate concerns
• **Assess** issues student wants help with AND nature of student’s needs
• **Teach** basic tools to empower students

Provides a structured triage approach to assess and inform intervention planning.
BRISC practices

- Using **Top Problems approach** for idiographic assessment of the student’s top needs as a method for establishing interventions goals.
- Set **specific short-term treatment goals** with a time plan and treatment contract in place.
- Use of both **standardized and individualized assessment tools** to monitor progress and direct the course of treatment.
Mental Health Services in School-Based Health Centers in King County:
Describing mental health practices through the Multi-Tiered Systems of Support Framework
School-based health center services at Tier 2 & 3 also provide:
- Integrated mental health care in the clinic: Use of case management strategies, sharing and prioritization of strategies and goals, including those for medication and treatment.
- Family engagement: Outreach to family about availability of school-based health center services and community mental health services for students with demonstrated need.
- Prioritized population-based consultation and case review: Ongoing, timely consultation with psychiatrists/psychologists at Seattle Children’s Hospital and sponsor-based resources.
- School-wide service integration: Collaboration with the school nurse, student intervention team, teachers, administrators, school counselors and other building staff.
- Standardized assessment and progress monitoring: Use of screening/assessment tools, treatment plan implementation, and follow-up.

Tier 3 Intensive Interventions
Initial assessment and connection to intensive, ongoing services through referral to community-based mental health and/or wraparound services
Examples: Referral to community providers, individualized treatment for students with barriers to accessing community mental health services

Tier 2 Selective Interventions
Problem-focused, time-limited approach to mental health service provision
Examples: Brief, goal/problem-focused, individualized and group therapy

Tier 1 Universal Interventions
SBHCs provide minimal supports to school-wide health and safety education
Examples: Health promotion, crisis/suicide prevention planning, social-emotional learning, bullying, and violence prevention
Feedback Opportunities

- Summer 2019--Individual meetings with SBHC Agency managers
- Fall 2019-- Feedback Session with SBHC Providers
Next Steps

- Incorporate feedback into pilot training plan
- Pilot training and implementation January 2020
- Develop an implementation plan for the new model of care
- Develop supports and accountability systems to support agency and practitioner uptake of the revised model of care
- Include agency management and practitioners in the development of the model of care and implementation plan.
Paper 2: Linking complete mental health screening in schools to Tier 2 intervention

Screening for Complete Mental Health

Why ask 100% of students questions to find answers that are most relevant to a few?
Screening for Complete Mental Health

Mental Health / Wellbeing

Mental Illness/Pathology

High

Low
Screening for Complete Mental Health

Mental Health / Wellbeing

Low → High

<table>
<thead>
<tr>
<th>Mental Illness/Pathology</th>
</tr>
</thead>
<tbody>
<tr>
<td>High</td>
</tr>
</tbody>
</table>

- Languishing
- Complete Mental Health
- Troubled
- Symptomatic but Content
Difficulties at Tier 2

- Several reviews of the literature suggest many available Tier 2 interventions
  - Bruhn, Lane, & Hirsch, 2014; Yong & Cheney, 2013

- Difficulties with implementation:
  - Which interventions to implement at Tier 2?
  - How to prioritize different interventions?
  - Which students best fit with different intervention aims and goals?

- Most screening done is deficit focused

- Lack of Tier 2 interventions OR too many Tier 2 interventions (over-burdened)
“Languishing” Students

- Mental Health / Wellbeing
  - Low
  - High

- Languishing
  - Mental Illness/Pathology
  - High

- Troubled
  - Mental Illness/Pathology
  - Low

- Complete Mental Health
  - Engagement
  - Academic self-concept
  - Beliefs about school importance
  - Physical health
  - School belonging

- Symptomatic but Content

(e.g., Antaramian et al., 2010; Moffa, Dowdy, & Furlong, 2016; Suldo & Shaffer, 2008)
Current Project

1. How do schools implement universal complete mental health screening?
2. How do schools identify students in need of Tier II services, particularly those students who would not be identified by traditional deficit-focused screening methods (i.e., languishing students)?
3. How do schools select appropriate Tier II intervention based on the needs of students?
4. How do schools evaluate outcomes for students receiving Tier II intervention?
Case Example: Context & Participants

University-High School Partnership

- Existing relationship
- Recognized need for Tier 2 & 3
- Support with MTSS structure
- Conducted universal screening
- University provided support for a Tier 2 intervention based on school needs

2015-2016 School Year

- 2,181 students
- 9th-12th grades
- 54% Hispanic, 39% non-Hispanic White
- 44% economically disadvantaged
- 14% EL
Social Emotional Health Survey

What does the SEHS-Secondary Measure?

Social Emotional Health Survey Domains and Subscales

12 Individual Strength Subscales

Optimism + ZEST + Gratitude = Engaged Living

Emotion Regulation + Self-Control + Empathy = Emotional Competence

Family Support + Peer Support + School Support = Belief in Others

Self-Awareness + Self-Efficacy + Persistence = Belief in Self

Website:
https://www.covitalityucsb.info/

Images were created by Project Covitality and located on the following website: www.covitalityucsb.info
Social-Emotional Distress Survey

Hard time breathing
Embarrass self
Tense and uptight
Hard time relaxing
Felt sad and down
Easily irritated
Hard to cope; panic
Hard to get excited
Annoyed and sensitive
Scared for no reason

Depression Symptoms
Anxiety Symptoms
SEHS Covitality
Life Satisfaction

Dowdy, Furlong, Nylund-Gibson, Moore, & Moffa, 2018
### Dual-Factor Mental Health Triage Groups

<table>
<thead>
<tr>
<th></th>
<th>Average Distress (≤1 SD)</th>
<th>Above Average Distress (1 SD to 2 SD)</th>
<th>High Distress (≥2 SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Strengths (≤ 1 SD)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low Average Strengths (1 SD to 0 SD)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Average Strengths (0 SD to 1 SD)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High Strengths (≥ 1 SD)</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
# Dual-Factor Mental Health Triage Groups

<table>
<thead>
<tr>
<th>Low Strengths</th>
<th>Average Distress</th>
<th>Above Average Distress</th>
<th>High Distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Average Strengths</td>
<td>5. Getting By 460</td>
<td>3. Lower risk 77</td>
<td></td>
</tr>
<tr>
<td>High Average Strengths</td>
<td>6. Moderate Thriving 594</td>
<td>9. Symptomatic but Content 60</td>
<td></td>
</tr>
<tr>
<td>High Strengths</td>
<td>7. Complete Mental Health 282</td>
<td>8. Symptomatic but Content 22</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* Cells are numbered in order of need for follow-up. Shaded cells indicate highest priority for intervention.
Youth with Languishing Mental Health
## Tier II Intervention Selection

- **Intervention goal**: increase student engagement and school climate, build on existing strengths and prevent future mental health problems

### Complete Mental Health Screening
- Identify students in the Languishing group

### Additional Data Points
- **School Connectedness Scale**: about 50% of Languishing students have below average score
- Most also had attendance or grade issues as identified by school counselor

### Matrix of Interventions
- Create a matrix of available school resources/interventions and skills/needs targeted
- Feasibility: Resources available through University partnership to implement an intervention

### Selection of an Appropriate Intervention
- Mentorship, goal setting, strengths-based, individualized
- Check Connect & Respect (CCR) (adaptation of Check & Connect)
Progress Monitoring & Evaluation of Intervention Effects

Identification, Recruitment & Pre-Test

- SEHS-S
- SEDS-S
- SCS

Implementation

- Session notes
- Component delivery checklist
- Individual and group supervision

Post-Test and Decision Making

- SEHS-S
- SEDS-S
- SCS
- Mentor-Student Relationship Survey
- Attendance
- Suspensions
- Quarterly Grades
- Teacher-rated feedback (weekly)
Best Practices & Recommendations

- Consider whether a complete mental health screening approach will help the school better identify strengths and problem areas (across all tiers).
- Before screening, ensure there is a plan for follow-up and clearly explicated procedures.
- Develop a menu of services
  - High quality, that will meet diverse needs (don’t need one unique intervention for every problem).
- Interventions must be acceptable to the consumers
  - If Tier 2 is not used or supported, puts more pressure on more intensive Tier 3 interventions.
- Follow an implementation framework
  - Multidisciplinary team
  - Start small, then scale up
  - Facilitate buy-in
References and Resources

Paper 3: Adaption of a Tier 2 Mental Health Intervention (BRISC) for School-Employed Mental Health Providers
**Overview of BRISC**

<table>
<thead>
<tr>
<th>School-Based Usual Care</th>
<th>BRISC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention is often crisis-driven (Langley et al., 2010)</td>
<td>Structured / systematic identification of treatment targets</td>
</tr>
<tr>
<td>Focused on providing nondirective emotional support (Lyon et al., 2011)</td>
<td>Focused on skill building / problem solving</td>
</tr>
<tr>
<td>Interventions do not systematically use research evidence (Evans &amp; Weist, 2004; Rones &amp; Hoagwood, 2000)</td>
<td>All intervention elements are evidence-based</td>
</tr>
<tr>
<td>Standardized assessments are used infrequently (Weist, 1998; Lyon, Ludwig, et al., in press)</td>
<td>Utilizes structured processes and standardized tools for progress monitoring</td>
</tr>
<tr>
<td>Interventions are not engaging of young people and service dropout is common</td>
<td>Uses motivation strategies, terms tailored for youth (“Stress,” “Game plan,” “Problem solving”)</td>
</tr>
</tbody>
</table>
BRISC Integration in MTSS
## BRISC Session Format

<table>
<thead>
<tr>
<th>01</th>
<th>Engagement, Assessment, &amp; Problem Identification</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Administer and review brief standardized assessment measure(s)</td>
</tr>
<tr>
<td></td>
<td>- Assess current functioning: school, peers, family</td>
</tr>
<tr>
<td></td>
<td>- Identify Problems</td>
</tr>
<tr>
<td></td>
<td>- Informal monitoring</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>02</th>
<th>Problem Solving</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Introduce problem solving</td>
</tr>
<tr>
<td></td>
<td>- Identify barriers and plan to address</td>
</tr>
<tr>
<td></td>
<td>- Create a game plan for the week</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>03</th>
<th>Continue Problem Solving &amp; Teaching Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Individualized plan to address barriers</td>
</tr>
<tr>
<td></td>
<td>- Teach new skills: Stress &amp; Mood Management, Communication Skills, Realistic Thinking</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>04</th>
<th>Review Student Needs &amp; Plan for Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Come back if you need it</td>
</tr>
<tr>
<td></td>
<td>- Ongoing school-based counseling or other school-based services</td>
</tr>
<tr>
<td></td>
<td>- Referral to outside services</td>
</tr>
<tr>
<td></td>
<td>- Regular check-ins with identified person at school</td>
</tr>
</tbody>
</table>
BRISC Studies

**BRISC GOAL 2**
- BRISC Intervention Development & Pilot Testing in Seattle Public Schools funded by IES (R305A120128: PIs McCauley & Bruns)

**BRISC GOAL 3**
- BRISC Efficacy Trial 3 states 52 public schools, funded by IES (R305A160111: PIs Bruns & McCauley)

**Pilot study: Adapting BRISC for School Social Workers**
- Current Study--Presented BRISC to SSWs in Chicago, Summer 2018

**NEXT Study**
- Seek funding to adapt BRISC for School Social Workers and Interns
Brief BRISC Training for School Social Workers

- Family School Partnership Program Summer Institute @ Loyola University Chicago
  - [https://www.luc.edu/socialwork/resources-initiatives/consultation-groups/](https://www.luc.edu/socialwork/resources-initiatives/consultation-groups/)
- Introduced to BRISC over 3 hour period by two BRISC developers

Post-Training Survey
N=37 participants

Post-Training Focus Group
N=10 participants
Survey Participants

- N=34 (3 participants excluded who were not social workers)
- 50% had 10+ years of experience
- All school or clinical social workers
- 88% currently provide direct services in a school
- Variety of grade levels served
- 98% Masters or Masters+
- 42% have provided supervision to an intern now or in the past
- None were current interns
## Survey Measures

- Optional, anonymous survey following brief BRISC training

<table>
<thead>
<tr>
<th>Part</th>
<th>Survey Type</th>
<th>Description</th>
<th>Items</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part 1</td>
<td>Professional demographics</td>
<td>Years of experience, title, schools served, education, experience with supervision</td>
<td></td>
</tr>
<tr>
<td>Part 2</td>
<td>Open-Ended Discussion Questions</td>
<td>Usefulness, barriers, needs in order to implement</td>
<td>3 items</td>
</tr>
<tr>
<td>Part 3</td>
<td>ALFA-Q</td>
<td>Acceptability, likely effectiveness, feasibility, appropriateness</td>
<td>15 items</td>
</tr>
<tr>
<td>Part 4</td>
<td>CSEMM</td>
<td>Confidence in ability to implement EBPs and new practices generally</td>
<td>10 items</td>
</tr>
</tbody>
</table>
Focus Group Participants

$N=10$

- 90% female
- 50% White
- 50% have 10+ years experience
- 70% currently provide social work services in schools
- Work in a variety of school levels
- 90% Masters or Masters+ education level
- 70% have supervised an intern currently or in the past
- From three different states: Colorado, Illinois, Florida
Focus Group Protocol

60 minute focus group

1. What are your general impressions of the BRISC intervention? (helpfulness and fit)
2. What barriers do you think might interfere with the implementation of BRISC?
3. What factors do you think would make BRISC a good fit for SSWs?
4. What adaptations or modifications do you think would be needed to make BRISC work for SSWs?
5. Is there anything else you would like to tell us that might help us make BRISC better or more helpful for SSWs?
### Acceptability, Feasibility & Perceived Effectiveness

<table>
<thead>
<tr>
<th>Question</th>
<th>N</th>
<th>M</th>
<th>SD</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>To what extent are you satisfied with the content of BRISC?</td>
<td>34</td>
<td>3.16</td>
<td>.66</td>
<td>1-4</td>
</tr>
<tr>
<td>How compatible do you think BRISC will be with the practical realities and resources of working with students in the school setting?</td>
<td>34</td>
<td>2.96</td>
<td>.67</td>
<td>1.5-4</td>
</tr>
<tr>
<td>How relevant do you believe BRISC is to improving school-based supports and services for students who are at risk?</td>
<td>34</td>
<td>3.08</td>
<td>.80</td>
<td>0-4</td>
</tr>
<tr>
<td>To what extent do you believe BRISC is likely to improve students’ social, emotional, and academic success?</td>
<td>34</td>
<td>3.19</td>
<td>.77</td>
<td>1-4</td>
</tr>
<tr>
<td>Overall Score</td>
<td>34</td>
<td>3.11</td>
<td>.63</td>
<td>1-4</td>
</tr>
</tbody>
</table>
Helpfulness, Fit & Improved Services

<table>
<thead>
<tr>
<th>Helpfulness</th>
<th>Fit</th>
<th>Improved Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth Empowerment</td>
<td>Fits within MTSS</td>
<td>Fills a gap for Tier 2 services</td>
</tr>
<tr>
<td>Simplicity</td>
<td>Triage</td>
<td>Includes measurement/assessment tools</td>
</tr>
<tr>
<td>Tools &amp; Skills</td>
<td>Accountability</td>
<td>Improves communication about services received</td>
</tr>
<tr>
<td>May not work for all students</td>
<td>Flexible</td>
<td>Provides structure for what to do in sessions</td>
</tr>
<tr>
<td>“I think it’s really good for students because it gives them a voice and gives them a role to play in intervention”</td>
<td>“Would be a perfect tool for [triage]”</td>
<td>“I think it was nice that it came with data that you can collect already. That’s helpful because sometimes I find that I’m like trying to… you know spending a lot of time figuring out ok what should I use to measure this and it’s already there”</td>
</tr>
<tr>
<td>“they are not just leaving feeling ‘oh I have been heard.’ They are leaving with a game plan that has some structure and that will give them something to think about for the entire week.”</td>
<td>“I really like how there are specific steps into each session so it’s not like we are kind of wondering around trying to figure out what to do.”</td>
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**Perceived Barriers**

**School**

“I feel that within the nature of our role that we have to attend to crisis and we just have to drop what we’re doing to focus on that.”

- Need MTSS in place for BRISC to be useful
- Consent process for assessment

**Student/family**

“The biggest issue I have would be the consent. Figuring out a way to approach that with parents. I would not do that. I wouldn’t even go about it.”

- May not fit for all students
- Interest/motivation
- Lack of self-awareness/maturity
- Complex problems

**Clinician**

“I think the only other barrier I see is because I’m a school social worker I understand the idea of letting the student pick the problem more”

- Shift in perspective on service delivery (i.e., youth choosing problems to work on)
- Cultural differences
Perceived Facilitators

**School**

“Yes, I think that’s one of the strengths of the tool and I think one of the key words is triage.”

- Enhances MTSS Tier 2 intervention
- Using data to encourage school buy-in

**Student/Family**

“I see this as really a nice sort of way to bridge that, to really put some ownership back onto the student and really truly start where the client’s at”

- Problem-solving approach less stigmatizing than mental health treatment

**Clinician**

“more accountable as school Social Workers in terms of caring about administration, parents, and the entire school community”

- Provides a way to communicate what you are doing with students
Adaptations

Training
Include partnerships with university; Address potential lack of mental health foundation

Content
Include assessment of academic functioning (data & observations); Assessment & consent procedures

Modality
Consider BRISC as a group intervention
Next Steps

● Using this information to propose a larger adaptation study of BRISC specifically for SSWs
  ○ Other school-employed MH providers too: school psychologists and school counselors
● Interested in increasing workforce development through cascading implementation model
  ○ Training supervisors to train their interns; increase capacity for training and supervision for SSWs
Feedback

- Are you a school-employed mental health provider?
- What barriers or facilitators to BRISC implementation do you anticipate?
- How could you envision imbedding something like this into your schools?
- What are your training and supervision needs?
Discussant: Eric Bruns, Ph.D.
University of Washington, SMART Center