Figuring out the Missing MTSS Puzzle Piece: Ti ental Health Supports

S 06. Figuring out the Missing MTSS Puzzle Piece: Tier 2 Mental Health Supports

National Center for School Mental Health Conference 2019
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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

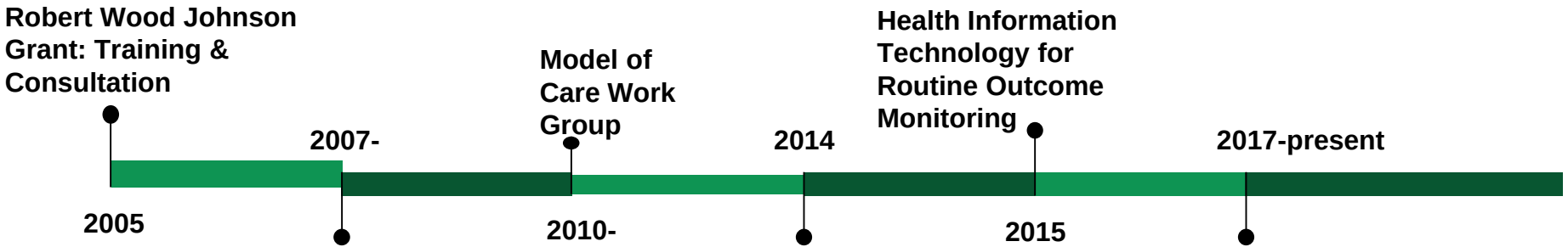
- Partnership between *School Districts in King County & Public Health of Seattle & King County 1990-present*
- 30+ SBHCs in high, middle, and elementary schools
- Funded by local public funding
- Staffed by 8 health care agencies

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



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 TREATMENT S 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).

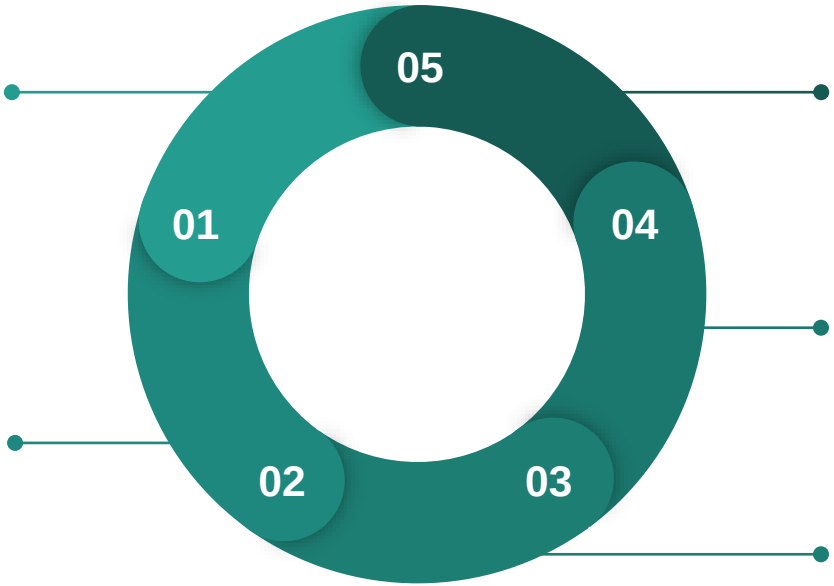
Recommendations

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:

- **F**eeling Calm
- **I**ncreasing Motivation
- **R**epairing Thoughts
- **S**olving Problems
- **T**rying the Opposite

(Weisz, Bearman, Santucci, & Jensen-Doss, 2016)

Selected Common Elements

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

Overview of BRISC

Brief-Intervention for School Clinicians (BRISC)
Structured / systematic identification of treatment targets
Focused on skill building / problem solving
All intervention elements are evidence-based
Utilizes structured processes and standardized tools for progress monitoring
Uses motivation strategies, terms tailored for youth (“Stress,” “Game plan,” “Problem solving”)

Common element	Steps of Care					
	1	2	3	4	5	6
Anxiety	Psychoeducation	Problem solving /Assessment	Feeling calm	Trying the opposite	Repairing Thoughts	Practice Exposure
Depression	Psychoeducation	Problem solving /Assessment	Getting Active/Motivated	Trying the opposite	Repairing Thoughts	
Relationship issues	Psychoeducation	Problem solving /Assessment	Communication skills: see BRISC, IPT-A			
School problems	Psychoeducation	Problem solving /Assessment	Connecting with additional services in school as needed			
Anger/Externalizing	Psychoeducation	Problem solving /Assessment	Anger Management Training	Parent Education	Referral to Social Psych for FBA	
Trauma	Psychoeducation	Problem solving /Assessment	Feeling Calm	Trying the opposite	Trauma Narrative	Repairing Thoughts

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

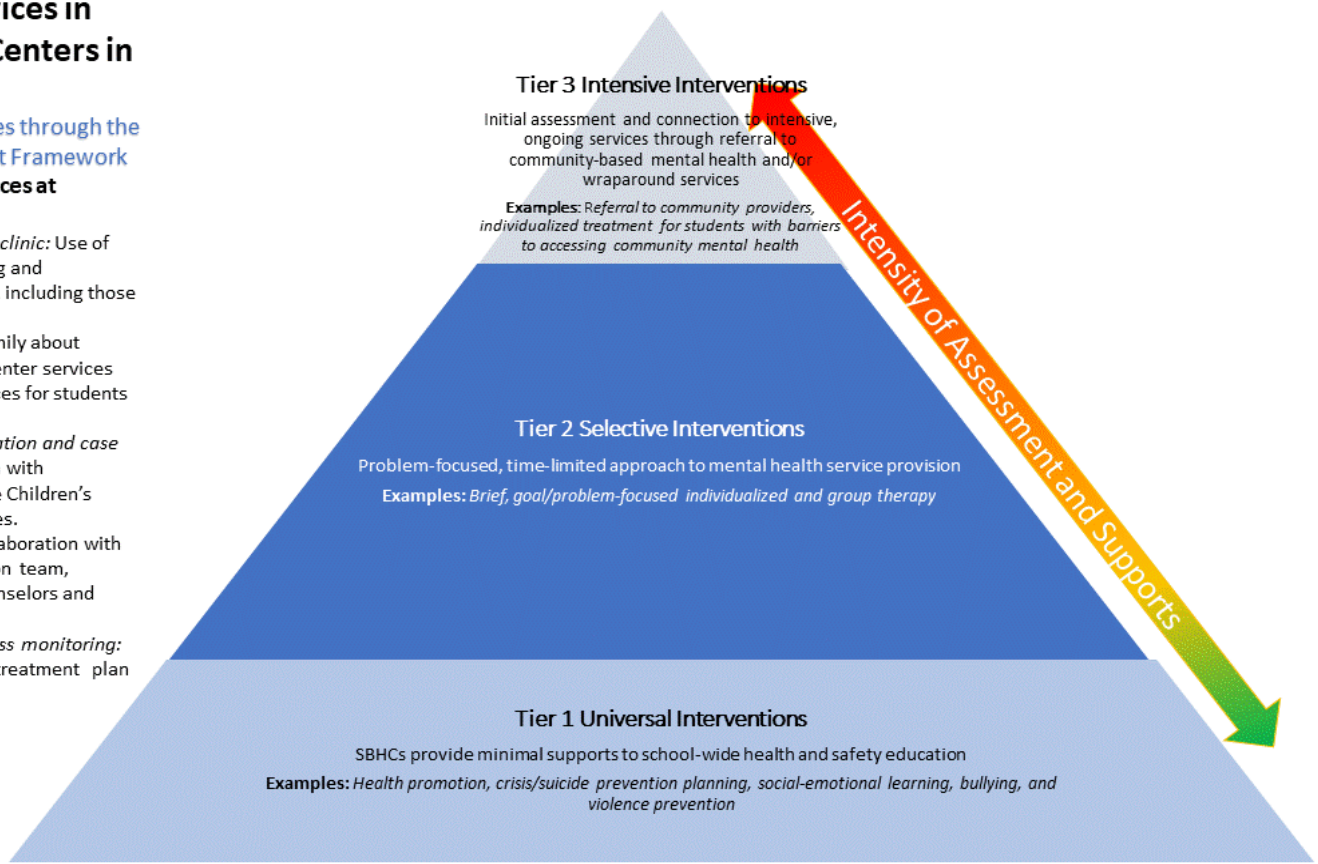
- Using **Top Problems approach** for idiographic assessment of the student's top needs as a method for establishing interventions goals.
- Set **specific short-term treatment goals** with a time plan and treatment contract in place.
- Use of both **standardized and individualized assessment tools** 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 Tiers 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.



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.

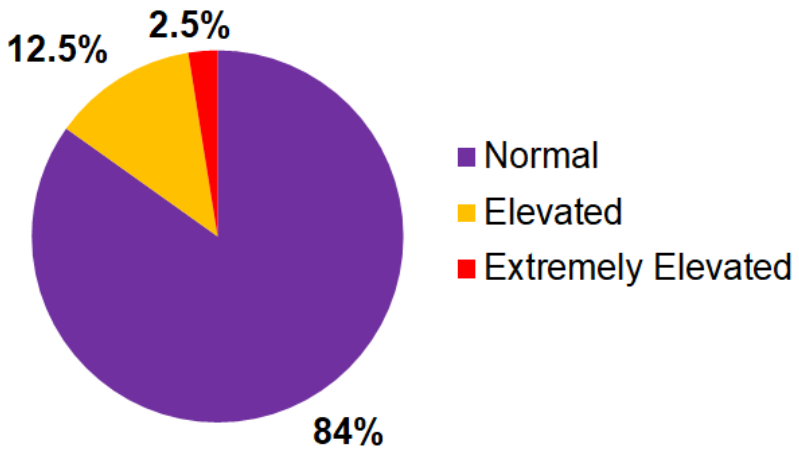
Paper 2: Linking complete mental health screening in schools to Tier 2 intervention

Article: *Journal of Applied School Psychology* (2019)
https://www.tandfonline.com/doi/full/10.1080/15377903.2019.1577780

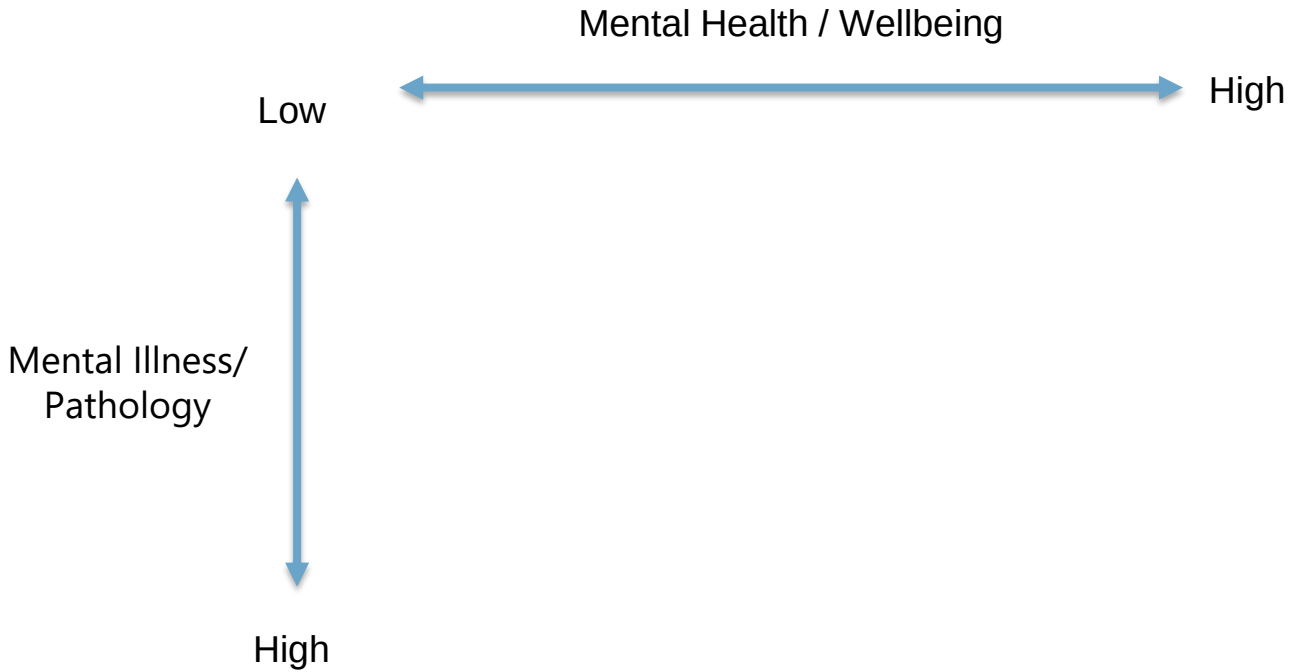
Screening for Complete Mental Health

Mental Illness/ Pathology ⟷ Mental Health/ Wellness

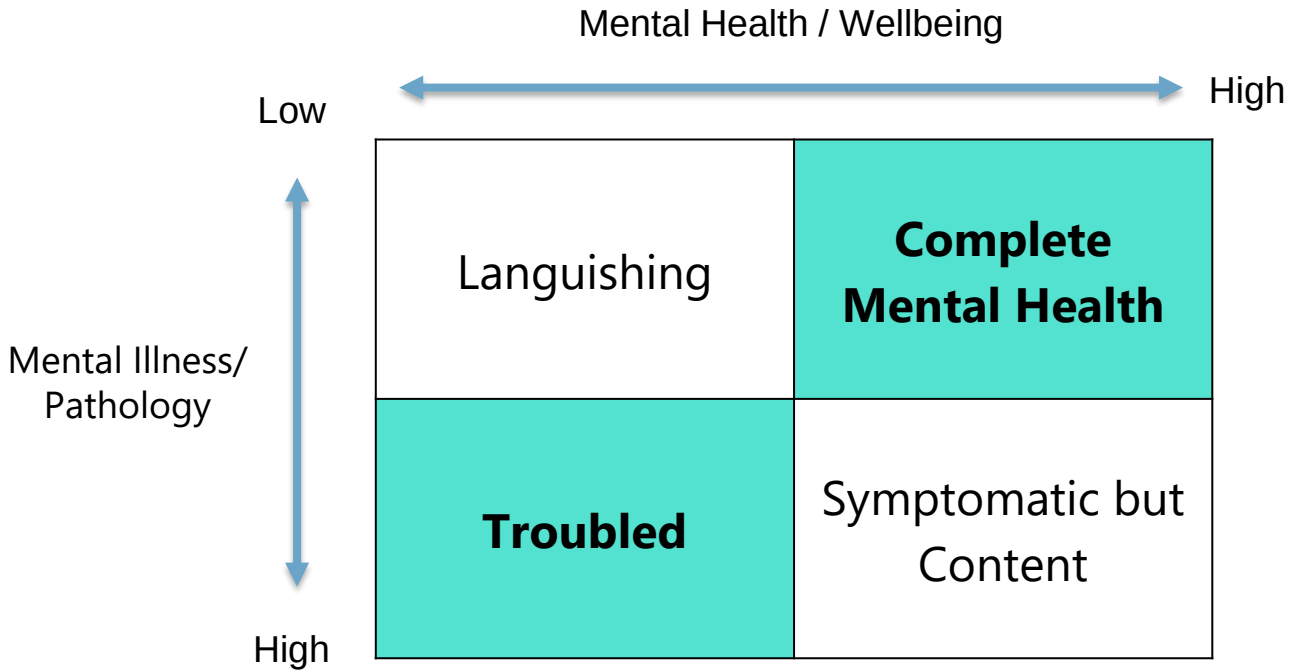
Why ask 100% of students questions to find answers that are most relevant to a few?



Screening for Complete Mental Health



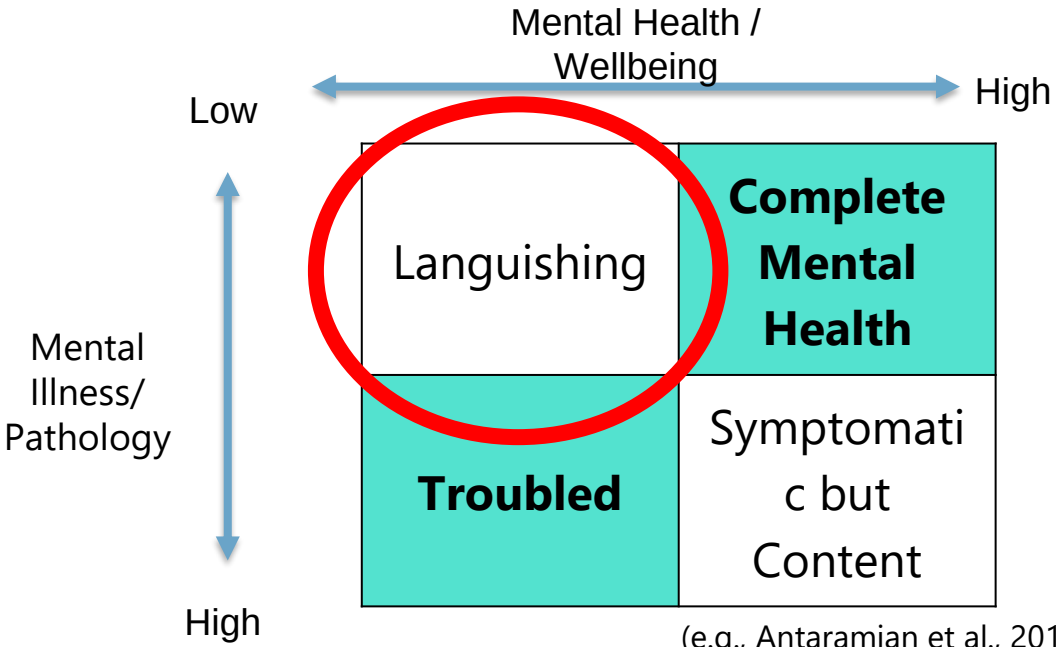
Screening for Complete Mental Health



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



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

(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?; and
4. How do schools evaluate outcomes for students receiving Tier II intervention?

Case Example: Context & Participants

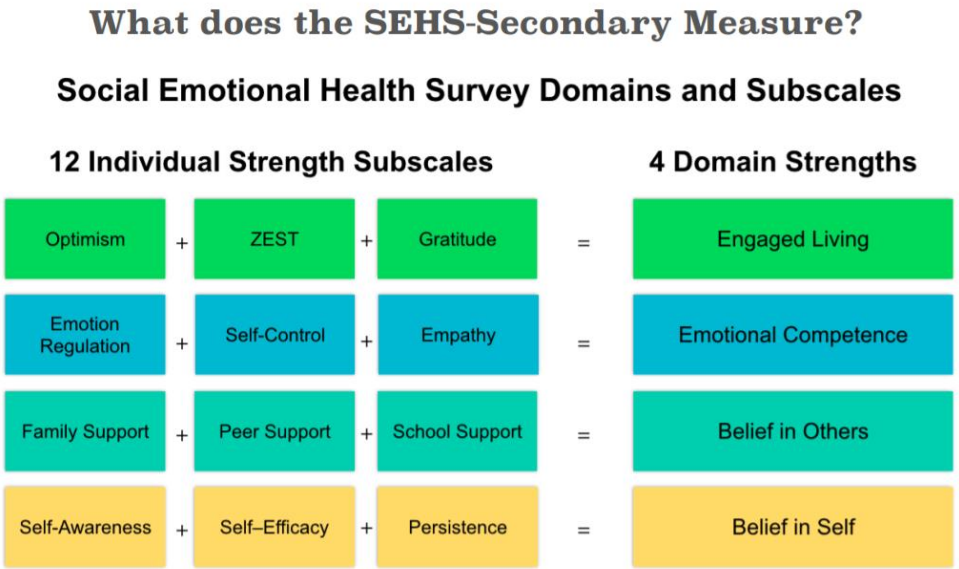
University-High School Partnership

- 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

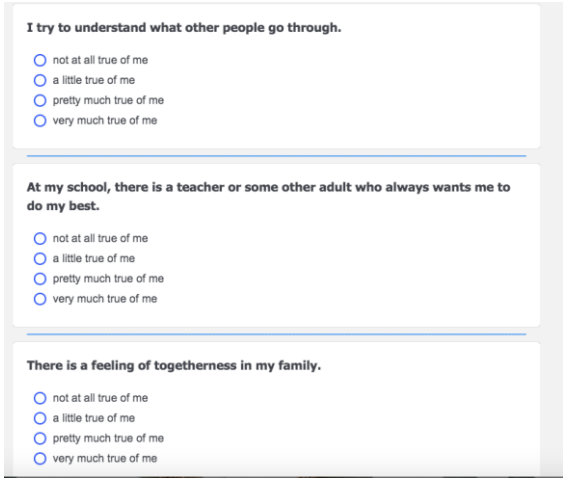
2015-2016 School Year

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

Social Emotional Health Survey

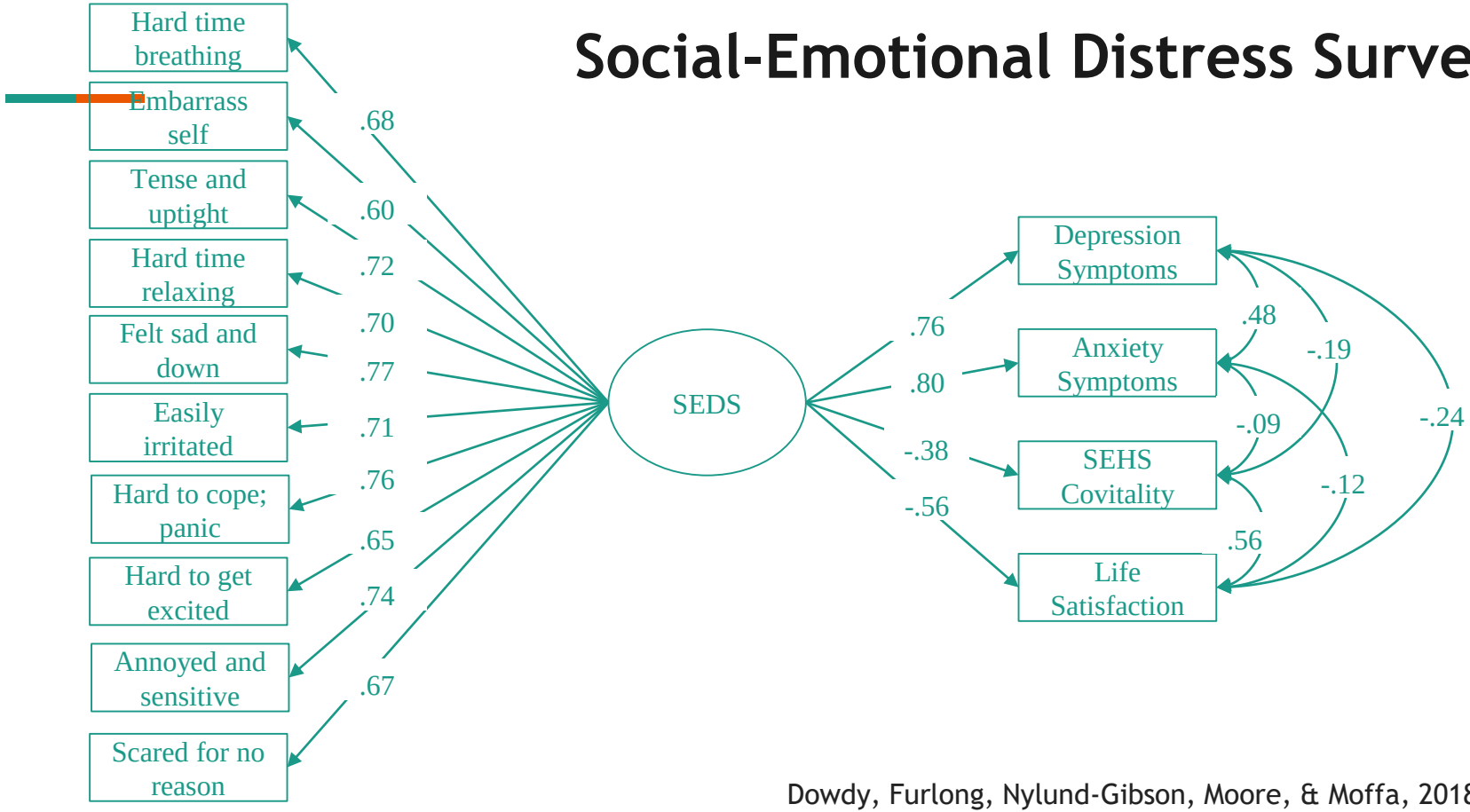


Website:
https://www.covitalityucsb.info/



Images were created by Project Covitality and located on the following website: www.covitalityucsb.info

Social-Emotional Distress Survey



Dowdy, Furlong, Nylund-Gibson, Moore, & Moffa, 2018

Dual-Factor Mental Health Triage Groups

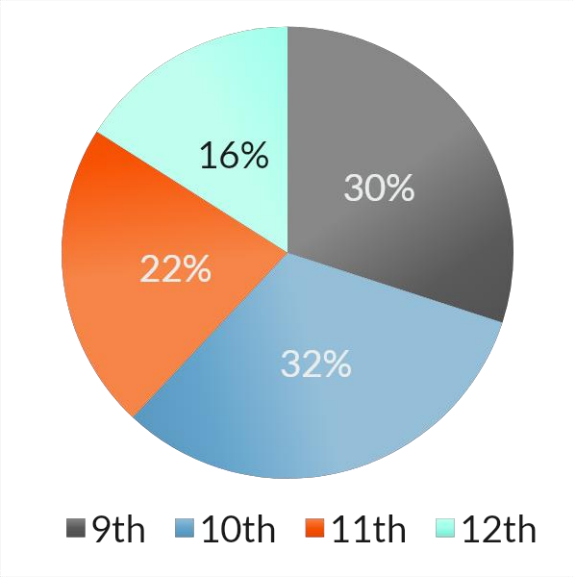
	Average Distress (≤1 SD)	Above Average Distress (1 *SD* to 2 *SD*)	High Distress (≥2 *SD*)
Low Strengths (≤ 1 *SD*)			
Low Average Strengths (1 *SD* to 0 *SD*)			
High Average Strengths (0 *SD* to 1 *SD*)			
High Strengths (≥ 1 *SD*)			

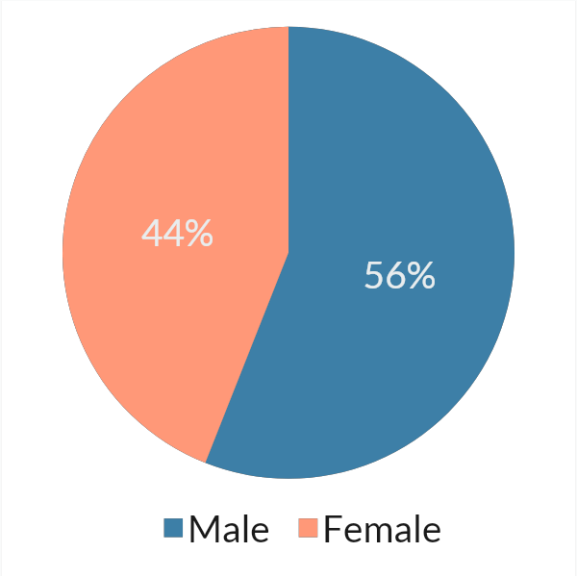
Dual-Factor Mental Health Triage Groups

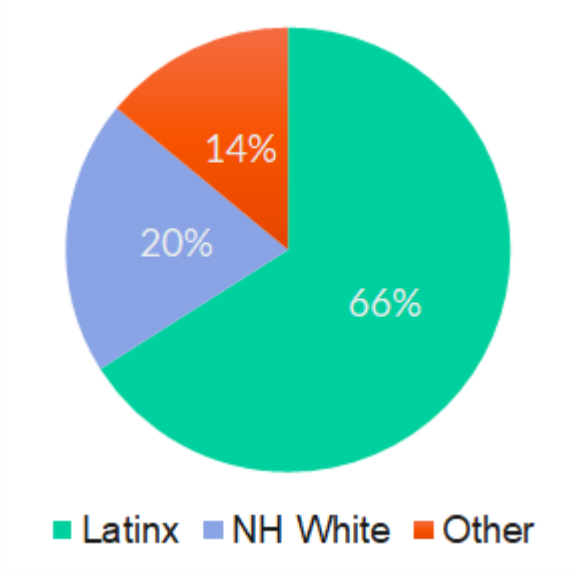
	Average Distress	Above Average Distress	High Distress
Low Strengths	4. Languishing 183	2. Moderate Risk 51	1. Troubled 82
Low Average Strengths	5. Getting By 460	3. Lower risk 77	
High Average Strengths	6. Moderate Thriving 594	9. Symptomatic but Content 60	8. Symptomatic but Content 22
High Strengths	7. Complete Mental Health 282		

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

1

Complete Mental Health Screening

Identify students in the Languishing group

2

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

3

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

4

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	Implementation	Post-Test and Decision Making
• SEHS-S • SEDS-S • SCS	• Session notes • Component delivery checklist • Individual and group supervision	• 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

- Antaramian, S. P., Huebner, E. S., Hills, K. J., & Valois, R. F. (2010). A dual-factor model of mental health: Toward a more comprehensive understanding of youth functioning. *American Journal of Orthopsychiatry, 80*, 462–472. doi:10.1111/j.1939-0025.2010.01049.x
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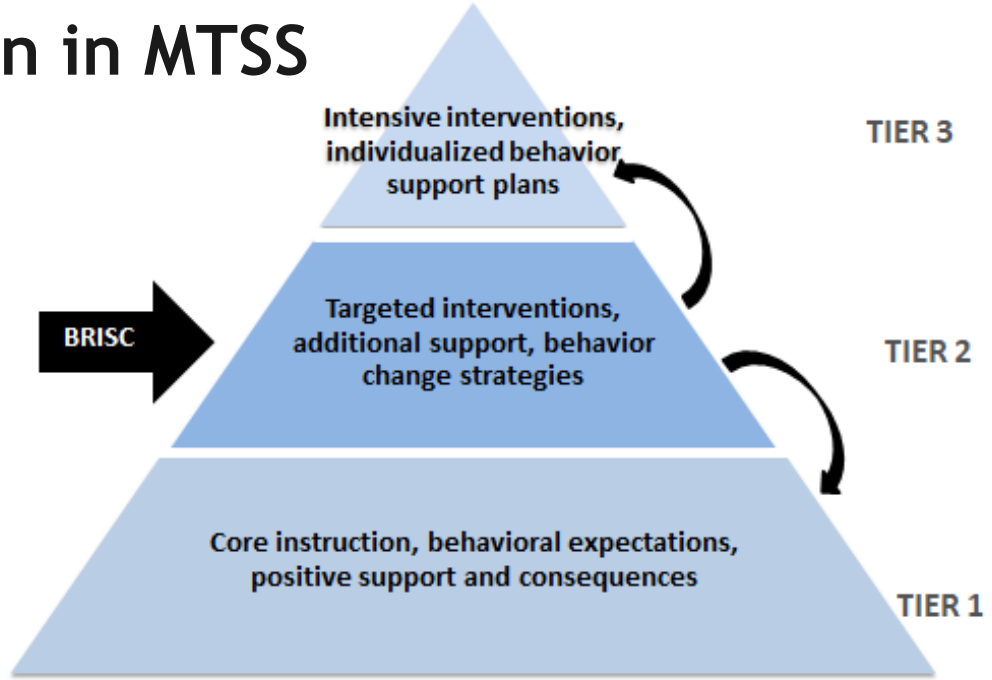
Paper 3: Adaption of a Tier 2 Mental Health Intervention (BRISC) for School-Employed Mental Health Providers

Overview of BRISC

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

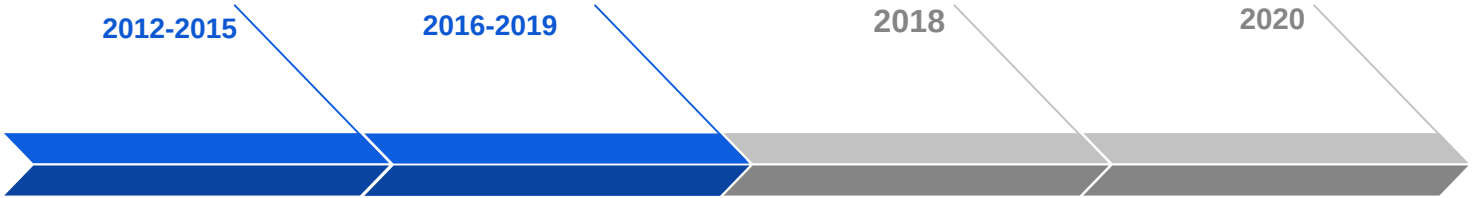
BRISC Integration in MTSS



BRISC Session Format

01	**Engagement, Assessment, & Problem Identification**	• Administer and review brief standardized assessment measure(s) • Assess current functioning: school, peers, family • Identify Problems • Informal monitoring
02	**Problem Solving**	• Introduce problem solving • Identify barriers and plan to address • Create a game plan for the week
03	**Continue Problem Solving & Teaching Skills**	• Individualized plan to address barriers • Teach new skills: Stress & Mood Management, Communication Skills, Realistic Thinking
04	**Review Student Needs & Plan for Next Steps**	• Come back if you need it • Ongoing school-based counseling or other school-based services • Referral to outside services • Regular check-ins with identified person at school

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/
- 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

Part 1	Professional demographics	Years of experience, title, schools served, education, experience with supervision	
Part 2	Open-Ended Discussion Questions	Usefulness, barriers, needs in order to implement	3 items
Part 3	ALFA-Q	Acceptability, likely effectiveness, feasibility, appropriateness	15 items
Part 4	CSEMM	Confidence in ability to implement EBPs and new practices generally	10 items

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

To what extent are you satisfied with the content of BRISC?

How compatible do you think BRISC will be with the practical realities and resources of working with students in the school setting?

How relevant do you believe BRISC is to improving school-based supports and services for students who are at risk?

To what extent do you believe BRISC is likely to improve students' social, emotional, and academic success?

Composite	*N*	*M*	*SD*	Range
Acceptability	34	3.16	.66	1-4
Feasibility	34	2.96	.67	1.5-4
Appropriateness	34	3.08	.80	0-4
Likely Effectiveness	34	3.19	.77	1-4
Overall Score	34	3.11	.63	1-4

Helpfulness, Fit & Improved Services

Helpfulness

- Youth Empowerment
- Simplicity
- Tools & Skills
- May not work for all students

"I think it's really good for students because it gives them a voice and gives them a role to play in intervention"

"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."

Fit

- Fits within MTSS
- Triage
- Accountability
- Flexible

"Would be a perfect tool for [triage]"

Improved Services

- Fills a gap for Tier 2 services
- Includes measurement/assessment tools
- Improves communication about services received
- Provides structure for what to do in sessions

"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"

"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."

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?

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