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Development & Research Case Study

Brief Intervention for School Clinicians (BRISC)

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Executive Summary

This case study describes how the Brief Intervention for School Clinicians (BRISC) was introduced to schools across Ontario. BRISC is a Tier 2 intervention for high school students, developed to fit the school context and align with the scope of School Mental Health services. BRISC engages students and triages mental health needs through four individually-focussed sessions.

Resource exploration

School Mental Health Ontario (SMH-ON—formerly SMH ASSIST) recognizes that School Mental Health (SMH) providers need treatment approaches designed for the school context. SMH-ON partnered with the developers of BRISC (from the University of Washington SMART Center) to determine if the BRISC approach would meet the mental health needs of Ontario students.

Resource development

Research and experience have shown that training alone is insufficient to support the uptake of a new intervention. In addition to providing free training, the provincial SMH-ON team supported the exploration and development of BRISC in Ontario by:

- Adapting resource content for a Canadian audience
- Translating training and intervention materials into French
- Offering post-training consultation calls to practitioners, where the developers provided clinical support
- Communicating with the SMH-ON coaching team to help them support implementation
- Providing a Community of Practice (CoP) for MHLs/supervisors to share their experiences, ideas, and questions
- Gathering feedback from participants about the BRISC training, resources, and intervention, and working alongside the BRISC developers to make necessary adjustments

Lessons learned through exploring and developing BRISC

1. Use effective, evidence-based interventions to support youth mental health in schools.
2. Tailor treatment approaches to help school-based clinicians overcome barriers to providing mental health services.
3. Focus on common elements of effective approaches to keep school-based interventions brief.
4. Support students to learn to how to tackle one concern at a time.
5. Explore existing promising practices, rather than starting from scratch.
6. Consider implementation conditions from the start, such as thoughtfully engaging leadership, no matter the purpose of training.
7. Provide intentional supports as a strong foundation for update.
8. Be prepared to make significant changes in response to feedback.

Lessons learned through piloting BRISC

9. Provide tips, tools, and support to internal supervisors/MHLs to sustain implementation of the intervention.
10. Be creative and flexible when identifying trainers that have both the clinical experience and availability to be trainers.

Lessons learned about implementation and sustainment

11. Continue to improve the training, resources, and supports iteratively.
12. Plan for sustained uptake from the outset.

Next Steps

Drawing Connections

For students who require additional services due to anxiety, OCD, depression, post-traumatic stress, or misbehaviour, a newly developed intervention—FIRST—offers a promising supplement to BRISC. US and Ontario developers are interested in exploring how to sequence the two interventions (BRISC and FIRST) for optimal effectiveness.

Considering Booster Sessions

To help maintain engagement, keep momentum, and adjust to evolving needs, SMH-ON is considering the development of brief BRISC booster sessions. Topics include:

- Booster for supervisors
- Booster on how to offer BRISC in a virtual context

Developing Online Training

The BRISC development team at the University of Washington is developing online/virtual training. This training will be piloted in the US during the 2020-21 school year.

Implementing this online training in Ontario could:

- Increase access to the training
- Reduce time away from work
- Decrease travel expenses
- Condense training time from a day and a half to a very interactive 4-6 hours

Future Research

And finally, as BRISC continues to evolve, the developers and SMH-ON want to learn to what extent training offered in different formats leads to positive outcomes for students?

BRISC in Ontario: A Learning Journey Towards Provincial Scale Up

The *Brief Intervention for School Clinicians* (BRISC) is an efficient and effective School Mental Health (SMH) strategy, tailored to high school students. BRISC offers a Tier 2 intervention that triages mental health needs and engages students through four individually-focussed sessions.

School Mental Health Ontario (SMH-ON) partnered with the developers of BRISC to determine if this approach would meet the mental health needs of Ontario students. SMH-ON aimed to provide Ontario's school-based mental health professionals with a brief, standardized assessment, triage, and initial intervention that works well in schools.

Phases of Development and Quality Improvement

This case study describes how the BRISC intervention was introduced and adapted to Ontario schools through the following five phases:

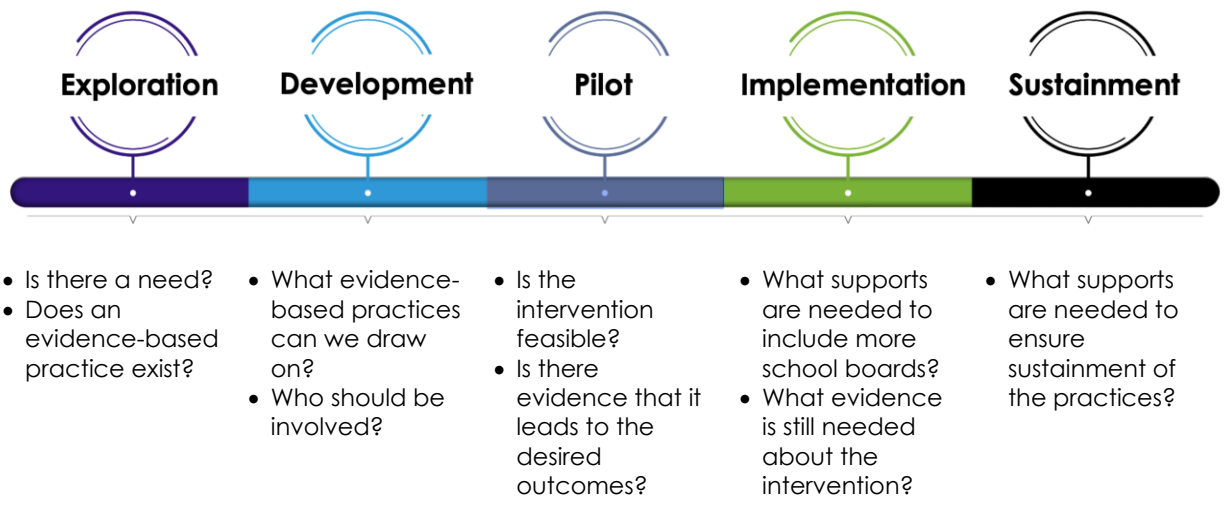

Figure 1: Phases of Development and Quality Improvement

Note: While Figure 1 shows these phases in sequence, in practice, they are iterative.

Phases 1a & 2a: Exploring and Developing the BRISC Approach

The following section highlights the research that guided the exploration (phase 1a) and development (phase 2a) of the BRISC intervention, which was conducted by the University of Washington School Mental Health Assessment, Research, and Training (SMART) Center. (While research has continued to explore how schools can support students' mental health , we do not unpack this further research in this case study, which focusses on the implementation of BRISC in Ontario.)

The Need

Many youth face mental health challenges. Among young people ages 13 through 18, 11% have a mood disorder, 10% have a behaviour disorder, 8% have an anxiety disorder, and 4% experience depression (Pratt & Brody, 2008). Unfortunately, fewer than half of all young people in need receive mental health services; this service gap increases their risk of academic failure, delinquency, and suicide (Bohnenkamp, Stephan, & Bobo, 2015; Green et al., 2013).

Schools are an Ideal Setting to Reach Youth and Support Their Mental Health

Because most youth spend a lot of time in school, school settings offer many advantages for observing, screening, and assessing student emotions and behaviour (McCormick, Thompson, Vander Stoep, & McCauley, 2009; Owens & Murphy, 2004). Schools can also provide accessible and timely mental health services (Kataoka, Stein, Nadeem, & Wong, 2007; Lyon, Ludwig, Vander Stoep, Gudmundsen, & McCauley, 2013).

Barriers To Effective Youth Mental Health Service Delivery in Schools

Although schools are an ideal setting to offer accessible youth mental health services, School Mental Health (SMH) providers often receive minimal training in evidence-based interventions. Barriers to training include practical demands on practitioner time, poorly coordinated resources, and fragmented service systems (Evans & Weist, 2004; Graczyk et al., 2003). While exemplary SMH services identify treatment targets systematically, and focus on skill-building and problem-solving (Lyon, Bruns, et al., 2015), research indicates that "usual care" in schools often fails to incorporate these common factors of evidence-based treatment (Langley et al., 2010). All too often, SMH services are crisis-driven (Langley et al., 2010) and/or provide nondirective emotional support (Lyon et al., 2011). Research has also shown that SMH services rarely use structured processes and standardized tools to monitor progress, which may account for substantial variance in treatment effects (Lyon, Ludwig, et al., 2013; Weist, 1998).

Additional barriers that hinder the adoption and effectiveness of youth mental health service delivery in schools include:

- school calendar adjustments (outings, school events, snow days, etc.)
- student absences from school
- large caseloads for SMH clinicians
- diverse mental health needs among the student population
- limited time and training opportunities for SMH clinicians

For these reasons, school-based clinicians need flexible and adaptive interventions that fit the school context.

Key Learning: Use effective, evidence-based interventions to support youth mental health in school settings.

A Brief Intervention to Meets Students' Mental Health Needs

BRISC was developed to fit the school context, align with the scope of SMH services, and overcome school-based barriers to treatment effectiveness and efficiency (Lyon, Bruns, et al., 2014; Lyon et al., 2015). It is positioned at the "Tier 2" level (early intervention) of the *Multi-tiered System of Support* (MTSS) framework (Barrett, Eber, & Weist, 2013).

Key Learning: Tailor treatment approaches to help school-based clinicians overcome school specific barriers to providing mental health services.

What is BRISC?

BRISC is a manualized approach to providing mental health treatment in schools (Weisz et al., 2016). It incorporates common elements of evidence-based mental health treatment for youth (Chorpita & Daleiden, 2009) and provides a flexible structure with up to four sessions lasting between 30 and 50 minutes. In these sessions, clinicians and students assess, identify, and address difficulties that cause students distress and impact their academic, behavioural/social, and overall functioning. Clinicians deliver empirically supported engagement strategies, use effective skills, and apply systematic outcome monitoring within a problem-solving framework to address identified problem(s).

Key Learning: Focus on common elements of effective, evidence-based approaches mental health treatment to keep school-based interventions brief.

How Does BRISC Work?

During BRISC sessions, clinicians guide students to identify a problem that's important to them, then apply a step-based approach toward solving that problem. BRISC moves clinicians and students away from addressing the "crisis of the week" or overwhelming and unchanging life circumstances. Instead, students learn how to resolve challenges they have control over. Students also identify ways to cope with challenges outside their control. BRISC engages students in the treatment process by helping them effectively address their chosen concern in 3-4 sessions. During the sessions, clinicians assess whether additional treatment, services, or referrals are needed. BRISC pathways are modelled on the "response to intervention" (RTI) framework that is typical in schools. Specifically, BRISC uses empirically-supported, skill-based modules to address barriers to problem-solving that may be associated with specific mental health problems such as anxiety or depression.

Key Learning: Support students to learn to how to tackle one concern at a time.

Phase 1b: Exploring BRISC's Potential in Ontario

Ontario children and youth have mental health needs similar to those that led to the development of BRISC. Recognizing that school environments provide an opportunity to access, identify, and support students in need of mental health services, School Mental Health Ontario (SMH-ON—formerly SMH ASSIST) viewed BRISC as a promising practice to try in Ontario's education system. With this learning stance, SMH-ON partnered with BRISC developers from the University of Washington SMART Center to determine BRISC's fit and feasibility in Ontario schools.

Key Learning: Explore existing promising practices, rather than starting from scratch.

Intentional Planning Towards Scale Up

Figure 2 illustrates the timeline of major events that occurred in Ontario to adopt, implement, and scale up BRISC to all school boards in the province. The following section provides more detail on the exploration phase in Ontario (phase 1b).

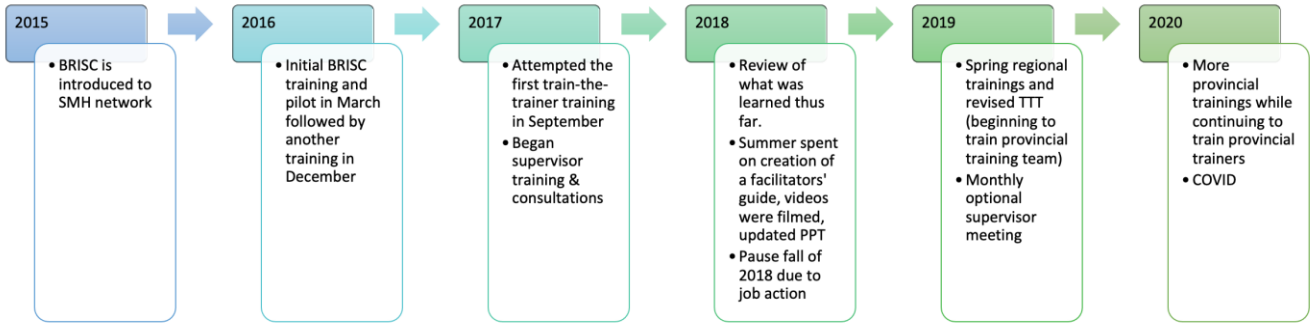

Figure 2: Timeline of major events leading to provincial scale-up of the BRISC intervention.

[Note: Timeline does not include US randomized control trials.]

To determine the level of interest among Ontario school boards in exploring the fit and feasibility of the BRISC intervention, the SMH-ON team introduced the intervention to its network of Mental Health Leads (MHLs) and Superintendents (SOs) during their October 2015 provincial leadership meeting. At the meeting, school board leaders asked if they could train a variety of mental health practitioners, such as child and youth workers, social workers, and psychologists, in the BRISC approach. Because the intervention takes a manualized, step-by-step approach, SMH-ON and the BRISC developers agreed to offer the training to this range of practitioners.

Following the meeting, 12 Ontario school boards participated in a co-learning process with the BRISC developers. This process helped shape the intervention to fit Ontario's diverse context. By engaging in the project, school boards agreed to:

- Register 3 participants for a 2-day training in March 2016.

    - One participant must be the chief social worker, chief psychologist, and/or mental health leader within their board.
    - Two participants must be mental health practitioners who would apply the intervention.
- Try BRISC with fidelity with at least two students by June 2016.
- Track the interventions used in each session and indicate any adaptations made.
- Offer feedback through a phone interview for continuous quality improvement purposes.

These criteria allowed boards to try the intervention on a small scale. While clinicians could try BRISC with as many students as they wanted, they were first asked to try the intervention with fidelity with a few students. Also, training the MHL or clinical supervisor meant clinicians had someone they could turn to internally for support and guidance when trying the intervention.

Key Learning: Consider implementation conditions from the start, such as thoughtfully engaging leadership, no matter the purpose of training.

Research and experience have shown that effective uptake of a new intervention requires more than just training. In addition to training support, the provincial SMH-ON team provided the following essential support in the exploration phase of BRISC:

- Adaptation of the resource for a Canadian audience
- Translation all of training and intervention materials into French
- Provision of free training
- Delivery of a series of post-training consultation calls where developers provided support to clinicians
- Communication with the SMH-ON coaching team to help them support implementation
- Facilitation of a community of practice (CoP) for MHLs/supervisors to share their experiences, ideas and questions.
- Collection of feedback from participants about the training, resources and intervention and worked alongside the BRISC developers to make necessary adjustments.

Key Learning: Provide intentional supports as a strong foundation for uptake.

Phase 2b: Developing and Adapting BRISC in Ontario

The SMH-ON team and BRISC developers worked collaboratively to develop and adapt BRISC for Ontario schools. They collected and analyzed feedback from BRISC-trained clinicians to refine the training format and training materials.

Refining BRISC Training

Originally, the BRISC training was prepared for a pilot research project and delivered to groups of 4 to 6 clinicians. In March 2016, this training was delivered to 40+ people in Ontario. Observations and feedback from participants revealed some areas for improvement. In this section we describe how BRISC training was adapted and improved for use in Ontario.

Engaging participants in larger groups. Because practice is an essential component of clinical training, the original training format had participants practice individual components of BRISC. However, in the larger group training, many participants were not engaged in the practice. Unlike the smaller trainings that had occurred in the US, where trainers participated in practice groups, trainers in the larger group context found it challenging to monitor and encourage participants to practice.

Putting components together. Participants in the larger group training indicated that they were familiar with individual BRISC components, which limited their engagement in practicing them. During the consultation sessions that followed the training, participants reported having difficulty putting all the components together as one session. Subsequently, the training was adapted so that participants would first teach a session in its entirety, then practice doing the whole session in the same amount of time they would typically have in the school setting. This adaptation simulated a real-life in-person session with a youth.

Making participants accountable. Feedback on the training also revealed that learning was enhanced and participants were more engaged when supervisors also actively participated in the practice (rather than leaving the room or using mobile devices during practice time). Eventually, the training evolved to have each group report back on specific aspects of their practice. This adaptation ensured participants were accountable to their peers and added valuable opportunities for the facilitator to provide specific and relevant guidance and feedback to the practice sessions.

Increasing confidence. Trainings were also updated in response to challenges shared by practitioners during their consultation calls with the developers. For example, the training was refined to help practitioners feel more confident applying specific aspects of the intervention (e.g., clarifying a problem, identifying a goal, and coming up with steps).

Demonstrating components through videos. In response to feedback, the developers created videos to demonstrate the implementation of specific BRISC components. These videos provided tangible examples on how to apply certain intervention concepts. These videos also were instrumental in the development of the train-the-trainer model.

Key Learning: Be prepared to make significant changes in response to feedback.

Phase 3: Piloting

To increase long-term uptake of BRISC, the SMH-ON team provided a series of training opportunities for Ontario school board mental health practitioners. In December 2016, SMH-ON offered a second training to the 12 boards that had taken part in the first training. Of those, nine boards chose to increase their BRISC capacity by involving their staff in the second training. The second training incorporated the adaptations made in Phase 2b.

Refining Post-Training Support

In addition to adapting the training, the developers made an important refinement to the post-training support. In the exploration model, weekly small group consultations between trainees and trainers/developers had been effective. However, these consultation calls were not viable when the training was going to be offered more broadly. Consequently, the BRISC developers introduced a peer-to-peer format for post-training support. They provided a half-day training to one front line practitioner per school board ("the lead") on how to support their colleagues with implementing BRISC. The "lead" training included tips, tools, and templates. In addition, the developers held bi-weekly calls with the nine leads to help them troubleshoot challenges as they arose. To be eligible to be a lead, the developers required participants to have delivered BRISC with students. This criterion meant MHLs and/or supervisors could not take on this lead role, as in most cases, they do not have active caseloads.

However, this new model posed new challenges. For instance:

- Some practitioners did not feel comfortable enough with the BRISC intervention to provide support to their colleagues; and,
- In certain circumstances, labour issues bubbled up, as the role of "lead" was perceived as supervisory.

A need for BRISC supervisory training. The pilot revealed the importance of having the board clinical supervisor and/or MHL lead attend the consultation sessions and provide ongoing BRISC consultation within their respective boards. It also exposed a need for specific training geared to BRISC supervisors and re-enforced the need for supervisors to attend and actively participate in BRISC training.

Support through a Community of Practice. To help clinicians implement BRISC effectively, the SMH-ON team organized optional monthly community of practice calls for clinical supervisors and/or MHLs. These communities of practice have a simple design. Each month, supervisors/MHLs join the scheduled meeting if they are available. These meetings are facilitated by a SMH-ON implementation coach and a BRISC trainer. At the beginning of the call, the facilitator asks participants if they have a particular challenge they would like to share. These challenges can either be clinical (e.g., one clinical supervisor encountered a challenge where their staff had difficulty supporting a student in articulating their own goal because the clinicians kept providing answers for the students) or implementation related (e.g., challenges getting buy-in from some team members). Then, the facilitator asks if anyone has encountered

something similar and, if so, what they did. If no one has faced the issue, the facilitator provides guidance. At the end of each meeting, participants are asked if the structure, flow, and content of the community of practice meets their needs and if they have any suggestions for improvements. This process allows participants to ensure meetings stay relevant to their learning needs.

Key Learning: Provide tips, tools, and support to internal supervisors/MHLs to sustain implementation of the intervention.

Aiming for Scale Up: Building Training Capacity

To scale up the BRISC intervention in Ontario, SMH-ON needed to build provincial capacity to deliver training and support implementation. This section describes how SMH-ON helped build that capacity.

Train-the-Trainer Approach. The need to develop training and support capacity prompted the SMH-ON team and BRISC developers to create training for Ontario trainers, called Train-the-Trainer (TTT). The developers considered the following logistical components:

1. Who is eligible for TTT training?
2. What is an optimal training format?

To guide the identification of potential trainers, the BRISC developers suggested that participants must have:

- trained in BRISC
- implemented BRISC successfully with several students
- been in a "lead" peer-to-peer support role (ideally)

First TTT Attempt. In 2017, the SMH-ON team reached out to the nine boards that took part in the December 2016 training and asked if they were interested in taking part in TTT training. Five boards expressed interest. However, boards found it difficult to identify individuals who met the eligibility criteria. Frontline workers who met the criteria did not have the necessary flexibility in their schedule to deliver training in their board. Conversely, supervisors and MHLs were available but did not provide direct service to students.

At the TTT training, the following six individuals represented five boards:

- Two boards sent a front line social worker and indicated they would ensure flexibility in their schedules for them to deliver training within their respective boards.
- A third board sent a child and youth worker (CYW) and her supervisor who would co-facilitate board-level training; one would provide an implementation lens, the other would implement the practice.
- The fourth board sent a CYW.

- The fifth board sent their MHL, who is also their clinical supervisor, as she had the flexibility, clinical knowledge, and credibility to implement BRISC within her board. Although supporting students was not part of her role at the school board, she applied the intervention in her private practice, thus meeting all of the eligibility criteria.

Key Learning: Be creative and flexible to identify trainers that have both the clinical experience and availability to be trainers.

The first TTT training involved a one-day retreat where participants worked in two teams of three and delivered the training to their peers as if they were facilitating in front of a group of clinicians. During this day, participants edited and refined the training slides to suit their needs (for example, simplifying content, adding references to the speaker's notes, and including more images and transition slides).

In September 2017, the two teams of TTT trainees (with expert trainers observing and supporting them) each delivered the full BRISC training to approximately 40 attendees. These trainings, which required a supervisor and/or MHL to be present, increased the number of Ontario school boards with staff partially or fully trained in BRISC to 22.

Learning from initial TTT efforts. The SMH-ON and BRISC developers team learned a great deal about training needs from the first TTT attempt. Below, we describe what was learned about selecting trainers, training materials, and the approach to training.

Potential trainers must be carefully selected. For instance, demonstrating fluency in applying the BRISC intervention is important (Whitaker et al., 2018), but not sufficient to deliver the content with knowledge and credibility. During the September 2017 training sessions, a baseline knowledge gap became evident when audience members asked fundamental clinical questions, which some facilitator-trainees found difficult to answer. In addition, even though trainees had all received the BRISC training and follow-up supports, some were not comfortable delivering the materials as they were presented.

Training materials must be customisable. One trainee highlighted the importance of adding her own stories and examples to the slides to bring the training to life.

The training approach must be comprehensive. All six initial participants indicated that a facilitator's guide would have helped them greatly in preparing to train others. Finally, participants were unanimous in saying that one day to be trained before offering a full training did not allow them to feel prepared and successful in their role as facilitators.

TTT adaptations. In 2018, the developers adapted the initial train-the-trainer training to better fit their scale up and sustainment goals.

Adaptations to eligibility included the following:

- Train-the-trainers must be regulated mental health clinicians
- Train-the-trainers must have previous experience as a facilitator

- Training audience (i.e., recipients of BRISC training) must also be regulated mental health clinicians

Adaptation to training format included:

- Enhanced training materials and resources, including:
  - A detailed train-the-trainer guide for facilitators
  - A redesigned slide deck
  - Various demonstration videos on the implementation of BRISC elements
- A longer and more supportive training process where:
  - Fewer potential trainers trained at once (1 or 2 at a time)
  - First, trainees observe a full training
  - Next, trainees co-facilitate with an expert trainer
  - Finally, trainees offer the training independently and receive feedback from an expert trainer

The adapted TTT training was first offered in early 2019 where the focus was to build a provincial training team. The objective is to have one BRISC trainer per region (n=6) and two French-speaking trainers on the team. To be considered for this team, interested candidates must first complete an application form, which includes an assessment of the clinician's fidelity in delivering BRISC. Of the six clinicians who applied (four English-speaking clinicians and two French-speaking clinicians), all were interesting candidates, however, for personal reasons, the two French-speaking candidates needed to retrack their application.

Phase 4: Implementing BRISC Across Ontario

In early 2019, SMH-ON funded the BRISC developers to offer a TTT training, which incorporated the adaptations described above. At the same time, the BRISC developers and newly-identified potential Ontario trainers (n=4) cohosted a series of training opportunities in each region of the province.

These events incorporated all of the previously learned lessons about training (i.e., added videos and a new supervisor specific training), resources (updated slides, manuals and handouts), and supports (CoPs for supervisors and MHLs). Also, trainings were tailored to meet local needs. For example, in the Thunder Bay area, regulated mental health professionals from community agencies offer mental health supports to students; these local professionals participated in the training to build local capacity.

The province-wide training sessions incorporated an additional modification to the TTT model; specifically, they included a dedicated TTT training day for the provincial trainer recruits. This full-day support allowed the BRISC developers to offer personalized and in-depth guidance regarding the content and delivery of the training. This practice seems very promising; participants said this targeted day was very helpful in bolstering their skills and confidence in delivering BRISC training.

Key Learning: Continue to improve the training, resources, and supports iteratively.

Phase 5: Sustaining BRISC in Practice

Building capacity through training and following up with implementation supports is critical to the uptake of a new intervention; however, more supports are needed for a practice to be maintained over time.

In addition to training, school-based clinicians need ongoing support from peers and clinical supervisors/MHLs to sustain the uptake of any intervention. Ideally, these pivotal stakeholders' roles and capacity are considered and supported from the outset.

While there is still much to learn about supporting sustainment, this case study revealed some efforts that can help supervisors and MHLs to sustain BRISC in practice. For example, setting up clear procedures within existing school structures helped maintain accountability and engagement. Specific actions included:

- providing an online platform to clinicians where forms and notes could be added to students' files
- setting clear expectations that each new student referral starts with BRISC
- offering clear communication to stakeholders (parents, teachers, and school leaders) about what the intervention is and is not
- including BRISC as an ongoing agenda item in clinical meetings

To support each board in their sustainment efforts, SMH-ON provides local implementation coaching and regional or provincial communities of practice where supervisors and MHLs can share their challenges and successes with the BRISC intervention.

Key Learning: Plan for sustained uptake from the outset.

Next Steps

Exploring Connections

For students who require additional services due to anxiety, OCD, depression, post-traumatic stress, or misbehaviour, a newly developed intervention, FIRST, offers a promising supplement to BRISC. US and Ontario developers are interested in exploring how to sequence the two interventions (BRISC and FIRST) for optimal effectiveness.

Considering Booster Sessions

To maintain engagement, keep momentum, and adjust to evolving needs, SMH-ON is considering developing brief BRISC booster sessions on the following topics:

- Booster for supervisors
- Booster on how to offer BRISC in a virtual context

Developing Online Training

The BRISC development team at the University of Washington is developing an online/virtual training option for BRISC. This training consists of an online component followed by a live/virtual practice. It will be piloted in the US during the 2020-21 school year.

As well as being more accessible, offering online training in Ontario has the potential to reduce time away from work and decrease expenses associated with travel. The online training may condense training time from a day and a half to a very interactive 4-6 hours.

Future Research

And finally, as BRISC continues to evolve, the developers and SMH-ON want to learn to what extent does training offered in different formats lead to positive outcomes for students?

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