Implementing a Brief Evidence-Based Tier 2 School Mental Health Intervention: The Enablers and Barriers as Seen through a Clinical Team Supervisor Lens

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ABSTRACT

This paper describes the implementation of BRISC, a brief evidence-based intervention within an implementation framework; specifically, we provide a 5-year retrospective on the successes and remaining gaps of the approach. Interviews were conducted with 13 clinical team leads from diverse school boards in Ontario. Seven themes emerged from our coding: BRISC being seen as an effective and efficient practice, clinicians' attitudes and self-efficacy, promoting system readiness, high-quality training, data-informed decision-making, effective clinical supervision, and communities of practice to create ongoing learning and professional development. These themes highlight the importance of considering different levels and systems in developing an implementation plan.

Keywords: school mental health; intervention; implementation; scale-up

RÉSUMÉ

Le présent article décrit la mise en œuvre de CIBLE, une intervention brève en santé mentale structurée et fondée sur les données probantes. Plus particulièrement, il explore les succès et les défis inhérents à cette approche au cours des cinq dernières années. Treize entrevues ont été menées auprès de superviseurs cliniques issus de divers conseils scolaires en Ontario. Sept thèmes sont ressortis : CIBLE, une pratique efficiente ; attitudes et sens de l'efficacité du personnel clinique ; promotion de la fonctionnalité du système ; formation de haute qualité ; décisions fondées sur les données ; supervision clinique efficace et communautés de pratique pour favoriser l'apprentissage continu et le développement professionnel. Ces thèmes soulignent l'importance de considérer différents niveaux et systèmes dans l'élaboration d'un plan de mise en œuvre.

Mots clés : santé mentale en milieu scolaire ; intervention ; mise en œuvre ; mise à l'échelle

Mental health challenges are prevalent among youth. Among young people aged 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, increasing their risk of academic failure, delinquency, and suicide (Bohnenkamp et al., 2015; Green et al., 2013).

Schools offer many advantages for effective, accessible, and timely mental health services (Kataoka et al., 2007; Lyon et al., 2013). Research shows that school-based usual care typically does not incorporate common factors of evidence-based treatment. All too often, school mental health (SMH) is crisis-driven (Langley et al., 2010) and/or consists of providing nondirective emotional support (Lyon et al., 2011) rather than incorporating systematic identification of treatment targets and focusing on problem-solving and skill-building (Lyon et al., 2015). Research has also shown that structured processes and standardized tools for progress monitoring, which may account for substantial variance in treatment effects, are rarely used in school mental health (Lyon et al., 2013; Weist, 1998).

Considering the many challenges, there is a need for effective interventions that fit the school context (Forman et al., 2013; Lyon, Bruns et al., 2014; Lyon, Ludwig et al., 2014; Owens et al., 2014) and allow school-based providers to efficiently assess students' needs, fully engage students in care, and flexibly tailor the level and type of services provided. The Brief Intervention for School Clinicians (BRISC) was developed

to better fit the school context and overcome barriers to effectiveness, efficiency, and scope of SMH services (Lyon, Bruns et al., 2014; Lyon et al., 2015). BRISC is a four-session, individually focused, assessment, engagement, triage, and brief intervention strategy for high school students. Recognizing that SMH providers are often asked to rapidly assess and provide a first-line intervention with students, BRISC is designed as a place to begin and triage. It's positioned at the Tier 2 early intervention level of the Multi-tiered System of Support (MTSS) framework (Barrett et al., 2013).

BRISC is a manualized protocol that is based on the concept of providing a transdiagnostic approach to mental health treatment (Weisz et al., 2017) that incorporates common elements of evidence-based mental health treatment for youth (Chorpita & Daleiden, 2009). There is not a universally accepted definition of transdiagnostic approaches, but in general, they are approaches that apply common underlying treatment principles across mental health challenges, without adapting the approach for specific diagnoses (McEvoy et al., 2009).

Based on treatment elements shared across effective interventions for internalizing and externalizing problems in adolescents, BRISC provides a flexible structure with up to four sessions (each lasting between 30 and 50 minutes) to assess, engage, identify, and begin to address difficulties that cause distress and impact academic performance, behavioural/social, and overall functioning. Empirically supported engagement strategies, skills, and systematic outcome monitoring are delivered within a problem-solving framework to address the student's identified problem(s). BRISC is delivered by regulated school mental health professionals (i.e., social workers and psychologists).

In BRISC sessions, students are guided to solve at minimum a first step or small problem and clinicians are encouraged to move away from addressing the "crisis of the week" or overwhelming and unchanging circumstances of the student's life. BRISC activates student engagement in the treatment process by helping them to effectively address a specific concern, with a focus on one thing they can impact in 3–4 sessions, while assessing what additional treatment, services, or referrals are needed. BRISC includes empirically supported, skill-based modules (stress and mood management, realistic thinking, and communication) to address barriers to problem solving that may be manifested in specific mental health problems such as anxiety or depression. BRISC was developed in collaboration with school-based clinicians and structured to align with student needs and to be appropriate for the school context (Bruns et al., 2019; Lyon et al., 2015). A recent randomized trial (3 states, 49 schools, 457 students) found that BRISC was viewed as feasible and acceptable and implemented with fidelity (mean 78% to 94% across the four sessions). Students receiving BRISC showed significantly greater SMH treatment engagement (91% vs. 77%), treatment completion (53% vs. 15%), and reductions in problem severity (Bruns et al., in press).

BRISC in Ontario, Canada

School Mental Health Ontario (SMH-ON) is an intermediary organization that provides resources, training, leadership, and supports to all district school boards in Ontario in the development and application of their board's mental health and addictions strategy (Short et al., 2022). In 2015, SMH-ON began to explore whether BRISC would fit their context and meet the needs of both students and school mental health clinicians. The end goals of scalability and sustainment were considered from the outset and informed the

design of the fit and feasibility pilot. Because of the significant diversity across school districts in terms of size, location, and school mental health service capacity, SMH-ON included participants from all areas of the province to ensure regional perspectives were heard. The initial training was limited to 40 participants, so SMH-ON placed limits on the number from any one school board to promote equity in access for all boards. From the outset, the implementation of BRISC in Ontario included a data-informed, measurement-based care framework entailing the use of data at the clinician level through the brief assessment tools integrated in BRISC (such as PHQ9, GAD7, top problems, and stress ratings), as well as efforts for supervisors to monitor clinicians' implementation of BRISC.

SMH-ONs goal was to set up successful implementation conditions locally (Damschroder et al., 2009) and offer ongoing implementation support (Fortier et al., 2017) following the training so that clinicians would feel accountable and supported while trying the intervention with students. Interested boards, hoping to take part in the pilot, were required to agree to a few parameters. These included sending up to three people to the 2-day training seminar; regardless of the size of their clinical team, one of these three trainees needed to be the clinical supervisor and/or mental health leader[1] (MHL) and the remaining two were clinicians. Furthermore, the two participating clinicians from each board were required to commit to trying BRISC with at least two students each by the end of the school year. The purpose of these expectations was to promote implementation readiness through leader engagement related to the intervention; to enhance clinician uptake by facilitating a self-selection process prior to registering for the training, by limiting the number of participants allowed per board, and by requiring a commitment to try BRISC with a set number of students. As such, it was expected that clinicians who registered and took part in the training had a sense of accountability and motivation to try a new approach. There was also a focus on building board-level supervisors'/MHLs' capacity, alongside SMH-ON's coaching model, to offer internal implementation and clinical support and guidance to clinicians, rather than relying on an external consultation model.

Since the first pilot, SMH-ON and the BRISC developers have worked on various post-training implementation supports. In general, these supports align with different constructs and domains in the *Consolidated Framework for Implementation Research (CFIR*; Damschroder et al., 2009); including attention to the inner setting and outer setting, and implementation processes. Initially this support took the form of small group, direct consultation calls between the BRISC developers and front-line clinicians. However, while this model was much appreciated by clinicians, it was not sustainable in terms of costs and human resources needed to support the province's 1,500 regulated school mental health professionals. Thus, to bolster supervisor/MHL implementation support capacity, SMH-ON now offers supplemental training to BRISC supervisors/MHLs. This additional training addresses topics such as structures that support BRISC uptake, key points to support clinicians, expectation management, communication to stakeholders, and tips to lead a community of practice.

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1. MHL is a unique role in the Ontario education system. They are senior mental health clinicians with local responsibility to develop and enact their board's mental health and addictions strategy. A MHL reports directly to the superintendent with responsibility for the mental health portfolio.

In addition, SMH-ON facilitates a supervisor/MHL-focused community of practice (CoP), where attendance is optional. Recognizing that there are a plethora of CoP models and approaches, the intention of this particular CoP was to create a network of co-learning among peers. Co-led by an Ontario BRISC trainer and a SMH-ON implementation coach, the purpose of these CoPs is to develop supervisors'/MHLs' implementation support capabilities by having them come together around a common topic to discuss and troubleshoot with their provincial peers (Wenger et al., 2002). A summary of the BRISC Ontario implementation supports components is provided in Table 1, along with the corresponding CFIR constructs and domains, and connections to best practices.

In the five years since the first BRISC pilot, Ontario has reached the point where virtually all regulated school mental health professionals have been offered BRISC training. This milestone prompted SMH-ON to take stock and to learn about the enablers and barriers of implementing the intervention across the province. The purpose of this article is to reflect on these successes of the supported implementation model from the perspectives of clinical supervisors/MHLs. Specifically, we sought to identify components of the model that worked well, and consider possible extensions or refinements to the model that could improve implementation support moving forward, with attention aimed at a descriptive and content-focused methodology. Although the impact of the Covid-19 pandemic on the implementation of BRISC was not the focus of the study, the interviews were conducted in the context of Covid-19 and this context was reflected in many of the interviews.

Table 1

Components of the BRISC Implementation Support Model

Component	CFIR Construct/Domain(s)	Description	Features/Alignment with recommended practice
Readiness for implementation	Inner setting (Readiness for implementation)/ Leadership engagement Characteristics of individual/ Self-efficacy	Prior to the registration process, participants were provided with clear expectations to school boards, leaders, teams, and clinicians. Clear expectations increase both leader engagement and a sense of accountability.	Increase readiness for implementation through leadership engagement and individual characteristics such as the belief in their own self-efficacy towards achieving the intended goal (Damschroder et al., 2009).
Role specific supplemental training	Inner setting (Readiness for implementation)/ Leadership engagement Characteristics of individual/ self-efficacy	As the intention is to build local capacity towards BRISC uptake, SMH-ON offers a clinical supervisor/MHL–specific training.	Importance of clinical supervision as it relates to clinical and implementation outcomes (Choy-Brown et al., 2022).
Community of Practice (CoP)	Outer setting/ Cosmopolitanism Inner setting/Networks and communication; implementation climate; readiness for implementation Process/Engaging; executing	Provincial level CoP holds an optional monthly meeting for supervisors/MHLs and focuses on BRISC implementation-related challenges and barriers, such as encouraging ongoing use of the intervention with fidelity and clinical-specific questions. Individual boards are also encouraged to develop a CoP with their clinical staff to promote ongoing engagement and collegial support between colleagues. These CoPs vary in structure and function according to local context and capacity.	Cross learning among professionals from multiple jurisdictions (Wenger et al., 2002).
SMH-ON implementation coaching	Outer setting/ Cosmopolitanism Process/planning; engaging	SMH-ON provides implementation support to all publicly funded school boards in the province. Regional coaches are available to provide locally relevant implementation-related guidance.	Targeted implementation coaching support, builds provincial coordination, leverages knowledge, and facilitates resource-sharing between boards (Fortier et al., 2016).
Rapid feedback loops	Process/planning; engaging; reflecting and evaluating	Frequent communication opportunities are established to adjust quickly to meet the implementation needs of the field.	An implementation process includes the opportunity to reflect upon the progress and quality of the implementation efforts, which allows for adjustments (Damschroder et al., 2009).

Table 2

Characteristics of Participating School Boards

Interview No.	School Board	Language	Rural/Urban	# of Schools	# of Students
1	Public	English	Rural	<50	5,000–15,000
2	Public	English	Rural	<50	5,000–15,000
3	Public	French	Urban	<50	15,000–50,000
4	Catholic	English	Urban	>100	50,000+
5	Public	English	Rural	50–100	15,000–50,000
6	Public	English	Urban	<50	5,000–15,000
7	Catholic	English	Rural	<50	<5000
8	Catholic	English	Rural	50–100	15,000–50,000
9	Public	English	Urban	50–100	15,000–50,000
10	Catholic	English	Rural	<50	<5000
11	Catholic	English	Rural	<50	5,000–15,000
12	Catholic	French	Urban	50–100	5,000–15,000

METHODS

Participants

All Ontario school boards using BRISC (i.e., $n = 64$ of 72 possible boards) were considered for inclusion. To ensure representation across Ontario, English-speaking boards were divided into six regions. Within each region, one Catholic[2] and one public board were picked at random to participate. Similarly, one Catholic and one public board were selected at random from all French-speaking boards. Because four boards initially declined, we invited another four to meet our target sample. A total of 18 boards were invited to participate with 14 boards confirming participation prior to the cut-off date. Two boards consented to participate but were subsequently not able to schedule interviews because of end-of-year commitments, leaving a final sample of 12 school boards *(n = 12)*. The participating school boards represented a diverse sample with respect to location, size, English/French, and public/Catholic, as shown in Table 2.

The participants in this study included 13 clinicians responsible for supervising the use of BRISC in their respective school boards (in one school board, two representatives were interviewed together at the original invited participant's request). All participants were registered mental health professionals in Ontario, and all identified as female. One of the participants was a School Mental Health Lead, three were clinical supervisors, and nine were both Mental Health Leads *and* Clinical Supervisors. Of the 13 participants, four were provincial SMH-ON BRISC trainers. Participants were required to have a minimum of 8 months' experience in their respective role(s) to be eligible for this study. Participant experience ranged from 2–9 years, with an average of approximately 6 years.

2. In Ontario, there are parallel, government-funded public and Catholic school boards across the province.

Procedure

Interviews were conducted online via Zoom (Version 5.6.6 [950]) and lasted approximately 30 minutes. Interviewers used an interview guide that was provided in advance of the interview while allowing for flexibility in the direction of the discussion (see Appendix A). All interviews were recorded and transcribed verbatim using Trint (Version 2021.32.97042), a cloud-based automated transcription service. The French interviews were conducted by one of the bilingual authors of this study (MH). The interviews were transcribed in French and then translated by the interviewer so that she could attend to context.

All research procedures were approved by the university Non-Medical Research Ethics Board.

Data Analysis

Data analysis was an exploratory and iterative process. Several implementation frameworks were considered to support data analysis including the *CFIR* (Damschroder et al., 2009) and the *School Implementation Strategies, Translating ERIC Resources (SISTER)* framework (Cook et al., 2019). Through iterative preliminary coding and group consultation, it was determined that the proposed frameworks did not encapsulate the nuance evident in the transcripts. The team opted to take a more inductive approach to thematic analysis, following the guidelines of Braun and Clarke (2012). Each transcript was coded by two researchers using Dedoose (Version 9.0), an online application providing mixed-methods analytic software. After the initial inductive coding had been completed, the analysis team discussed and resolved coding discrepancies and revised the coding scheme. The transcripts were then coded a second time by two other researchers, and discrepancies were again resolved by consensus. Throughout the coding process, notable and key concepts were flagged and discussed by the analysis team. Subsequently, key concepts regarding successes, challenges, and recommendations for improving the use of BRISC within school boards were modified and reviewed by a larger team of researchers of ISU Lab, leading to the formation of six themes. Over the course of multiple rounds of coding, the researchers concurred that new concepts and themes were not being introduced by latter interviews (i.e., saturation was achieved). The reporting of our results was guided by attention to the consolidated criteria for reporting qualitative research (COREQ; Tong et al., 2007).

Positionality

Consistent with COREQ reporting standards (Tong et al., 2007), we are providing descriptive information about our research team and our pre-existing relationships relevant to this project. Interviews were conducted by four of the authors (RG, MH, EC, CC) who were graduate students and/or research coordinators at the time of the study. The interviewers held undergraduate and MA degrees and were provided with training and supervision by two of the senior authors (CVC and AF) who hold doctorate degrees. All of the interviewers identify as female.

The second and last authors had pre-existing relationships with the interviewees, and thus remained arm's length from the interviewing and data coding processes. They were involved with the interpretation of the results, at which point their understanding of the broader context and history of the BRISC initiative were invaluable. In this way, we sought to find a balance between countering our own biases (for those who had longstanding involvement with the project) and benefiting from that expertise and relationship history.

Furthermore, the first six authors are members of the School Mental Health Ontario Innovation and Scale-Up Lab (Short, 2022), and attend regular meetings where issues of implementation and scale-up are discussed across multiple projects. As a result, all of the authors are predisposed to believe in the importance of attending to implementation processes in achieving effective and sustained school mental health practices.

RESULTS

Seven themes emerged from our coding as important factors for successful implementation of BRISC: *BRISC being seen as an effective and efficient practice, clinicians' attitudes and self-efficacy, promoting system readiness, high-quality training, data-informed decision-making, effective clinical supervision, and communities of practice to create ongoing learning and professional development.* Although we moved away from using the *CFIR* categories as predetermined codes in our data analysis process, we return to the *CFIR* categories now as they remain a useful way to organize our findings. Below we discuss the themes, link them to *CFIR* domains and constructs (Damschroder et al., 2009), and provide exemplar quotes. We begin with the intervention characteristics and characteristics of individuals domains, before moving outward to themes addressing specific implementation strategies and challenges (which align with implementation processes, inner settings, and outer settings in the *CFIR* model; Damschroder et al., 2009). We include examples of the constructs that were provided as success strategies, as well as instances where supervisors described a struggle or recommendation to improve practice in a particular area.

Intervention Characteristics: BRISC Viewed as an Effective and Efficient Practice

The perception that BRISC was viewed by clinicians as an effective and efficient practice was highlighted as important. Supervisors were clear that without BRISC presenting a clear value-add for clinicians, ongoing implementation would pose a struggle. For example, numerous supervisors noted that the clinicians appreciated the structure of the program.

> They like the short, structured approach. They like that it's client driven and not system driven. So, you're basing it on what students want, which naturally will lead to better engagement. They love anything that's kind of manualized and canned for them because they're so busy, right? It's just nice too, something that keeps you focused. (Interview 10).

Beyond the structure provided by BRISC, many supervisors noted the effectiveness of it, and how clinicians seeing their students succeed provided inherent motivation to keep using the approach: "We've seen great student success with it, especially the tier two kids, and it empowers the students to handle the problems as they arise" (Interview 11).

Another supervisor noted that in addition to being effective and efficient, BRISC contributes to seamless referral to community partners, in that youth are more ready to engage with services when referred.

> I think the other strength is it's efficient. It's easy to track. The buy-in with the youth is greater. We get comments from our partners, our community partners, that the kids are more treatment ready when they get…if we're referring them for longer-term service. (Interview 2).

The other way that supervisors discussed the efficiency of BRISC was to contrast it with previous approaches to care, noting that BRISC was experienced as an improvement by clinicians who were disheartened by seeing repeat clients who were not making progress.

> And now [clinicians are] getting referred the same kids again that they spent 16 sessions with last year. So, this year, their attitude changed a little bit too, because last year they spent a long time, and a lot of effort, and 16 sessions trying to do work with this one particular student. And now this year, the student's back for the exact same thing. So, their take on it is a little bit different in that, okay, no, we're going to do the four to six session brief work here, because we need to promote…that resilience and coping, and that they can make it without me, and that I don't need to see them every two weeks for ten months, like they're going to be okay. (Interview 1)

A couple of supervisors spoke of challenges encountered by clinicians in that they felt BRISC did not match the complexity and severity of issues faced by youth on their caseloads. However, this theme of BRISC being perceived as effective was evident across interviews.

Intervention Characteristics (Relative Advantage): Data-Informed Decision-Making

The other intervention characteristic that participants highlighted was the data-informed decision-making component; interestingly, the interview questions did not ask about this specifically because it is not considered part of the implementation supports, yet this characteristic emerged organically across interviews. Participants talked about both measurement-based care and supervisor monitoring practices as part of the data-informed decision-making theme. Although school mental health in Ontario has historically not had a tradition of measurement-based care, supervisors identified the measurement practices as instrumental to supporting implementation of the model. These included using data at the clinician level (i.e., measurement-based care) as well as brief assessment tools, and to help monitor clinicians' implementation of BRISC. One supervisor noted that the measurement-based care practices allowed clinicians to zero in on significant concerns quickly and was more efficient that previous assessment approaches:

> They really like using the rating scales, especially for an initial assessment. They are finding that it actually prompts the conversation about thoughts of suicide. So, they're able to flag students quite quickly and do some crisis intervention if needed. And they're also used to monitor, so they do re-rate them again later. So, it gives them some idea of progress. They really like doing the problem list to be able to get a good picture of what the student perceives as their issues that they're coming with. Because one of the things we had struggled with when the social workers came on, was they were so used to doing comprehensive family assessments and taking in massive amounts of information and then formulating a clinical impression through this. So, this is a change of practice to say, OK, you're not going to need to gather all of that information, but you're still going to get the student's perception of what they're coming with that is important to them. (Interview 6)

Supervisors noted that the utilization of measurement-based care allowed them to better monitor implementation fidelity and quality (although not all supervisors were monitoring implementation). They monitored BRISC through supervision, but also more formally through reviewing clinicians' databases and charts. In some cases, BRISC had been integrated into software tools used to track clinicians' activities. In some boards, supervisors had the ability to review progress notes and could look at what approaches were being used, and whether the specific assessments (i.e., PHQ-9 and GAD-7) were being collected routinely.

Success with measurement-based care was not universal, and challenges arose; however, the overall success with measurement-based care is noteworthy because it is so new to the Ontario context and requires clinicians to work in a different way than that to which they are accustomed. One supervisor noted that embedding the measurement-based care components into their database had helped make the transition smoother for clinicians:

> Yeah, [the assessments] are definitely helpful. Our staff like them. They're embedded in our system, like our database. They're actually in there. So, you just plug in the numbers, and it scores it for you. It's awesome. But, they like them as measurement-based care, that's something that we haven't really done well. So, it's good to have. (Interview 10)

Characteristics of Individuals: Clinicians' Attitudes and Self-Efficacy

Related to intervention characteristics, clinicians' attitudes and self-efficacy played a role in successful implementation. Supervisors noted that in many cases clinicians who were earlier in their careers were more open to implementing BRISC, because it gave them a clear toolkit, which lead to increased self-efficacy. Self-efficacy, in turn, has been shown to predict quality of practice, knowledge of evidence-based practices, and use of evidence-based practices (Schiele et al., 2014). The observation that professionals earlier in their career were more open to using BRISC is consistent with previous findings that early-career professionals exhibit more favourable perceptions towards implementing evidence-base practices (Stadnick, 2018).

> In fact, because I have a young staff who have, this would be their first experience in providing clinical services, they're fairly new out of school. They really like how scripted out it is and that it helps them to contain the session because we have very limited time between bells and that kind of thing. And it helps them continue to move forward in a direction and see outcomes when they're there. So, it has been really good for keeping them organized in their session pace when they wouldn't have had previous experience, say, in a clinical setting doing that. (Interview 7)

However, while 60% of participants noted that newer practitioners were more appreciative of the model compared to experienced clinicians (who tended to be more resistant), two supervisors noted that even experienced clinicians appreciated new ideas and ways of working with youth:

> I think that was a breath of fresh air for some of them to try a new way of going at it, the team that I hired are very experienced … Sometimes you get that excitement as a clinician that's been doing it for a long time, something fresh, something new. (Interview 2)

Implementation Processes – Planning: The Importance of High-Quality Training

Consistent with other research that has identified important strategies for the implementation of school mental health approaches (Cook et al., 2019), the quality of the BRISC training was identified as an important foundation for implementation success. Interestingly, supervisors expressed high levels of satisfaction when the training moved to virtual because of the pandemic, even though their expectations were low:

> The BRISC virtual shift. I didn't think it would go very well. But I was surprised. The breakout rooms probably were our saving grace…I talked to my staff that were trained face-to-face. I've talked to my staff that have been trained virtually. And the social workers that were trained virtually were pretty positive. They said, you know what, we were dreading it, but the breakout rooms were so good. And when we got to meet other people and colleagues from across the province, and they were quite excited about the training, thought it was quite effective. (Interview 2)

Although the quality of training was identified as a foundation of implementation success, there were several challenges that had to do with access. Some supervisors noted that their inability to have their whole team trained at once undermined their implementation in that clinicians were not at the same stage of implementation:

> I would have preferred training my team as a group. And then looping those consultations, feedback loops, the fidelity model as a team instead. I had two people in August and then three people in January and then two people virtually, and it was spread over a good year and a half. So, I wanted to bring the whole team along. But the whole team hadn't received training. (Interview 5)

Conversely, one supervisor appreciated the intermittent training opportunities, as they felt it enabled them to get new staff trained quickly when they started at the board.

One specific challenge with training not being readily available on demand, was that in one case the supervisor was trained significantly after their clinicians, and there was already considerable inertia because the clinicians were not implementing the program:

> It's tricky because I can enforce BRISC with my high school social workers, and it's been a bit of a challenge because I was trained after the fact, so by the time I was trained in BRISC, they had been trained and not using it for a year and a half. (Interview 1)

Supervisors also offered several recommendations related to training. Some of these related to accessibility (e.g., more frequent training cycles, ensuring that training marketed as bilingual is truly bilingual). Other recommendations focused on content, such as including more complex examples in training, and clarity about for whom BRISC is intended. Interestingly, several of the items requested in BRISC training are already part of the current training, suggesting that perhaps these concepts need to be re-visited once clinicians have some experience with the intervention, potentially through a Community of Practice.

Approximately 70% of the supervisors voiced a desire for refresher or booster training (for both clinicians and supervisors):

> I feel like there should be refreshers. Like, I feel like we did a refresher one time when the pandemic started and my staff, who had been trained like two years ago, were like that was so nice. Right! I think it helps to bring the excitement back, because I think there are so many things being thrown at them that, and this is such a good intervention in my mind and the tool, that we need to continually remind them. So, I don't know what that looks like, but even just like a one-hour refresher of like, don't forget this is BRISC. And even as the trainers, here are some takeaways we've learned. (Interview 9)

Another supervisor noted that booster sessions could contribute to ongoing fidelity, by preventing clinicians from straying from the model: "I think booster sessions would be really helpful. Um, like I said, they're really good at going off track" (Interview 10).

Inner Setting – Readiness for Implementation: Promoting System Readiness

Supervisors identified several factors that they felt promoted readiness at the system, supervisor, and clinician levels that align with existing literature (Damschroder et al., 2009). At the system level, supervisors spoke of the importance of ensuring administrators have a solid understanding of BRISC and will support it. "I think the other thing that might have impacted our implementation process is system readiness. And by that, I mean like the leadership teams having a good understanding of a short-term model" (Interview 5).

At the supervisory level, participants identified supervisor buy-in and experience as critical. Specifically, some supervisors identified the importance of being a BRISC trainer: "I'm actually a BRISC trainer… So, I feel like I have a good handle on it, which is helpful" (Interview 10). Supervisors who were not BRISC trainers also identified the importance of being experienced and competent with the model: "And the other thing about me is I don't like bringing a model to my staff if I haven't tried it first. So, I took on a small caseload" (Interview 2).

In addition to leadership characteristics, systems-level readiness was also impacted by the characteristics of individuals delivering the program. Clinician readiness was enhanced by having clearly articulated expectations prior to the training. Clinicians were expected to commit to trying the model with a predetermined number of students as a condition of attending the training. This clear and concrete commitment helped clinicians persevere during the learning phase of the implementation.

> I think just being patient and not giving up right away on it…Like even for myself…I remember when I first got trained, I was kind of a doubter. So, you actually have to apply the model and try it numerous times. And you have to stick to the fidelity of it. For sure. So, I think you have to make sure there is the commitment to try it and properly implement it. […] I would suggest that there is a commitment from school boards to do that because it is a big change in practice for a lot of us. (Interview 10)

Inner Setting – Implementation Climate: Effective Clinical Supervision

Supervisors emphasized the benefits of offering a combination of individual and group supervision, noting that they offered different benefits. Individual supervision provided clinicians with the opportunity to focus more on individual students' needs. "My staff call me, like sometimes they'll call me after a session and they'll be like, I don't know where to go from here…So, it really is mostly through one-to-one supervision" (Interview 9).

A further advantage of individual supervision is the ability to address clinician resistance or lack of fidelity to the model.

> So, when I do my individual supervision meetings, there are some for whom I see a good use of BRISC then there are others that I don't see that. Then I start the conversation by saying I notice that you don't use the BRISC approach very much. Is there a reason why you don't? (Interview 3)

Clinicians noted that group supervision facilitated peer-to-peer learning. In some cases, peer supervision took place with the context of Communities of Practice.

Inner Setting/Outer Setting – Implementation Climate: Communities of Practice to Create Ongoing Learning

Participants almost universally identified Communities of Practice (CoP) as a key component of a successful implementation plan. Across interviews, participants from 11 of the 12 boards discussed CoPs, and 10 of those 11 were using CoPs (while the 11th intended to start one in the future). BRISC CoPs occurred at both the individual board level (inner setting) and at the supervisor level (outer setting; facilitated by SMH-ON).

At the individual board level, supervisors described different levels of formality with their CoPs, including a more informal coming together to support each other, which was enabled in part by working remotely during the pandemic:

> We have started working more informally right now, we haven't really called it a community of practice or called it anything, but, just because the virtue of us all being at home, we're kind of communicating a little bit more, bringing them together as opposed to…I still do the individual [supervision], but it's just informally happening because we're all at home. (Interview 6)

At the other end of the spectrum, a supervisor described a CoP that was undertaken in conjunction with another board, with additional funds from the region. Finally, another supervisor described a combination of formal and informal structure that supported the implementation of BRISC and created a sense of community:

> I think they do lean on each other a fair bit. It's a very tight knit group. Obviously, they've [been] through this path together. So, they're a very connected team. And so, they do bounce off each other. So, there's a lot of the community of practice that does go on among the staff. Some of it's informal, some of it we do formally. So, I do think it's a very good model. (Interview 2)

Overall, CoPs were seen to promote consistency across clinicians and provide an important source of support for them as they implemented BRISC. They offered a consultation and coaching function that has been identified as a priority in supporting implementation efforts (Fortier et al., 2016; Lyon et al., 2019; Stirman et al., 2010). Several participants noted that maintaining CoPs had been particularly challenging in the face of pandemic-related disruptions.

The supervisor CoP helped supervisors deepen their understanding of the intervention, which in turn increased their ability to support others:

> I started attending the School Mental Health Ontario community of practices which have been extremely helpful for just growing my thinking in terms of the support that might be required in the board and to the social workers, you know, that it's way more than, "here you go. You've been trained." You know, there's just so much after that to say…even when they say I'm using BRISC well, it's still a larger conversation behind just them using it. (Interview 6)

The importance of peer-to-peer learning and sharing ideas across boards was identified as a success of the supervisor CoP:

> I think that the advantage that I have is having that provincial eye. Like as a trainer, you know, when you hear what everybody is doing across the province, I'm a robber, too. I rob their ideas, you know, as a community practice. So, you know, I have the advantage of hearing all the best ideas across the province. (Interview 2)

DISCUSSION

The purpose of this study was to learn from clinical supervisors and MHLs about their BRISC implementation experience over the past five years to determine (1) if the intentional implementation process helped facilitate the adoption of the intervention, and (2) if there were recommendations that would enhance its ongoing uptake. The three-pronged approach of promoting favourable pre-training conditions, offering high-quality training of an effective practice, and implementing post-training supports, was largely described by respondents as being helpful for both motivating their teams to try BRISC and supporting its ongoing use. However, even with these favourable implementation structures, respondents indicated that the global pandemic disrupted their "business as usual" school mental health practice and several found that maintaining a local CoP or participating in the provincial one was difficult. Furthermore, some of the implementation supports that were available (notably implementation coaching from regional coaches) were not identified

among interviewees, suggesting that the uptake and effectiveness of these supports might require further tailoring. Participants also highlighted their challenges in accessing timely training for all team members, which hindered their scaling-up efforts in some cases.

Participants offered several recommendations to help overcome barriers associated with maintaining the ongoing use of BRISC. Some of these recommendations constituted incremental improvements in processes already in place (e.g., more timely access to the initial training). Other recommendations were more substantive, such as introducing a provincially led CoP for front-line clinicians or a conference-type, peer-to-peer learning event where clinicians can share their success stories and learn from others across the province.

While some suggestions have yet to be piloted, or may not be feasible, others have already been put into practice; since BRISC was first introduced in Ontario, many additional learning opportunities have been created (Fortier et al., 2021). For example, a train-the-trainer model was developed, which provided SMH-ON the autonomy to offer more training sessions; enhanced supervisor training and supports were offered to help them in their role; and increased use of/comfort with virtual platforms as a side-effect of the Covid-19 pandemic, which allowed SMH-ON to reach more people across the province and offer synchronous online training and booster sessions. It will be important to continue collecting data on the feasibility and impact of these expanded implementation supports to ensure they are meeting the needs of clinicians.

Limitations

The results of this study are limited with respect to generalizability in that we utilized supervisors' voices only, and the process was done at the end of a challenging disruption-filled academic year. In addition, although the Covid-19 pandemic was not a focus of the study, it was the backdrop against which the interviews were conducted and likely influenced participants' responses. Many pandemic-related disruptions and adaptations were described by participants, but we were not able to include these within this article. Finally, the interviews were conducted late in the school year, which might have influenced supervisors' ability to participate.

Implications for Evidence-Based, Implementation-Sensitive Approaches to School Mental Health

Overall, the results of this study highlight the importance of thinking about implementation through an ecological model, or as Damschroder et al. (2009) indicate, accounting for the intervention characteristics, individual clinical characteristics, implementation processes, inner setting and outer setting. Having an ongoing, responsive, multi-level approach towards uptake was viewed positively by clinical supervisors in the current study. Providing province-wide supports, through an intermediary organization such as SMH-ON that proactively develops implementation supports from the outset to help promote the widespread adoption of an evidence-based brief structured psychotherapy approach, helped school boards to move beyond a "train and hope" approach. Furthermore, tailoring implementation planning and supports at a local level can help account for contextual factors such as size of the team, years of experience, or access to additional community-based mental health services. It also facilitates nimble adjustment to unforeseen situations, such as labour unrest, environmental/political events, or a pandemic. Having a range of supports was important, in

that different boards relied more heavily on different implementation support strategies. Finally, to facilitate implementation at the individual clinician level, it is important to have frequent communication opportunities across each implementation level to ensure the identification of barriers and enablers experienced by the field so that appropriate adjustment can be made to the implementation plan.

APPENDIX

INTERVIEW QUESTIONS

Descriptive Questions

1. What is your region?

2. What is your role?

3. How long have you worked in your current position?

4. What is your most advanced degree (discipline)?

5. Are you registered with your professional college?

6. When were you trained in BRISC?

7. Roughly what percentage of your staff is trained in BRISC?

8. What is the professional background of your BRISC trained staff (e.g., social work, psychology, other)?

Questions about Implementation of BRISC

1. In your role as a supervisor/mental health leader, what are the positive comments and complaints you are hearing from your team about BRISC?

2. What are the unique successes/challenges of implementing BRISC in your board?

3. Are you monitoring the use of BRISC? If so, how?

4. What kind of supports/supervisions are you providing to your team re BRISC (such as a community of practice, supervisory meeting, peer consultation, etc.)?

5. What additional supports are needed to ensure BRISC continues to be implemented with high quality in your board?

REFERENCES

Barrett, S., Eber, L., & Weist, M. (2013). Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support. http://www.pbis.org/common/pbisresources/publications/Final-Monograph.pdf

Bohnenkamp, J. H., Stephan, S. H., & Bobo, N. (2015). Supporting student mental health: The role of the school nurse in coordinated school mental health care. *Psychology in the Schools*, *52*(7), 714–727. https://doi.org/10.1002/pits.21851

Braun, V., & Clarke, V. (2012). Thematic analysis. In H. Cooper, P. M. Camic, D. L. Long, A. T. Panter, D. Rindskopf, & K. J. Sher (Eds.), (pp. 57–71). American Psychological Association. https://doi.org/10.1037/13620-004

Bruns, E. J., Lee, K., Davis, C., Pullman, M. D., Ludwig, K., Sander, M., Holm-Hansen, C., Hoover, S., and McCauley, E. M. (2022). Effectiveness of a brief engagement, problem-solving, and triage strategy for high school. In press.

Bruns, E. J., Pullmann, M. D., Nicodimos, S., Lyon, A. R., Ludwig, K., Namkung, N., & McCauley, E. (2019). Pilot test of an engagement, triage, and brief intervention strategy for school mental health. *School Mental Health*, *11*(1), 148–162. https://doi.org/10.1007/s12310-018-9277-0

Chorpita, B. F., & Daleiden, E. L. (2009). Mapping evidence-based treatments for children and adolescents: Application of the distillation and matching model to 615 treatments from 322 randomized trials. *Journal of Consulting and Clinical Psychology, 77*(3), 566–579. https://doi.org/10.1037/a0014565

Choy-Brown, M., Baslock, D., Cable, C., Marsalis, S., & Williams, N. J. (2022). In search of the common elements of clinical supervision: A systematic review. *Administration and Policy in Mental Health and Mental Health Services Research*. https://doi.org/10.1007/s10488-022-01188-0

Cook, C. R., Lyon, A. R., Locke, J., Waltz, T., & Powell, B. J. (2019). Adapting a compilation of implementation strategies to advance school-based implementation research and practice. *Prevention Science*, *20*(6), 914–935. https://doi.org/10.1007/s11121-019-01017-1

Damschroder, L. J., Aron, D. C., Keith, R. E., Kirsh, S. R., Alexander, J. A., & Lowery, J. C. (2009). Fostering implementation of health services research findings into practice: A consolidated framework for advancing implementation science. *Implementation Science*, *4*(1). 1–15. https://doi.org/10.1186/1748-5908-4-50

Forman, S. G., Shapiro, E. S., Codding, R. S., Gonzales, J. E., Reddy, L. A., Rosenfield, S. A., Sanetti, L. M. H., & Stoiber, K. C. (2013). Implementation science and school psychology. *School Psychology Quarterly, 28*(2), 77–100. https://doi.org/10.1037/spq0000019

Fortier, A., Lalonde, G., Venesoen, P., Legwegoh, A. F., & Short, K. H. (2017). Educator mental health literacy to scale: From theory to practice. *Advances in School Mental Health Promotion*, *10*(1), 65–84. https://doi.org/10.1080/1754730X.2016.1252276

Fortier, A., Short, K., McCauley, E., Ludwig, K., Bruns, E., & Lyon, A. (2021). *Development and research case study: Brief Intervention for School Clinicians (BRISC)*. Centre for School Mental Health, Western University. https://www.csmh.uwo.ca/docs/publications/isulabpublications/brief-intervention-for-school-clinicians-brisc-development-and-research-case-study-2021.pdf

Green, J. G., McLaughlin, K. A., Alegría, M., Costello, E. J., Gruber, M. J., Hoagwood, K., Leaf, P. J., Olin, S., Sampson, N. A., & Kessler, R. C. (2013). School mental health resources and adolescent mental health service use. *Journal of the American Academy of Child & Adolescent Psychiatry*, *52*(5), 501–510. https://doi.org/10.1016/j.jaac.2013.03.002

Kataoka, S., Stein, B. D., Nadeem, E., & Wong, M. (2007). Who gets care? Mental health service use following a school-based suicide prevention program. *Journal of the American Academy of Child & Adolescent Psychiatry*, *46*(10), 1341–1348. https://doi.org/10.1097/chi.0b013e31813761fd

Langley, A., Nadeem, E., Kataoka, S., Stein, B., & Jaycox, L. (2010). Evidence-based mental health programs in schools: Barriers and facilitators of successful implementation. *School Mental Health, 2*(3), 105–113. doi:10.1007/s12310-010-9038-1

Lyon, A. R., Bruns, E. J., Ludwig, K., Vander Stoep, A., Pullmann, M. D., Dorsey, S., Eaton, J., Hendrix, E., & McCauley, E. (2015). The Brief Intervention for School Clinicians (BRISC): A mixed-methods evaluation of feasibility, acceptability, and contextual appropriateness. *School Mental Health*, *7*(4), 273–286. https://doi.org/10.1007/s12310-015-9153-0

Lyon, A. R., Bruns, E. J., Weathers, E. S., Canavas, N., Ludwig, K., Vander Stoep, A., Cheney, D., & McCauley, E. (2014). Taking evidence-based practices to school: Using expert opinion to develop a brief, evidence-informed school-based mental health intervention. *Advances in School Mental Health Promotion, 7*(1), 42–61. https://doi.org/10.1080/1754730X.2013.857903

Lyon, A. R., Cook, C. R., Locke, J., Davis, C., Powell, B. J., & Waltz, T. J. (2019). Importance and feasibility of an adapted set of implementation strategies in schools. *Journal of School Psychology*, *76*, 66–77. https://doi.org/10.1016/j.jsp.2019.07.014

Lyon, A., Frazier, S., Mehta, T., Atkins, M., & Weisbach, J. (2011). Easier said than done: Intervention sustainability in an urban after-school program. *Administration and Policy in Mental Health and Mental Health Services Research, 38*(6), 504–517. doi: 10.1007/s10488-011-0339-y

Lyon, A. R., Ludwig, K., Romano, E., Koltracht, J., Vander Stoep, A., & McCauley, E. (2014). Using modular psychotherapy in school mental health: Provider perspectives on intervention-setting fit. *Journal of Clinical Child & Adolescent Psychology, 43*(6), 890–901. https://doi.org/10.1080/15374416.2013.843460

Lyon, A. R., Ludwig, K. A., Vander Stoep, A., Gudmundsen, G., & McCauley, E. (2013). Patterns and predictors of mental healthcare utilization in schools and other service sectors among adolescents at risk for depression. *School Mental Health, 5*(3), 155–165. doi: 10.1007/s12310-012-9097-6

McEvoy, P. M., Nathan, P., & Norton, P. J. (2009). Efficacy of transdiagnostic treatments: A review of published outcome studies and future research directions. *Journal of Cognitive Psychotherapy, 23*(1), 20–33. https://doi.org/10.1891/0889-8391.23.1.20

Owens, J. S., Lyon, A. R., Brandt, N. E., Warner, C. M., Nadeem, E., Spiel, C., & Wagner, M. (2014). Implementation science in school mental health: Key constructs in a developing research agenda. *School Mental Health, 6*(2), 99–111. doi: 10.1007/s12310-013-9115-3

Pratt, L. A., & Brody, D. J. (2008). *Depression in the United States household population, 2005-2006.* National Center for Health Statistics (U.S.). https://stacks.cdc.gov/view/cdc/5317

Schiele, B. E., Weist, M. D., Youngstrom, E. A., Stephan, S. H., & Lever, N. A. (2014). Counseling self-efficacy, quality of services and knowledge of evidence-based practices in school mental health. *Professional Counselor*, *4*(5), 467–480.

Short, K., Bullock, H., Crooks, C. V., & Georgiades, K. (2022). *Using implementation science to optimize school mental health during the Covid-19 pandemic.* [in press]

Stadnick, N. A., Lau, A. S., Barnett, M., Regan, J., Aarons, G. A., & Brookman-Frazee, L. (2018). Comparing agency leader and therapist perspectives on evidence-based practices: Associations with individual and organizational factors in a mental health system-driven implementation effort. *Administration and Policy in Mental Health and Mental Health Services Research*, *45*(3), 447–461. https://doi.org/10.1007/s10488-017-0835-9

Stirman, S. W., Bhar, S. S., Spokas, M., Brown, G. K., Creed, T. A., Perivoliotis, D., Farabaugh, D. T., Grant, P. M. & Beck, A. T. (2010). Training and consultation in evidence-based psychosocial treatments in public mental health settings: The access model. *Professional Psychology: Research and Practice, 41*(1), 48. https://psycnet.apa.org/doi/10.1037/a0018099

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): A 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*, *19*(6), 349–357.

Weist, M. D. (1998). Mental health services in schools: Expanding opportunities. In H. Ghuman & R. M. Sarles (Eds.), *Handbook of Child and Adolescent Outpatient, Day Treatment and Community Psychiatry* (pp. 347–358). Routledge.

Weisz, J. R., Bearman, S. K., Santucci, L. C., & Jensen-Doss, A. (2017). Initial test of a principle-guided approach to transdiagnostic psychotherapy with children and adolescents. *Journal of Clinical Child & Adolescent Psychology, 46*(1), 44–58. https://doi.org/10.1080/15374416.2016.1163708

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