BRISC IN ONTARIO!
Pilot test of an engagement, triage, and brief intervention strategy to prevent and treat MH problems

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Ontario School MH ASSIST

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University of Washington School of Medicine
School Mental Health Assessment, Research, and Training (SMART) Center
Overview of the session

• Background: The need for better approaches in school MH
• Ontario SMH ASSIST: mission and needs
• BRISC: An overview
• Evaluation: Goals, Methods and results
• Summary of findings and lessons learned
• Next steps
• Q&A
Schools play a major role in fostering children's mental wellness

Most youth who require mental health services do not receive them.

Positive school climate can buffer youth from external risk factors.

SMH accounts for >70% of all MH services – and can improve service access for underserved youth.

Social-emotional learning programs improve school achievement by 11% on average (Durlak et al., 2011).
School Mental Health

• Over 150,000 providers in the U.S.
• Operating costs of $20 billion (Wong, 2008)
“School mental health provisions are improving, providing time and space to allow all young people access to mental health education and care...but sadly many new innovations fail, uptake is incomplete, and effects are lower than was hoped.”

*The Lancet Psychiatry, 2014*
Access ≠ Effectiveness

1. Access & Utilization of Services

2. Service Quality and Outcomes

MIND THE GAP
Seattle School-Based Health Centers

• Integrated care clinics situated in schools
  • Provide primary care and mental health services
  • Improve access to care

• Seattle’s SBHCs:
  • Full time Nurse Practitioner, MH clinician, and admin staff person
  • Partnership of Seattle Schools and Public Health of Seattle & King County
  • 30+ SBHCs in high schools and middle schools
  • Funded by the Seattle Families and Education Levy
  • Staffed by sponsor organizations
  • Evidence of positive effects
BRISC: Finding a “Good Fit” for Schools

<table>
<thead>
<tr>
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<td>Utilizes standardized assessment tools for progress monitoring</td>
</tr>
<tr>
<td>Many students in need; only a handful get help (many continue after it’s needed)</td>
<td>Aimed at efficiency, so the clinician can get to the next student in need</td>
</tr>
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</table>

**BRISC Intervention** is often crisis-driven. It involves structured/systematic identification of treatment targets. Interventions are often focused on providing nondirective emotional support. Skill building and problem solving are also emphasized. All intervention elements are evidence-based. Standardized assessments are used infrequently, and the goal is to be efficient so that clinicians can move to the next student in need.
BRISC Integration with Educational Approaches

- **TIER 1**: Core instruction, behavioral expectations, positive support and consequences
- **TIER 2**: Targeted interventions, additional support, behavior change strategies
- **TIER 3**: Intensive interventions, individualized behavior support plans

BRISC

SMART School Mental Health Assessment Research & Training Center
SCHOOL MENTAL HEALTH-ASSIST ÉQUIPE D'APPUI POUR LA SANTÉ MENTALE DANS LES ÉCOLES
UW Medicine SCHOOL OF MEDICINE
Population roughly 13.7 million (of Canada’s 35.5 million)

72 school districts

- 31 English Public (secular or non-religious: open to all)
- 29 English Catholic
- 4 French Public
- 8 French Catholic

5000 schools

Approximately 2 million students

Approximately 117,000 teachers

Approximately 7400 principals/vice principals
School Mental Health ASSIST

Is a provincial implementation support team designed to help Ontario school districts to promote student mental health and well-being.
SMH ASSIST Services

Provincial Leadership in School Mental Health
Systematic, collaborative, intentional, explicit, nuanced, creative, evidence-based

Implementation Coaching
Province, Region, Board

Resource Development
Awareness, Literacy, Expertise
1. Organizational Conditions and Leadership
2. Capacity-Building for Education Professionals
3. Evidence-Based Mental Health Promotion and Prevention Programming
Knowing/Doing Gap in School Mental Health

**World of Evidence**
- What we KNOW
- Conditions, Capacity, and Evidence-Based Programming across the Tiers of Intervention, within a comprehensive and coordinated system of care

**World of Practice**
- What we DO (usually)
- Fragmented and uneven uptake of programs that are inconsistently aligned with evidence and without attention to elements of sustainability, like conditions and capacity building
Optimizing “The Space Between”

**World of Evidence**
- What we KNOW
- Conditions, Capacity, and Evidence-Based Programming across the Tiers of Intervention, within a comprehensive and coordinated system of care

**World of Practice**
- What we DO (hopefully)
- Systematic and coordinated uptake of evidence-based approaches in school mental health, with attention to conditions and capacity-building elements that enhance sustainability over time

**ATTENTION TO LEADERSHIP AND IMPLEMENTATION**

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SMART
School Mental Health Assessment Research & Training Center

SCHOOL MENTAL HEALTH-ASSIST
ÉQUIPE D’APPU POUR LA SANTÉ MENTALE DANS LES ÉCOLES

UW Medicine
School of Medicine
Vision for an Integrated System of Care

SCHOOL DISTRICTS

- Mental Health Promotion
- Targeted Prevention
- Intensive Support

COMMUNITY

- Mental Health Promotion
- Targeted Prevention
- Intensive Support
We’ve set the stage* (10 organizational conditions)

We’re building capacity to ensure that everyday well-being practices are integrated in the fabric of schools

We are now ready to introduce an evidence based approach to identify and intervene with youth at risk

BRISC offered the rigor and flexibility that our context was ready for.
BRISC Guiding Principles

- Engaging
  - Competence building
  - STRUCTURED Problem Solving framework
  - Measurement based

- Flexible/Stepped Care

- Got Problems?
  - Tell a Counselor

- SMART
  - School Mental Health Assessment Research & Training Center

- UW Medicine
  - School of Medicine
1. Administer and review brief standardized assessment measure(s)
2. Assess current functioning: school, peers, family
3. Identify Problems
   a) List problems
   b) Identify top 3
   c) Introduce cognitive triangle
4. Convey Helpfulness & Plan for Working Together
5. Introduce Informal Monitoring
BRISC Session TWO

1. Review informal monitoring
2. Recap problem list and identify problem to address
3. Discuss stress and obtain rating
4. Introduce problem solving
5. Identify barriers and plan to address
6. Create a game plan for the week
1. Review problem solving experiment
2. Ask for stress rating
3. Continue problem solving:
   a) Individualize approach based on barriers
   b) Incorporate new skill as/if needed:
      • Stress and Mood Management Guide
      • Communication Skills Guide
      • Realistic Thinking Guide
4. Create game plan for the coming week
1. Assess the outcome of the solution
2. Ask for stress rating
3. Administer and review brief standardized assessment measure
4. Review progress and continued use of problem solving skill
5. Identify and plan for next steps
Lessons Learned thus far:
Four Core Post-BRISC Pathways

1. Come back if you need it (54%)
2. Supportive monitoring (18%)
3. Continue BRISC or other school MH service (18%)
4. Intensive services – (2%) (referral to other services (i.e. special education, psychiatry, trauma treatment, family therapy, DBT, eating disorder treatment, etc.)
Lessons learned thus far:
SMH Clinicians’ practice shifted

Use of Practice Elements
Consistent with BRISC (more “evidence-based”)

SMH SAU (38 tapes)  BRISC (46 tapes)

Use of Practice Elements
Antithetical to BRISC (less “evidence-based”)

SMH SAU (38 tapes)  BRISC (46 tapes)
Lessons learned thus far:
BRISC youth showed improved functioning

![Bar chart showing % in Clinical Range on CIS for BRISC (n=29) and TAU (n=37) at Baseline and Follow-up.]

- **Baseline**:
  - BRISC: 60%
  - TAU: 70%

- **Follow-up**:
  - BRISC: 30%
  - TAU: 60%
Lessons learned thus far:
Other positive outcomes of BRISC

• Clinician-rated (n=8) feasibility of BRISC was (relatively) high (3.8 – 4.1 on 5 point scale)
• BRISC was higher than SAU on student alliance
• BRISC higher than SAU on student satisfaction
• BRISC superior on MH Outcomes
  • MH Functioning (CIS)
  • Anxiety (GAD-7) and Depression (PHQ-9)
Because of the diverse context in Ontario and high variability of available resources per district within the province, the “BRISC team” agreed to do a feasibility pilot to expand the approach to a broader audience of practitioners.

“We wanted to know if the approach would be appropriately used by different professionals and if the student outcome would be similar than if the practitioner was a master level clinician”

We also had the materials translated in French – but the manual wasn’t ready in time for the pilot...
Current evaluation: Research Questions

1. Is training and consultation viewed as high quality and as having a positive impact on staff skills and practice?
2. What are the presenting needs of students referred to BRISC?
3. With what degree of fidelity do practitioners implement BRISC?
4. What types of modifications do practitioners report?
5. What are the practitioners’ perceptions of acceptability and feasibility of BRISC?
6. What are the MH outcomes during BRISC enrollment?
7. What are the post-BRISC service pathways?
Current evaluation

- **Data sources**
  - Training evaluation
  - Practitioner reports
    - Fidelity
    - Reports of student functioning
  - Exit interviews with practitioners

- **Sample:**
  - 33 school practitioners
  - 40 students

- Compared results to previous results from Washington State (8 clinicians, 39 students)
### Practitioner Demographics (N=33)

<table>
<thead>
<tr>
<th>Age range</th>
<th>25-44</th>
<th>45-54</th>
<th>55-64</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>41%</td>
<td>18%</td>
<td>18%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>82%</td>
<td>18%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>White</th>
<th>Black</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80%</td>
<td>10%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>College</th>
<th>Bachelor’s</th>
<th>Master’s</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>29%</td>
<td>24%</td>
<td>47%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years in MH / current position</th>
<th>16 years / 6 years</th>
</tr>
</thead>
</table>

| Francophone/Anglophone | 29% (9) | 71% (24) |
# Results: Perception of Training

<table>
<thead>
<tr>
<th></th>
<th>Min</th>
<th>Max</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Existing mastery/competence</td>
<td>4</td>
<td>10</td>
<td>7.0</td>
</tr>
<tr>
<td>Post-training mastery/competence</td>
<td>5</td>
<td>10</td>
<td>8.4</td>
</tr>
<tr>
<td>Importance of training goals</td>
<td>7</td>
<td>10</td>
<td>9.2</td>
</tr>
<tr>
<td>Trainer credibility</td>
<td>5</td>
<td>10</td>
<td>9.1</td>
</tr>
<tr>
<td>Training organization</td>
<td>3</td>
<td>10</td>
<td>8.1</td>
</tr>
<tr>
<td>Training interest</td>
<td>5</td>
<td>10</td>
<td>7.6</td>
</tr>
<tr>
<td>Level of impact</td>
<td>5</td>
<td>10</td>
<td>8.3</td>
</tr>
<tr>
<td>Impact</td>
<td>5</td>
<td>10</td>
<td>8.5</td>
</tr>
</tbody>
</table>
# Results: Training Usefulness

<table>
<thead>
<tr>
<th>Theme</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structure/Organization</strong></td>
<td>12</td>
</tr>
<tr>
<td>(e.g. breakdown of sessions, structure of sessions, organizational model)</td>
<td></td>
</tr>
<tr>
<td>“This organizational format of the sessions was great information. The constant reinforcement of say, see, do was also great information.”</td>
<td></td>
</tr>
<tr>
<td><strong>Approach</strong></td>
<td>8</td>
</tr>
<tr>
<td>(e.g. philosophy, practicality, strategies, brief delivery, implementation)</td>
<td></td>
</tr>
<tr>
<td>“Practical, brief counseling to build resiliency with our students.”</td>
<td></td>
</tr>
<tr>
<td><strong>Materials</strong></td>
<td>8</td>
</tr>
<tr>
<td>(e.g. checklists, handouts, manual, examples)</td>
<td></td>
</tr>
<tr>
<td><strong>Assessment Tools</strong></td>
<td>5</td>
</tr>
<tr>
<td>(e.g. measures)</td>
<td></td>
</tr>
<tr>
<td>“Connection to rating scales and the problems gave the framework to integrate a variety of familiar techniques.”</td>
<td></td>
</tr>
<tr>
<td><strong>Content</strong></td>
<td>5</td>
</tr>
<tr>
<td>(e.g. examples, facilitators, strategies, modeling)</td>
<td></td>
</tr>
<tr>
<td>“Clear strategies to structure sessions.”</td>
<td></td>
</tr>
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</table>
## Results: Training Recommendations

<table>
<thead>
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<th>Theme</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resources</strong> (e.g. videos, teaching, more time, electronic versions of handouts, efficacy information, more examples)</td>
<td>9</td>
</tr>
<tr>
<td>“More examples of BRISC being used—video.”</td>
<td></td>
</tr>
<tr>
<td><strong>Organization</strong> (e.g. coordination, preparing things ahead of time)</td>
<td>2</td>
</tr>
<tr>
<td>“More coordination of the presenters.”</td>
<td></td>
</tr>
<tr>
<td><strong>BRISC for Younger Students</strong></td>
<td>2</td>
</tr>
<tr>
<td>“Resources and practical training to implement BRISC to younger students.”</td>
<td></td>
</tr>
<tr>
<td><strong>Miscellaneous</strong> (defining goals vs. strategies, positive feedback)</td>
<td>7</td>
</tr>
<tr>
<td>“Clarity of definitions. Perhaps clearly defining goals vs. strategies. This was the most challenging for me.”</td>
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## Results: Presenting Needs of Students

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<th>Frequency</th>
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<tbody>
<tr>
<td><strong>Internalizing Problems</strong></td>
<td>32</td>
</tr>
<tr>
<td>(depression, low mood, anxiety, worry, suicidality/self-harm, stress)</td>
<td></td>
</tr>
<tr>
<td><strong>Relationship Problems</strong></td>
<td>24</td>
</tr>
<tr>
<td>(peers, family members, friends, bullying, aloneness, belonging, conflict with others, parents separating or divorcing)</td>
<td></td>
</tr>
<tr>
<td><strong>School Problems</strong></td>
<td>16</td>
</tr>
<tr>
<td>(attendance, classes, teachers, grades/performance, focus and motivation, speaking in class, transportation, international exchange student support)</td>
<td></td>
</tr>
<tr>
<td><strong>Externalizing Problems</strong></td>
<td>9</td>
</tr>
<tr>
<td>(anger, ADHD, drug use, ODD, emotional regulation needs)</td>
<td></td>
</tr>
<tr>
<td><strong>Other Problems</strong></td>
<td>6</td>
</tr>
<tr>
<td>(Autism, sleep habits, appearance, home-life)</td>
<td></td>
</tr>
<tr>
<td><strong>Trauma, Grief, Loss</strong></td>
<td>4</td>
</tr>
<tr>
<td>(death of a parent /relative, tragic accidents)</td>
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Fidelity Results: Session 1 (n=44)

- Standardized assessment: 100% ON, 100% WA
- Assess functioning: 93% ON, 93% WA
- ID 3 Top problems: 91% ON, 90% WA
- Informal monitoring: 91% ON, 93% WA
- ID Top problem to monitor: 91% ON, 97% WA
Fidelity Results: Session 2 (n=32)

- Review informal problem monitoring: 97% ON, 96% WA
- Recap problem list: 97% ON, 97% WA
- Assess impact of problem on school functioning: 97% ON, 93% WA
- ID barriers: 80% ON, 97% WA
- ID plan for week: 97% ON, 90% WA
Fidelity Results: Session 4 (n=22)

- Assess outcome of experiment: 100% ON, 100% WA
- Standardized measures: 100% ON, 100% WA
- Review standard measures: 96% ON, 100% WA
- Review progress: 96% ON, 100% WA

Assess outcome of experiment, Standardized measures, Review standard measures, Review progress
Results: Modifications

Few modifications

• 100% kept the recommended order of sessions
• 24% extended BRISC sessions beyond 4
• 16% stopped using the BRISC protocol during a session due to crisis or other interruption
• 15% repeated an entire BRISC session
# Results: BRISC Feasibility

<table>
<thead>
<tr>
<th>Scale: 1 (Not at all) to 3 (Moderately) to 5 (Extremely)</th>
<th>ON (n=35)</th>
<th>WA (n=30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>Usefulness of BRISC structure and tools in student’s treatment</td>
<td>3.94 0.73</td>
<td>3.73 0.87</td>
</tr>
<tr>
<td>Relevance of problem solving and other tools to this student</td>
<td>3.86 0.88</td>
<td>3.70 1.14</td>
</tr>
<tr>
<td>Extent to which clinician was able to incorporate BRISC concepts and techniques into their work with this student</td>
<td>3.89 0.72</td>
<td>3.70 0.95</td>
</tr>
<tr>
<td>Compatibility of BRISC with the practical realities and resources of this case</td>
<td>3.89 0.86</td>
<td>4.03 1.22</td>
</tr>
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## Results: BRISC Feasibility

<table>
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<tr>
<th>Scale: 1 (Not at all) to 3 (Moderately) to 5 (Extremely)</th>
<th>English Speakers (n=26)</th>
<th>French Speakers (n=9)</th>
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<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
</tr>
<tr>
<td>Usefulness of BRISC structure and tools in student’s treatment</td>
<td>4.12</td>
<td>0.65</td>
</tr>
<tr>
<td>Relevance of problem solving and other tools to this student</td>
<td>3.85</td>
<td>0.97</td>
</tr>
<tr>
<td>Extent to which clinician was able to incorporate BRISC concepts and techniques into their work with this student</td>
<td>3.92</td>
<td>0.74</td>
</tr>
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<td>Compatibility of BRISC with the practical realities and resources of this case</td>
<td>3.96</td>
<td>0.87</td>
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Student outcomes: PHQ-9 (Depression)

PHQ-PRE
PHQ-POST

ON
WA
Student outcomes: GAD-7 (Anxiety)

![Graph showing changes in anxiety levels before (PRE) and after (POST) intervention. The graph indicates a decrease in anxiety levels from 12.9 to 9.8 after the intervention.](image-url)
Results: Post BRISC pathways

- Support concluded: 55% (ON), 31% (WA)
- Supportive monitoring: 8% (ON), 18% (WA)
- Continue counseling: 11% (ON), 18% (WA)
- Referred to additional services: 50% (ON), 9% (WA)
## Practitioner Interview/Survey Findings (N=24)

<table>
<thead>
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<th>Rating (0-10) of:</th>
<th>Mean</th>
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<tbody>
<tr>
<td>Usefulness of Problem Solving Framework</td>
<td>8.95</td>
</tr>
<tr>
<td>Usefulness of Progress monitoring and feedback</td>
<td>9.10</td>
</tr>
<tr>
<td>Usefulness of Homework exercises for students</td>
<td>8.60</td>
</tr>
<tr>
<td>Motivation to continue to use BRISC</td>
<td>9.10</td>
</tr>
<tr>
<td>Effectiveness (compared to services as usual) using BRISC</td>
<td>7.95</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Item</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of caseload BRISC would be applicable for</td>
<td>Mean = 74%</td>
</tr>
<tr>
<td>Four sessions is...</td>
<td></td>
</tr>
<tr>
<td>Too many</td>
<td>0%</td>
</tr>
<tr>
<td>Too few</td>
<td>25%</td>
</tr>
<tr>
<td>About right</td>
<td>75%</td>
</tr>
<tr>
<td>Percent of clinicians who would do the project again</td>
<td>100%</td>
</tr>
</tbody>
</table>
Weaknesses / Things to focus on

• Coming out of the training, there was a sense that you can achieve anything in a short term. For future training it would be great to reinforce and clarify the doable short term rather than going at the long term issues, in a school setting.

• Adding a session: The second week, after monitoring, the kids realize the issue was different, so it feels like we are starting anew.

• Something on conflict resolution would be great.

• It felt mechanical, because I wasn’t used to it and comfortable with it. Practice will help.
Weaknesses / Things to focus on

• With this approach you do need a clear pathway to additional resources and to ensure that those services are available.

• Back and forth from French to English. Because the manual wasn’t yet translated.

• Just the time constraint (4 sessions). Maybe one day I’ll be able to do this, but right now, I need 4 to 6 sessions

• I like the Problem Solving piece, but I think the steps could be simplified.
Other lessons learned

BRISC-ON:

• Partnerships and communication are key!

BRISC-ON PILOT:

• A criteria that supports the efficiency of the model: having clear internal and external pathways/protocols to, from and through care

• If you’re engaging diverse cultures/languages, ensuring that the materials are translated AND adapted.
Other lessons learned (cont’d)

BRISC Training

• Important to involve site supervisor/coordinator
• Challenging to engage trainees in active “practice”/role playing

Consultation

• 1-2 practice cases an important step
• Every other week at first effective
• However, consultation process was longer than it needed to be—could have simply offered “as needed” after first about 8 weeks
Summary of findings

Lots of work still to be done

100% of the districts that were part of the initial pilot wish to scale up their implementation of the BRISC approach

23 of the 72 (32%) school districts wish to be part of a second pilot to determine if the approach will suit their context well.
Next steps BRISC-ON

Building on the current motivation and momentum that has been created
Planning for a Provincial scale-up of the BRISC intervention.

• Sequence
• Training
• Cost
• Monitoring and evaluation

Developing and evaluating a train-the-trainer model to promote sustainability of the approach