

Wisconsin School SBIRT Implementation Project



2018-2019 Report

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WISCONSIN DEPARTMENT
of HEALTH SERVICES



Executive Summary

Overview

Wisconsin is a leader in school mental health. Providing mental health services and supports to students within schools is critical to promote successful learning. SBIRT (Screening, Brief Intervention, Referral to Treatment) is a well-established evidence-based practice for addressing adolescent behavioral health issues, such as mental health and risky substance use. SBIRT begins with behavioral health screening followed by 3-4 protocol-guided Brief Intervention sessions (~20 minutes each). School SBIRT was adapted for delivery in middle and high school settings as a Tier 2 (selected students) or Tier 3 (indicated student) practice to increase school capacity for addressing student behavioral health issues.

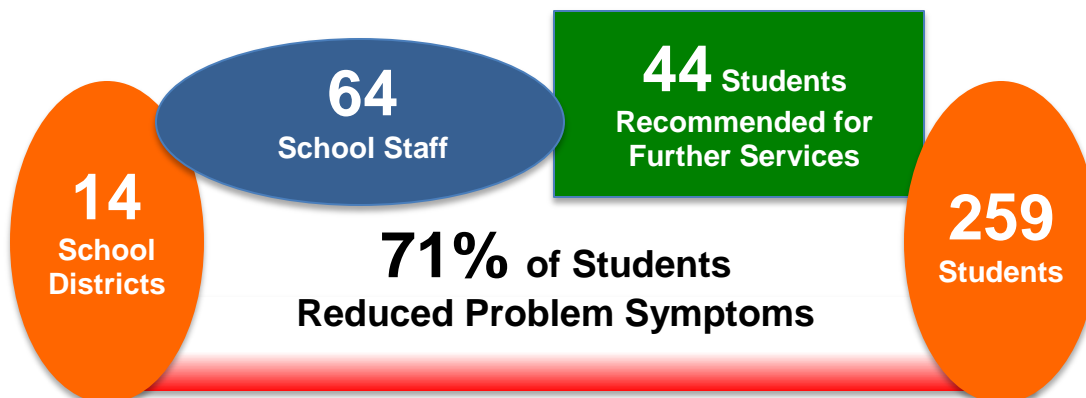
Implementation

The School SBIRT Implementation Project was designed to assist participating pupil services staff to integrate SBIRT into routine Tier 2/3 practice with fidelity. After completing a successful application, selected districts sent staff to training, then participated in ongoing technical assistance (TA) provided by the Wisconsin Safe & Healthy Schools Center. Participating staff were asked to document SBIRT activities in a spreadsheet. This data provided the basis of TA through assessing, monitoring, and improving the implementation process. Districts received a \$1,800 stipend for participating in TA.

Highlights

- 259 students received SBIRT delivered by 64 staff.
- Students received an average of 3.46 Brief Intervention sessions for an intervention “dose” of 70 minutes.
- Student response to the Brief Intervention showed statistically significant and clinically meaningful reductions in behavioral health symptoms and problem behavior from initial to follow screening.
- 44 students were recommended for further services upon completion of the brief intervention.

Student outcomes from this project are consistent with the research literature that shows SBIRT to be highly effective and efficient for addressing adolescent behavior health issues within opportunistic settings.



I. Overview

School mental health services and supports help to address the mental health needs of students so that students can successfully learn.¹ As a Tier 2/3 intervention, SBIRT (Screening, Brief Intervention, Referral to Treatment) can address a range of student behavioral health issues, including mental health, risky substance use, and conduct problems. SBIRT is a well-established evidence-based practice² designed for delivery by non-specialists in opportunistic settings, such as schools.³ The Wisconsin Safe & Healthy Schools Center, in collaboration with the Wisconsin Department of Health Services, developed the School SBIRT Implementation Project to assist pupil services staff to successfully implement SBIRT. Through successful implementation of SBIRT, schools can develop internal capacity to effectively and efficiently address student behavioral health issues. The purpose of this report is to describe the project activities and outcomes from the 2018-2019 school year. First, the School SBIRT model and implementation project is described, then SBIRT implementation and student outcomes are reported with conclusions and recommendations made.

II. The School SBIRT Model

The School SBIRT model comprised the following components:

- **Screening.** Two well-established behavioral health screening instruments were administered: the GAIN-SS (Global Appraisal of Individual Needs - Short Screen)⁴ and the TLFB (Timeline Followback) Calendar.⁵ The GAIN-SS comprised 20-items across 4 domains: Internalizing (mental health), Externalizing (conduct), Alcohol/Drug use, and Crime/Violence. Each domain contained 5 items (problem symptoms). “Red flag” symptoms indicating risk were based on student responses for past month or past 2-12 months. Each domain was scored on a 0-5 scale with results showing either no/low risk (0 symptoms), moderate risk (1-2 symptoms), or high risk (3 or more symptoms) for a clinically significant problem. After obtaining parental consent, the GAIN-SS took about 5 minutes to administer, score, and interpret. Focus of Brief Intervention was based on a selection of a change target (e.g., specific mental health symptom, substance, or conduct problem) indicated as moderate or high risk from the GAIN-SS, then the TLFB Calendar was administered for student to self-report frequency of change target occurrence during the past 30 days.
- **Brief Intervention (BI).** BI addressed the specific change target identified during screening. BI utilizes Motivational Interviewing⁶ which is an evidence-based practice for addressing adolescent risky substance use in school settings⁷ and is a promising practice to address adolescent mental health issues.⁸ BI works by exploring, eliciting, and strategically responding to the student’s own reasons



and motivations for change as part of a guiding style of conversation. Because pupil services staff refrain from educating, advising, directing, or problem-solving with students, delivering BI involves new ways of working. BI comprised 3-4 sessions lasting about 20 minutes each. Staff used a protocol to deliver each session which identified several tasks related to engaging, focusing, evoking student motivation, and planning. During the final BI session, the protocol guided staff to administer the follow up screening and ascertain response to intervention.

- **Referral to Treatment.** For students who showed continued high risk behavioral health symptoms and minimal response to BI, a referral could be made for further assessment and possible treatment by a licensed provider as an internal referral (within school) or as an external referral (community-based outpatient services).

III. The Implementation Project

Implementation of evidence-based practice means that participating staff integrate the new practice into routine practice with fidelity, that is, the practice is delivered as it is intended to be delivered. In the School SBIRT Implementation Project, the goal was to assist participating pupil services staff to integrate SBIRT into routine Tier 2/3 practice and work to achieve fidelity. Implementing SBIRT is an ambitious goal for any school because staff have to adopt new ways of working. Implementation is an ongoing process and the project was designed with several activities and supports to promote implementation success:⁹

- **Application.** Interested districts applied to participate in the implementation project. The purpose of the application was for districts to explore the need for SBIRT, to consider intervention fit into existing teams and systems, to select a team of staff to deliver the new intervention; and to consider available capacity and resources for supporting staff implementation. District applicants were informed of the expectations of participation, including: selected staff attend training, then begin delivering SBIRT; each member of team attempts SBIRT delivery with at least 1 new student per month; conduct follow up screening to ascertain response to intervention; document SBIRT activities for later evaluation; complete routine self-assessments of fidelity; and participate in technical assistance sessions. Districts were also informed that a \$1,800 project stipend would be given if expectations were met. Twenty districts successfully completed the application process and agreed to participate in the project.
- **Training.** Selected staff teams from each district completed two days of training held at statewide regional locations. Five trainings were offered involving 107 staff (see **Table 1**). Training was highly experiential and focused on staff learning the School SBIRT protocol, using SBIRT tools, and practicing requisite skills. At the conclusion of each training day, staff submitted an audio recorded sample of BI practice (based on role play) for fidelity review. Trainers conducted the review using a standardized fidelity instrument¹⁰ and provided detailed written feedback to each staff. Using the fidelity review results, staff completed an individualized professional development plan to continue learning and developing requisite SBIRT skills. Each district team also drafted a detailed plan for how to begin implementing SBIRT.

Table 1. Statewide SBIRT training.

Training location	# Staff Trained	Dates
Chippewa Falls	26	November 12, 2018 & January 17, 2019
Tomahawk	5	November 15, 2018 & December 13, 2018
Elmbrook-Brookfield	31	November 15, 2018 & January 8, 2019
Manitowoc	25	November 20, 2018 & January 9, 2019
Whitewater	20	December 10, 2018 & January 17, 2019

- **Technical Assistance.** An important feature of the implementation project was ongoing technical assistance (TA) following training. TA (3-5 sessions) was provided to teams to support integration of SBIRT into routine practice with fidelity. To monitor implementation, each district was provided a simple spreadsheet for staff to document SBIRT activities (e.g., student involvement in SBIRT, date of initiation, screening results, number of brief interventions provided, any referrals made). This data was used during TA sessions to acknowledge initial implementation successes, to reinforce practice, and to offer gentle accountability for teams' delivery of SBIRT. TA also comprised case consultation, some skill practice, review and update of professional development plans, and identifying/problem-solving implementation barriers.

IV. Implementation Outcomes

Districts submitted SBIRT data spreadsheets (any student-specific information was de-identified) to the Wisconsin Safe & Healthy Center to receive project stipend. Of the 20 districts accepted into the 2018-2019 implementation project, 10 districts submitted data (50% participation rate). An additional 4 districts that began participation during 2017-2018 submitted data for the current year. In sum, 14 districts participated representing 64 staff (see **Table 2**). Analysis and reporting of the implementation project is based on aggregate data from these districts. Analysis highlights several implementation outcomes in terms of staff engagement, identified barriers, extent of SBIRT delivery, referral sources, and delivery of BI sessions.

- **Staff Engagement.** Staff were expected to begin delivering SBIRT following training because students cannot benefit from an intervention they do not receive.¹⁰ Staff engagement was defined as those who delivered SBIRT to at least 1 student following training. As shown in **Table 2**, 64 staff delivered SBIRT out of 81 staff trained. Thus, rate of staff engagement in SBIRT delivery was 79%.

Table 2. Summary of district and staff participation.

Participating Districts	# Staff Trained	# Staff Delivered SBIRT	Total # Students Received SBIRT
School 1	4	4	12
School 2*	2	2	7
School 3	5	5	20
School 4	3	3	7
School 5	11	6	17
School 6*	2	2	8
School 7	4	5	20
School 8	4	3	16

School 9*	5	10	37
School 10	3	3	14
School 11	7	5	29
School 12	5	1	15
School 13*	22	13	40
School 14	4	2	17
Total	81	64	259

*Began implementation project participation with additional staff trained in 2017-2018.

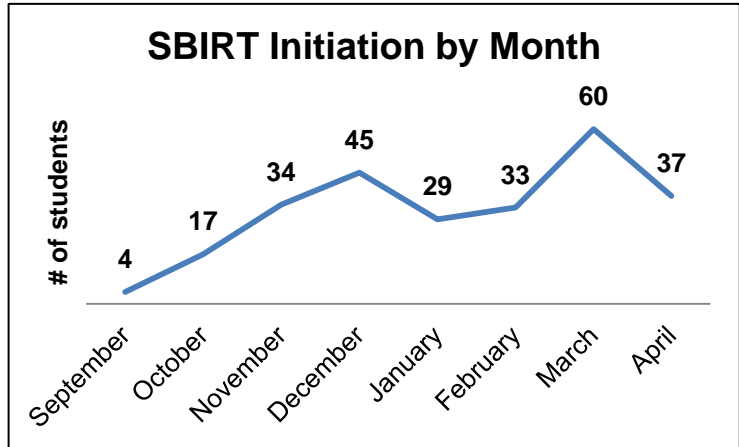
- Implementation Barriers.** Barriers are inherent to any implementation project because staff are asked to adopt new ways of working and change is not particularly easy—especially in a busy practice setting such as a middle or high school. In the final TA session with one group (3 districts, 15 staff), staff were asked to look back on the year and identify barriers to implementation. Barriers identified were:
 - Lack of time to deliver SBIRT; too many existing demands and responsibilities
 - SBIRT not on regular pupil services team meeting agenda
 - Lack of clarity on which students to select for SBIRT
 - Lack of clear path from referral source to SBIRT-trained staff
 - Lack of clear policy and procedure for obtaining parent consent on screening
 - Awkwardness of delivering a new service
 - Lack of administrator involvement or support at building-level
- Extent of SBIRT Delivery.** As noted in **Table 2**, 259 students received SBIRT delivered by 64 staff. On average, each staff delivered SBIRT to 4.0 students. The extent to which individual staff delivered SBIRT ranged widely from 1 to 15 students (see **Table 3**). Those who delivered SBIRT to 1, 2, 3, or 4 students comprised 66% of total staff. Eight “super users” of SBIRT (13% of total staff) collectively delivered services to 82 students (31.6% of total students).

Table 3. Extent of SBIRT delivery by staff.

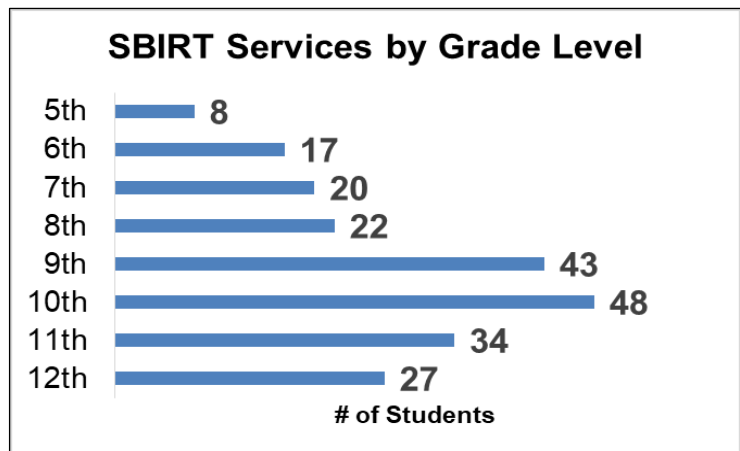
# Students Received SBIRT	# Staff Delivered SBIRT	% Total Staff
1	12	19%
2	9	14%
3	16	25%
4	5	8%
5	7	11%
6	5	8%
7	2	3%
8	3	5%
9	2	3%
11	1	1%
14	1	1%
15	1	1%

The extent to which staff delivered SBIRT likely reflected the relative presence or absence of implementation barriers. Analysis of variance showed that team size may also have played a role. A team size variable was created identifying small (1-3 staff; average=2.2 staff), medium (4-5 staff; average=4.4 staff), and large (6 or more staff; average=10.8) sized teams. For the average number of students who received SBIRT, the difference between teams approached statistical significance ($p < .10$) such that staff working in medium sized teams delivered SBIRT to more students (average 5.0 students) than staff working in small (1.5 students) or large (2.6 students) sized teams.

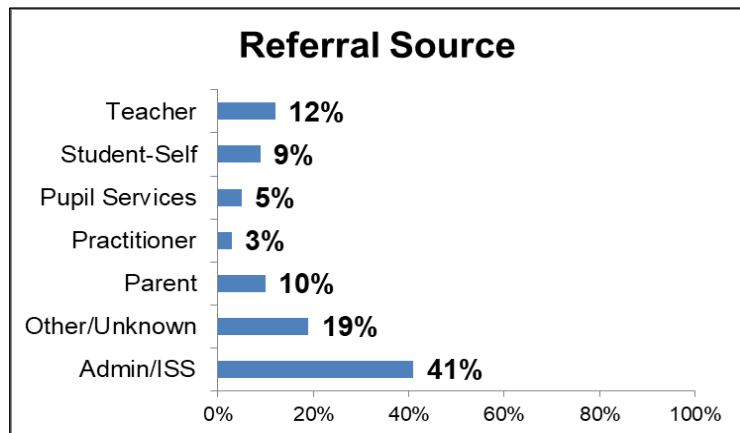
- SBIRT Initiation by Month.** SBIRT was delivered to students from September 2018 through April 2019. The December peak in number of students ($n=45$) likely reflected a culmination of delivery by districts that continued involvement from 2017-2018 while the March peak ($n=60$) included staff who completed January training, thus representing a culmination of delivery by all district participants.



- SBIRT Services by Grade Level.** Because SBIRT is designed for delivery with adolescents, those who received SBIRT were high school ($N = 152$) or middle school students ($N=67$). (One district did not submit student grade level information.) The most frequent number of students who received SBIRT were 10th graders ($n=48$), followed by 9th graders ($n=43$) and 11th graders ($n=34$).



- Referral Source for SBIRT.** Each district developed a plan for how students would be identified and referred to SBIRT-trained staff. There were multiple referral sources: students were referred infrequently by either SBIRT-trained staff themselves (3%) or by members of their pupil services team (5%); sometimes students self-referred (9%) or were referred by their parents (10%); but most students were referred by an administrator or on the basis of an in-school suspension (ISS; 41%).



- Delivery of Brief Intervention Sessions.** The BI component was the primary mechanism for promoting student change on selected behavioral health issue. On average, staff delivered 3.46 sessions with each student (standard deviation=1.33), ranging from 1 to 8 sessions. At about 20 minutes per session, the total dose of intervention with each student was approximately 70 minutes. BI sessions were delivered using a protocol. Staff were asked to complete a self-assessment for each student participant in order to monitor fidelity. The self-assessment comprised a 6-item measure related to BI task completion. For each item, staff made a rating on a 1 (not at all) to 5 (extensively) scale regarding the extent to which tasks were completed. Staff completed 186 self-assessments (71.8% completion rate) with an average score 3.68 (standard deviation=0.61). During the final BI session (approximately one month from initial screening), staff administered follow up versions of the GAIN-SS and TLFB Calendar instruments. These versions presented the same items from the initial screening, however, response options were only for the past month period. Staff completed follow up screening with 205 students (79.1% completion rate). On an individual-level, the follow up screening allowed staff to ascertain student response to intervention, celebrate changes made, and consider need for referral. On an aggregate-level, the follow up screening allowed comparison with the initial screening data in order to ascertain student outcomes, that is, “practice-based evidence”¹¹ of BI.

V. Student Outcomes

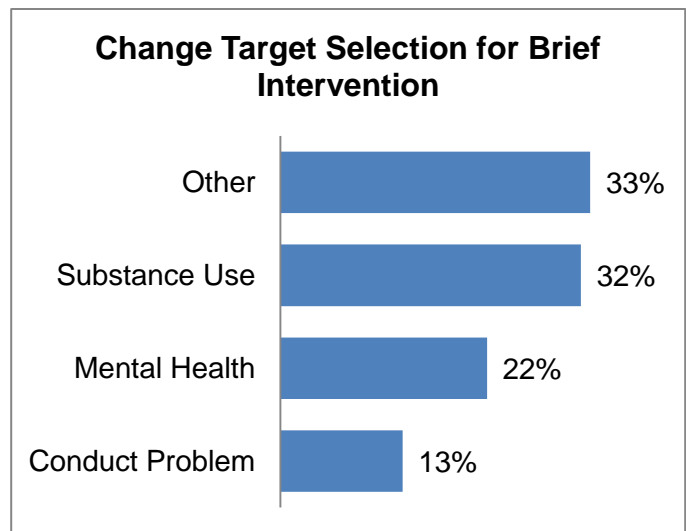
Several outcomes of SBIRT delivery were examined in terms of the data submitted by 14 districts. District data was aggregated, cleaned, and imported into a software program (SPSS) for descriptive and inferential statistical analysis.

- Initial Screening Results.** Students completed the GAIN-SS (Global Appraisal of Individual Needs - Short Screener) and the TLFB (Timeline Follow back) Calendar. Recall that GAIN-SS results were based on domain (Internalizing, Externalizing, Alcohol/Drug, Crime/Violence). Moderate risk (1 or 2 “red flag” symptoms) and high risk (3 or more symptoms) results were assessed in terms of student endorsement of symptoms experienced in the past month or past 2-12 months. As presented in **Table 4**, moderate and high risk results were the most prevalent for students regarding Externalizing (91.7%) and Externalizing (91.4%) symptoms, followed by Crime/Violence (48.9%) and Alcohol/Drug (43.4%) symptoms. Consistent with the research on adolescent self-reported behavioral health issues,¹³ the prevalence here confirms that student self-report is a valid method for ascertaining behavioral health risk levels through SBIRT screening in school settings.

Table 4. Average initial GAIN-SS results by risk level (N=259).

GAIN-SS Domain	Low risk	Moderate risk	High risk
Internalizing symptoms	8.2%	26.5%	65.2%
Externalizing symptoms	8.7%	31.5%	59.9%
Alcohol/Drug symptoms	56.6%	18.7%	24.7%
Crime/Violence symptoms	51.2%	38.7%	10.2%

- Change Target Selection for Brief Intervention.** Although students often present to pupil services with multiple concerns, BI focuses on a single concern or “change target.” Staff considered several factors when selecting a change target: high risk GAIN-SS results, context of referral, student preference, and staff judgment of the most salient concern. For districts that adopted SBIRT to address specific behavioral health issues such as alcohol/drug violations, selection of change target was driven by the context of referral. “Other” change targets included attendance and homework completion.



- Student Outcomes from Brief Intervention.** Outcomes were assessed using inferential statistical analysis (e.g., t-test, analysis of variance, Pearson correlation). For each GAIN-SS domain, number of past month symptoms were examined for initial and follow up screening. In other words, time period was controlled for by examining the past month period at each screening time. A statistically significant difference between initial and follow up results was ascertained when the probability (p) of the results due to chance were equal to or less than 5 out of 100 ($p \leq .05$). As presented in **Table 5**, students, on average, showed significant reductions in behavioral health symptoms from initial to follow up points across all screening domains.

Table 5. Student outcomes from Brief Intervention.

GAIN-SS Domain	Average screening results (N=205) for past month symptoms		Statistically significant difference?
	Initial	Follow Up	
Internalizing symptoms	1.88	1.30	Yes, $p < .001$
Externalizing symptoms	1.80	1.33	Yes, $p < .001$
Alcohol/Drug symptoms	0.71	0.44	Yes, $p < .001$
Crime/Violence symptoms	0.45	0.25	Yes, $p < .001$
Frequency of change target during the past 30 days*	13.31	4.37	Yes, $p < .001$

*Based on Timeline Followback Calendar.

For each student, the difference in total past month symptoms (0-20) from initial to follow up screening was calculated. Three unique groups of students were identified: *Improvers* (n=144, 70.6% of total) showed an average decrease of 2.8 symptoms from initial to follow up screening; *Decliners* (n=37, 18.1%) showed an average increase of 2.5 symptoms; and *No changers* (n=23, 11.3%) showed 0.0 symptom change. As presented in **Table 6**, BI was equally effective when the change target was specific to a behavioral health issue (i.e., risky substance use, mental health symptom, or conduct problem). However, when BI was

applied to “other” change targets, there was a significant difference in outcomes (Chi-Square, $p = .02$).

Table 6. Percentage of student outcome group by change target.

Student Outcome Group	Substance use	Mental health	Conduct problem	Other
Improvers	74.6%	76.6%	76.9%	59.4%
Decliners	10.4%	10.6%	15.4%	32.8%
No Changers	14.9%	12.8%	7.7%	7.8%

- Referral for Further Services.** As the outcome data shows, some students did not respond to BI and others even showed increased symptoms from initial to follow up screening. Because of this reality, the Referral to Treatment component of SBIRT was sometimes needed. Forty-four students were recommended for further services upon completion of BI. Of those students, 47.7% (21 students) successfully entered the recommended further service. Basis for referral was explored statistically. There was no difference ($p = .84$) between student outcome groups in terms of those referred for further services, such that improvers were referred (17.7%) at a rate similar to decliners (14.7%) and to no changers (13.6%). However, Pearson correlations showed that rate of referral was strongly correlated with the number of GAIN-SS symptoms present at initial screening ($r = .23$, $p = .002$) as well as follow up screening ($r = .28$, $p < .001$), such that more student symptoms were associated with more staff referrals. This finding suggests that staff used screening data to--at least partially--inform referral decision-making.

VI. Conclusions and Recommendations

- The School SBIRT Implementation Project was designed for participating district teams to adopt and initially implement SBIRT into school-based practice. Beyond “train and hope,”⁹ staff participated in a variety of activities following training that promoted successful SBIRT implementation: fidelity reviews with feedback on initial BI practice; participation in technical assistance sessions; and monitoring implementation efforts through self-assessment and documentation of SBIRT activities. District and staff engagement rates in SBIRT activities ranged from 50% to 79%. Data from 14 districts and 64 staff participants showed that 259 students received SBIRT.
- Students who received SBIRT needed the services. Initial screening results showed prevalent moderate-to-high risk “red flag” concerns across a range of symptoms related to mental health, substance use, and conduct problems. Student self-reported symptoms seemed valid and this finding is consistent with the research literature.¹² Anecdotally, some staff expressed surprise about student willingness to discuss struggles with behavioral health issues.
- Inferential statistical analysis showed that BI outcomes were positive and robust. Student participation in BI showed statistically significant and clinically meaningful reductions of symptoms and problem behavior frequency from initial to follow up screening. These findings are consistent with the emerging research literature on BI effectiveness for addressing adolescent behavioral health issues in school settings.^{6, 7, 8} In particular, the data showed that BI was equally effective in addressing risky substance use, mental health, and conduct problems, however, was less effective in addressing “other” behaviors. Beyond effectiveness, with a total intervention “dose” of about 70 minutes per student, BI proved to be a highly efficient service that could be delivered by busy pupil services staff.

- Clearly, delivery of SBIRT can increase school capacity to address student behavioral health issues. Furthermore, participating pupil services staff demonstrated the feasibility of delivering SBIRT. However, many implementation barriers were identified which impacted the extent to which staff could deliver SBIRT. As a Tier 2/3 practice, staff were encouraged to deliver SBIRT with at least 1 new student per month as a goal of initial implementation. If that rate of integration had occurred, twice as many students in the participating districts would have received this needed service.
- To achieve full implementation, participating staff will ultimately need to deliver SBIRT with 2-3 new students per month. This is an ambitious goal. Lessons learned in the 2018-2019 implementation project suggests districts will need to strategically develop infrastructure, policies, procedures, and supports so that staff can integrate the new practice into routine practice with fidelity.
- Recommendations for the 2019-2020 implementation project:
 - Continue application process to ensure that districts are at least somewhat ready, willing, and able to have selected teams fully participate in the ongoing implementation process.
 - The Wisconsin Safe & Healthy Schools Center should continue providing technical assistance sessions following training with focus on several areas: promote staff engagement in SBIRT delivery immediately following training; monitor documented SBIRT activities with regular feedback on implementation process measures (e.g., number of students receiving SBIRT, rate of initial and follow up screening completion; rate of staff self-assessment completion); ensure that selection of BI change target is a behavioral health issue (not “other”); continuously and proactively identify and address implementation barriers; provide guidance on using screening data to better inform referral decision-making.
 - For implementation success, school leadership must be involved. Building-level administrators can be involved in the School SBIRT Implementation Project in several ways: articulate “the why” of addressing student behavioral health issues; have vision for how SBIRT fits into the multi-tiered system of support; help staff proactively address barriers to implementation; help protect staff time to make SBIRT delivery happen; ensure that efficient procedures are in place to identify students in need, obtain parent consent for screening, and refer students to SBIRT-trained staff; provide accountability for staff engagement in the implementation process. The burden of implementation cannot rest upon the shoulders of staff. Leadership will be required in order to put necessary supports and systems in place so that staff can successfully implement SBIRT. It is only through successful implementation that students will experience the benefits of this evidence-based practice.

VII. Notes and References

1. Department of Public Instruction (2015). *Wisconsin School Mental Health Framework: Integrating School Mental Health with Positive Behavioral Interventions & Supports*. Accessed from <https://dpi.wi.gov/sites/default/files/imce/sspw/pdf/mhframework.pdf>
2. Babor et al. (2007). Screening, Brief Intervention, and Referral to Treatment (SBIRT): Toward a public health approach to the management of substance abuse. *Substance Abuse*, 28(3), 7-30. Accessed from <https://www.dhs.wisconsin.gov/aoda/sbirt/overview.pdf>
3. See Curtis et al. (2014). Translating SBIRT to public school settings: An initial test of feasibility. *Journal of Substance Abuse Treatment*, 46, 15-21. Also see Winters et al. (2007). Use of brief interventions for drug-abusing teenagers within a middle and high school setting. *Journal of School Health*, 77, 196-206. School SBIRT is an initiative created by the Wisconsin Department of Health Services and the Wisconsin Safe & Healthy Schools Center, with funding from the Wisconsin Department of Public Instruction (DPI). For more information, go to the School SBIRT webpage at <http://www.wishschools.org/resources/schoolsbirt.cfm>
4. The GAIN-SS is a psychometrically reliable and valid instrument for screening adolescents in non-clinical settings (Dennis, Chan, & Funk, 2006). Through a cooperative agreement with DPI, the GAIN-SS is available at no charge for administration by Wisconsin pupil services staff. For more information, see <http://dpi.wi.gov/sites/default/files/imce/sspw/pdf/gainssmanual.pdf>
5. The Timeline Followback (TLFB) procedure is a well-established method for obtaining reliable self-report on frequency of behavioral health concerns within a specific period. See alcohol example from the National Institute on Alcohol Abuse and Alcoholism, accessed from https://pubs.niaaa.nih.gov/publications/assessingalcohol/instrumentpdfs/13_tlfb.pdf
6. Motivational Interviewing is an evidence-based practice for delivery in school settings: Herman et al. (2014). *Motivational interviewing in schools: Engaging parents, teachers, and students*. New York: Springer Publishing Company; Reinke et al. (2011). *Motivational interviewing for effective classroom management: The classroom check-up*. New York: Guilford Press; Rollnick, Kaplan, & Rutschman (2016). *Motivational interviewing in schools: Conversations to improve behavior and learning*. New York: Guilford Press.
7. Brief Intervention is one of the most well-researched approaches to addressing adolescent substance use. See Winters et al. (2012). Brief intervention for drug-abusing adolescents in a school setting: Outcomes and mediating factors. *Journal of Substance Abuse Treatment*, 42, 279-288; and for a meta-analysis of 185 studies see Tanner-Smith and Lipsey (2015), accessed from <http://www.ncbi.nlm.nih.gov/pubmed/25300577>
8. Frey et al. (2011). The promise of motivational interviewing in school mental health. *School Mental Health*, 3, 1-12.
9. The implementation project was designed based on best practices from Fixsen et al. (2005). *Implementation research: A synthesis of the literature*; and Forman (2015). *Implementation of mental health programs in schools: A change agent's guide*. Washington DC: American Psychological Association.
10. Fidelity of BI practice samples was assessed using the Motivational Interviewing Treatment Integrity instrument, behavior count component. This instrument is the most widely used standardized instrument for assessing MI skills (see Moyers et al., 2005; Moyers et al., 2016).
11. This concept is from Kratochwill et al. (2012). Practice-based evidence for children and adolescents: Advancing the research agenda in schools. *School Psychology Review*, 41(2), 215-235.
12. Adolescent self-report for alcohol/drug use has been shown to be a valid method of assessment. See Winters (2004). Assessment of AOD use behaviors among adolescents at <http://pubs.niaaa.nih.gov/publications/AssessingAlcohol/behaviors.htm>