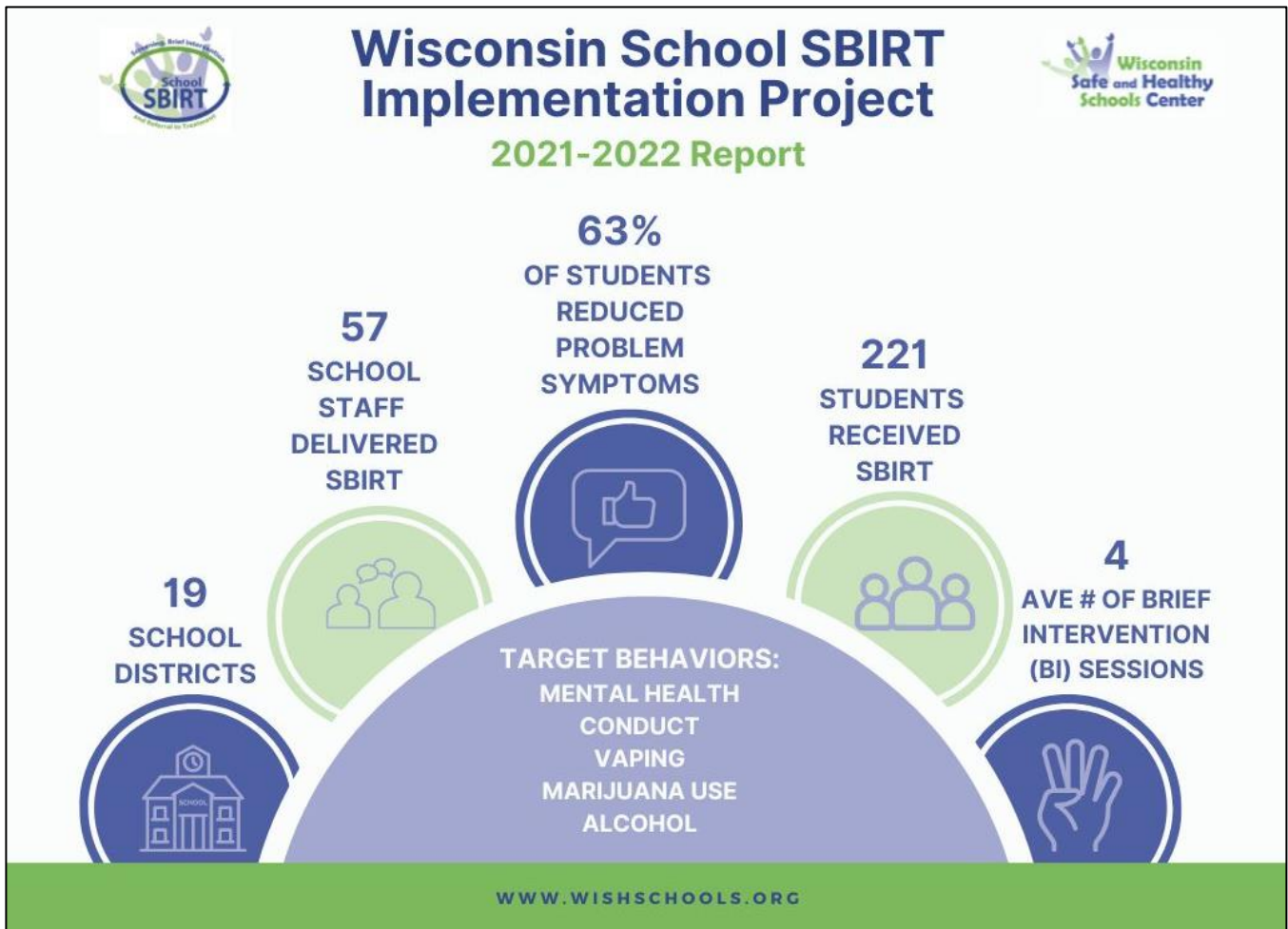


Wisconsin School SBIRT Implementation Project 2021-2022 Report

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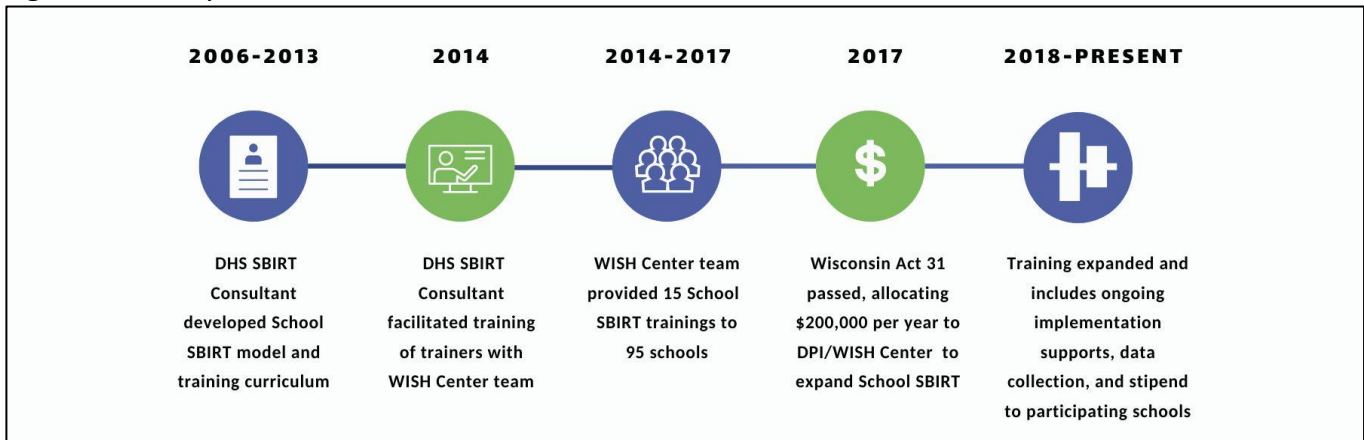


Overview

School-based services to address student mental health are critical to promote successful engagement and learning.¹ Although many evidence-based practices exist for delivery by school services staff, few school districts achieve successful implementation. In a national review of 300 school-based prevention curriculums, only 3.5% were deemed evidence-based and well-implemented.² SBIRT (Screening, Brief Intervention, Referral to Treatment) is a well-established evidence-based practice³ that holds great promise for implementation in schools for several reasons. First, SBIRT can flexibly address a range of student behavioral health issues that can interfere with learning, such as risky substance use, mental health, and conduct problems. Second, the application of SBIRT in schools has an increasingly large base of evidence for effectiveness. The evidence shows that SBIRT reduces student problem symptoms and frequency of substance use in the short-term^{4,5,6,7} as well as long-term⁸, and that students rate the service with high levels of satisfaction.⁹ Third, SBIRT is a highly efficient service which makes it feasible for delivery by busy school services staff.¹⁰ And fourth, SBIRT is designed for delivery by non-specialists who do not have a background in behavioral health but who can readily learn the practice.³

In collaboration between the Wisconsin Department of Health Services and the Wisconsin Safe & Healthy Schools (WISH) Center, the School SBIRT model was developed for delivery by school services staff as a Tier 2/3 intervention. As seen in **Figure 1**, School SBIRT has evolved. After a period of model development and training (2006-2013), the WISH Center began providing regular training in School SBIRT (2014-2017). With the passage of Wisconsin Act 31 and the allocation of funding (2017), personnel and infrastructure was expanded to support districts in an implementation process (2018 to present).¹¹ In parallel to the evolution of School SBIRT, the Wisconsin Department of Public Instruction developed policies, procedures, and practices as part of a framework for supporting student mental health.¹ Districts can now use participation in the SBIRT implementation project to align policy with a practice that can effectively and efficiently address student behavioral health issues.

Figure 1. History of School SBIRT in Wisconsin.



The purpose of this report is to describe the School SBIRT implementation project activities and outcomes for the 2021-2022 academic year. First, the School SBIRT model and implementation project is described, then outcomes are reported, key findings are summarized, and recommendations are made.

Description of School SBIRT

As seen in **Figure 2**, the School SBIRT model comprises components (Screening, Brief Intervention, Referral to Treatment), processes (engaging, focusing, evoking, planning), core skills (asking, listening, informing), and tools. SBIRT begins with an engaging process to rapidly establish a productive and caring working relationship with the student, then the service comprise the following components.

Screening (S)

Two standardized instruments are administered. First, the GAIN-SS (Global Appraisal of Individual Need–Short Screen)¹² provides brief assessment of 20 symptoms across 4 domains: Internalizing (mental health), Externalizing (conduct), AOD (alcohol/other drug use), and Crime/Violence. Red flag symptoms are identified as occurring within the past 30 days or past 2-12 months. Within each domain, these symptoms are counted for a 0-5 scale with results showing no/low risk (0 red flag symptoms), moderate risk (1-2 symptoms), or high risk (3 or more symptoms). Risk is considered the likelihood that a clinically significant problem exists within a domain. After obtaining parent consent to administer, the GAIN-SS screen takes about 5 minutes to administer, score, and interpret. The second instrument is the TLFB (Timeline Follow Back) calendar.¹³ Following the GAIN-SS, the TLFB allows the student to self-report frequency of the most salient risk symptom occurring within the past 30 days (e.g., AOD: number of times a substance was used; Internalizing: number of days a mental health symptom occurred). Identifying risky substance use, behavior, or mental health symptom informs the focus for brief intervention.

Brief Intervention (BI)

BI is delivered to students who show moderate risk or high risk screening results with focus on a specific change target (i.e., a substance, symptom, or behavior). BI involves evoking the student’s own ideas and motivations for change, then planning with a change goal and plan for the selected target. BI typically involves 4 sessions (~20 minutes each) and delivery is guided by a 1-page protocol and corresponding tools. BI utilizes motivational interviewing skills and strategies for the change conversation.^{14,15,16,17}

During the final session, the GAIN-SS and TLFB calendar is re-administered for the past 30-day period to ascertain student response to BI.

Referral to Treatment (RT)

During the final session, for students who show continued red flag symptoms or who show little or no response to BI, a referral is considered for further services. The referral conversion typically involves a caregiver and considers service options that may be available in-school or options in the community such as referral to an outpatient behavioral health treatment clinic.

Figure 2. Visual depiction of the School SBIRT model.



Design of the SBIRT Implementation Project

As highlighted in the **Table 1** logic model, design of the implementation project was based on funding, resources, time, and expertise (INPUTS) with the goal of participating staff to integrate SBIRT into routine Tier 2/3 services with fidelity (OUTPUTS). It is through integration into routine services with fidelity that students can receive the anticipated benefits of SBIRT (EXPECTED OUTCOMES). Implementing any evidence-based practice is an ambitious goal because staff must engage new ways of working. To support staff new ways of working, the project featured several components based on best practices of implementation:^{18,19} school selection through application, training, fidelity review, self-assessment of practice, implementation planning, community of practice, and a data system.

Table 1. School SBIRT implementation logic model.

INPUTS →	OUTPUTS →	EXPECTED OUTCOMES
Investments of funding, resources, time, and expertise <ul style="list-style-type: none"> • DPI funding • WISH Center staff • DHS consultant Initial training for school staff <ul style="list-style-type: none"> • Introduction to the SBIRT model and tools • Fidelity review and feedback • Team-based implementation planning Community of practice meetings <ul style="list-style-type: none"> • Technical assistance • Ongoing learning 	Staff engage new ways of working <ul style="list-style-type: none"> • Staff acquisition of SBIRT knowledge and skills to fidelity standards • Staff integration of SBIRT into routine Tier 2/3 services • Staff increased confidence for addressing student behavioral health issues 	Student benefits <ul style="list-style-type: none"> • Engagement in services • Reduced problem symptoms • Reduced problem behavior • Satisfaction with services School benefits <ul style="list-style-type: none"> • Alignment with PBIS and school mental health policies and procedures • Increased access, efficiencies, and effectiveness of services

Application

Districts had to successfully apply to enter the project.²⁰ Expectations for project participation included identification of an administrator to help identify and problem-solve barriers to implementation; identify an existing team or create an SBIRT implementation team; engage all implementation activities (e.g., training, follow up technical assistance); experiment with new ways of working in SBIRT and deliver services with 1-2 new students monthly; and track SBIRT data in a simple data system. Each school received a \$2,000 stipend for successful project participation.

Training

Virtual training commenced staff's participation in the project. Two training options were offered in November and December 2021: initial training for new districts (7 hours of virtual workshop + 4 hours of asynchronous learning) or booster training (2.5 hours of virtual workshop) for districts previously involved in the project. A total of 133 staff participated (n = 92 for initial training; n = 41 for booster training) representing 24 school districts. In all training, staff received a comprehensive packet of SBIRT materials and practice resources. An important resource was a 1-page protocol that guided the delivery of SBIRT. Use of a protocol is highly recommended to support school services implementation of an evidence-based practice.²¹ Training was highly experiential and skill-focused with opportunities to practice BI skills.²² Research shows that a 2-day training can yield small but statistically significant gains in BI skills.²³

Fidelity review

At the conclusion of the initial training, 83 staff submitted (90% submission rate) an audio recorded sample of BI practice. Practice samples were based on a 10-minute brief intervention using the 1-page protocol. Completed with a training partner, staff took turns in the practitioner role and student role in which the change target was risky alcohol use. WISH Center staff collected the recorded practice samples for fidelity review using an adapted fidelity instrument.²⁴ Direct observation of practice with structured observation and performance-based feedback is the gold-standard of learning any evidence-based practice.¹⁸ Staff received individualized written feedback and results with comparison to established fidelity standards (see **Table 2**).^{24,25} Consistent with the training research, staff were able to meet or exceed fidelity standards on most measures of practice.

Table 2. Average fidelity review results of staff BI skills.

Brief Intervention Skill Measure	Fidelity standards		Average results of staff practice samples (N = 83)	Range
	Basic	Advanced		
% Open Questions of total questions	≥ 50%	≥ 70%	77% **	40% to 100%
% Complex Reflections of total reflections	≥ 40%	≥ 50%	52% **	0% to 100%
Ratio of Reflections to Questions	≥ 1.0	≥ 2.0	0.9	0 to 10
# BI Adherent behaviors	≥ 1	≥ 2	1.5 *	0 to 6
# Non-Adherent behaviors	= 0	= 0	0.7	0 to 5

Note. Advanced fidelity standard met denoted by **. Basic fidelity standard met denoted by *.

Self-Assessment

Following training, staff were asked to complete a self-assessment of BI following one session with each student. The self-assessment comprised 6-items based on BI processes (i.e., engaging, focusing, evoking, planning) and use of the protocol. Staff responded to each item using a 1-5 scale to indicate the extent to which each process/protocol was used during a session: 1(*not at all*), 2(*a little*), 3(*somewhat*), 4(*a lot*), or 5(*extensively*). Staff completed 81 self-assessments (37% completion rate) with overall average score 3.7 (range 1-5, SD = 0.8).

Implementation Planning

Each participating team was encouraged to plan for implementation. SBIRT implementation was conceptualized at a Tier 2/3 practice. It was recommended that staff strive to deliver SBIRT with 1-2 new students per month. This recommendation was a consistent message throughout the project. Team planning utilized a worksheet created for the purpose of the project which consisted of a brief assessment of implementation factors (leadership accessibility, policies/procedures to support SBIRT, teaming structure, and referral pathway) and an initial plan for improving these factors with “next right steps.” Teams were informed that planning would be an ongoing, iterative process to improve SBIRT deliver during project involvement.

Community of Practice

A community of practice (CoP) followed staff training and allowed professionals “who share a concern, a set of problems, or a passion about a topic... [to] deepen their knowledge and expertise in this area by interacting on an ongoing basis.”²⁶ Starting in January 2022, three 90-minute meetings (each had two time options) were offered to participating staff. As shown in **Table 3**, meetings focused on continued

learning, skill practice, and addressing implementation issues. Meeting attendance in any one meeting ranged from 36% to 43% of total staff. For aggregate attendance, 29% of staff attended 0 meetings (n = 39), 33% attended 1 meeting (n = 44), 26% attended 2 meetings (n = 35), and 11% attended all 3 meetings (n = 15). There was no difference (p = .71) between average rate of CoP meeting attendance for staff who received initial training (M = 39%) or who received booster training (M = 41%).

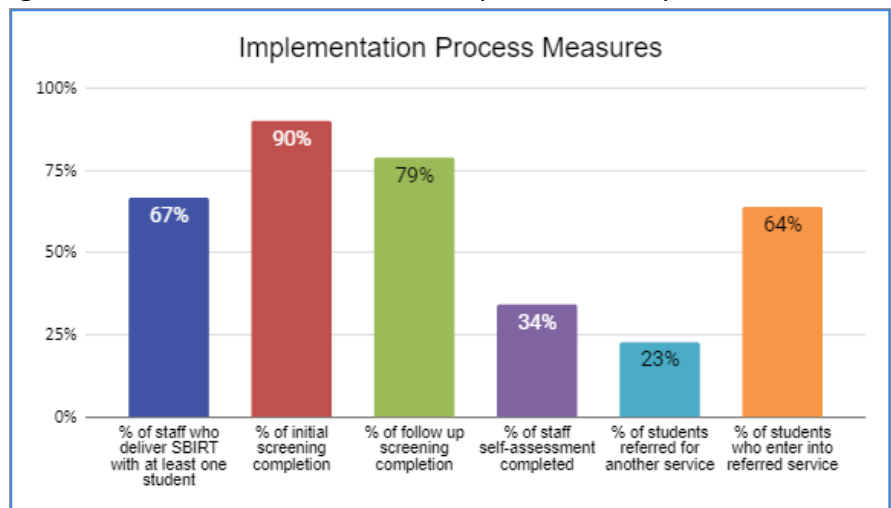
Table 3. Focus and attendance of the community of practice by meeting.

Meeting number and month in 2022	Meeting focus	Number of staff in attendance (% total staff)
#1 January	<ul style="list-style-type: none"> Purpose, agreements, and engaging activity Feedback on aggregate staff fidelity results Small group work (screening procedure, skill practice, implementation challenges, use of data) 	48 (36.1%)
#2 March	<ul style="list-style-type: none"> Skill practice activity Review BI processes Consider student readiness for planning Structured discussion on implementation successes and challenges 	54 (40.6%)
#3 May	<ul style="list-style-type: none"> Review of data dashboard results Team implementation planning Closing activity 	57 (42.9%)

Data System

A data system was created for the project based on recommended measures.¹ The system comprised highly salient implementation process measures (e.g., percentage of staff who delivered SBIRT to at least one student, percentage of follow up screening completed), fidelity measures (e.g., staff self-assessment results), and student outcome measures (e.g., results of initial and follow up screening). Each school team received a standardized spreadsheet for SBIRT data entry. A designated team lead ensured data was entered by participating staff in a timely manner. No identifying student information was included in the data system. Data was linked to a dashboard which allowed each team to track their in-process results regarding implementation measures (see example in **Figure 3**) and student outcomes. During CoP meetings, WISH Center staff encouraged teams to examine in-process results to assess implementation progress and areas for improvement. At the end of the academic year, each school team submitted their spreadsheet to the WISH Center. Schools received the stipend for project participation based on submission of completed spreadsheet.

Figure 3. Data dashboard of SBIRT implementation process measures.



At the end of the academic year, each school team submitted their spreadsheet to the WISH Center. Schools received the stipend for project participation based on submission of completed spreadsheet.

SBIRT Implementation Project Outcomes

Evaluation of project outcomes are based on carefully collected data from each participating school. School datasets submitted to the WISH Center were aggregated into a single dataset, then shared with the DHS SBIRT consultant who imported the data into SPSS for statistical analysis. Descriptive statistics are reported for mean (M) and standard deviation (SD) as well as results of inferential statistical testing (i.e., analysis of variance [ANOVA] and correlation). A statistically significant result was assessed when the probability (p) of results due to chance was less than or equal to 5 out of 100, that is, $p \leq .05$. Outcomes are reported for staff level of implementation, results of SBIRT delivery by component, and student outcomes.

Staff Level of Implementation

Of 133 staff participants, 57 staff (42.8% of total staff) representing 19 school districts delivered SBIRT to at least one student. During the spring semester, 221 students received SBIRT services. There was a wide range of delivery with most staff delivering SBIRT to 1-2 students and a few staff delivering SBIRT to many students. As shown in **Table 4**, three unique levels of implementation were identified based on staff delivery: low, moderate, and high. In the low implementation level, staff seemed to experiment with SBIRT and delivered the service to 1 or 2 students. In the moderate implementation level, staff seemed to adopt SBIRT into some routine delivery (M = 4.8 students per staff, range 3-9); this level best approximated the stated expectation that staff deliver SBIRT monthly to 1 or 2 students. In the high implementation level, four staff delivered SBIRT with 82 students (37% of total students). This level of implementation underscored regular use of SBIRT as a Tier 2/3 intervention. High implementation staff showed, on average, a significantly higher ($p < .03$) rate of follow up screening completion (M = 90%) compared to moderate (M = 80%) or low (M = 72%) implementation staff.

Table 4. Staff delivery of SBIRT represented three unique levels of implementation.

Level of Implementation	Number of students who received SBIRT per staff	Total number of staff by level	Total number of students by level (% of total students)	Average number of students who received SBIRT per staff
Low	1-2	35	53 (24%)	1.5
Moderate	3-9	18	86 (39%)	4.8
High	10 or more	4	82 (37%)	20.5

Staff attendance in the community of practice (CoP) directly supported delivery of SBIRT. There was a significant correlation ($r = .36$, $p < .001$) between the number of CoP meetings attended and the number of students who received SBIRT, such that the more meetings staff attended, the more staff delivered SBIRT to students. To further examine this relationship, an ANOVA was conducted on the number of CoP meetings attended. Results showed a robust CoP attendance effect ($p = .001$) such that when staff did not attend any CoP meetings, on average, almost no students received SBIRT (M = 0.2 students). However, when staff attended two CoP meetings, significantly more students received SBIRT (M = 2.3 students) and this attendance effect was maintained for staff who attended three meetings (M = 2.0 students).

Results of SBIRT Delivery

- Initial Screening Results.** Results were based on data from 221 students. Students represented grades 6-12 with about half in middle school (n = 106) and half in high school (n = 112). (Grade level was not indicated for 3 students.) On average, students reported 4.7 red flag symptoms (range 0-15) out of 20 possible GAIN-SS symptoms during the past 30 days at time of screening. There was no

difference in the number of red flag symptoms for middle school or high school students. Further, there were 10.2 occurrences, on average, of the change target (e.g., occurrence of substance use, mental health symptom, or problem behavior) in the same 30-day period. GAIN-SS results are presented in **Table 5**. The overall risk profile of students was moderate-to-high risk with internalizing and externalizing symptoms showing highly prevalent rates of 87.8% and 92.3%, respectively. Consistent with clinical assessment research,²⁷ there was a strong correlation between internalizing and externalizing symptoms ($r = .49, p < .001$) meaning these sets of symptoms commonly co-occur among at-risk adolescents.

Table 5. Percentage of student response on initial GAIN-SS by risk level.

GAIN-SS Domain	Low risk	Moderate risk + High risk = Total %
Internalizing symptoms	12.2%	34.4% + 53.4% = 87.8%
Externalizing symptoms	7.7%	31.7% + 60.6% = 92.3%
Alcohol/Drug symptoms	50.2%	31.2% + 18.6% = 49.8%
Crime/Violence symptoms	51.6%	43.4% + 5.0% = 48.4%

- Brief Intervention.** The BI component of SBIRT services addressed a specific change target that was salient from initial screening. Staff reported using BI to address the following change targets: substance use such as marijuana, vaping, and alcohol (n = 65 students; 29% of total students); mental health such as a symptom of depression or anxiety (n = 69, 31%); a conduct problem such as fighting (n = 45, 20%); and “other” behaviors (n = 38, 17%) which staff anecdotally described as relating to academic performance or school attendance. (There was not a change target reported for 4 students.) Of note, number of past 30-day initial GAIN-SS symptoms, on average, were significantly higher ($p < .02$) for students who received BI to address substance use (M = 5.2) or mental health (M = 5.1) compared to other change targets (M = 2.4); a similar pattern existed for the TLFB frequency of behavior/symptom. On average, staff delivered 4.0 sessions (range 1-12 sessions; SD = 1.5). At about 20 minutes per session, the overall average dose of intervention time with each student was approximately 80 minutes. During the final BI session (approximately one month from initial screening), staff administered the follow up versions of the GAIN-SS and TLFB screening instruments. These versions presented the exact same items from the initial screening, but response options were based on the past 30 days. Staff completed follow up screening with 181 students (81.9% completion rate). On an individual-level, follow up screening allowed staff to ascertain student response to BI, recognize successful change and conclude, or consider referral for further services. On an aggregate-level, follow up screening allowed comparison with the initial screening to examine student outcomes in this statewide project.
- Referral to Treatment.** This final component of SBIRT was for students who showed continued red flag symptoms at follow up screening. Fifty-seven students were referred for further services (e.g., comprehensive behavioral health assessment by a licensed provider). ANOVAs showed a severity effect ($ps < .05$) such that students who were referred showed, on average, significantly more GAIN-SS symptoms (M = 4.0 versus M = 2.9) and significantly higher TLFB frequency of change target (M = 8.3 versus M = 3.2) compared to students who were not referred. Of the 57 students referred, 36 students followed through on the referral (63% rate of entry into next service).

Student Outcomes

An important component of the data system was examining student outcomes from SBIRT. Student outcomes were readily evaluated through examining the difference between initial and follow up screening results. Outcome results here are based on the students who received both initial and follow

up screening (N = 181). ANOVA showed no difference ($p = .37$) in number of average GAIN-SS symptoms on the initial screening for students who received follow up screening (M = 4.7) compared to students who did not receive follow up screening (M = 4.3). This finding shows that there was not a systematic difference in initial symptom severity for students who were included in the outcome evaluation. The same time period (past 30 days) was used for initial screening and follow up screening, thus allowing meaningful comparison. As presented in **Table 6**, there was a robust BI effect for symptom reduction.

Table 6. There was a robust brief intervention effect for students (N = 181) based on initial and follow up screening results.

Screening instrument	Initial Screening (past 30-day) Average Results	Follow Up Screening (past 30-day) Average Results	Significant difference between initial and follow up screening?
GAIN-SS: number of symptoms (0-5) by domain			
Internalizing symptoms	1.8	1.4	Yes, $p < .001$
Externalizing symptoms	1.9	1.4	Yes, $p < .001$
Alcohol/Drug symptoms	0.7	0.3	Yes, $p < .001$
Crime/Violence symptoms	0.4	0.2	Yes, $p < .03$
Timeline Follow Back calendar: frequency of change target	10.2	4.9	Yes, $p < .001$

Across all domains of the GAIN-SS, students showed statistically significant reductions in behavioral health symptoms from initial to follow up screening. A similar pattern was shown for the TLFB screening. The BI was equally effective for middle school and high school students. Further analysis of outcome calculated the difference between initial and follow up GAIN-SS screening results for each student in terms of number of symptoms. Three unique groups of students emerged from this analysis: **Improvers** (n = 115, 63.5% of total) showed an average *decrease* of 3.0 symptoms from initial to follow up screening; **Decliners** (n = 36, 20.0%) showed an average *increase* of 2.2 symptoms; and **No Changers** (n = 30, 16.5%) showed 0.0 symptom change. Notably, Improvers showed a significantly ($p < .001$) higher number of average GAIN-SS symptoms (M = 5.7) at initial screening compared to the Decliners (M = 3.4) or the No Changers (M = 2.8). This finding suggests the BI was particularly effective for the most high-risk students. However, there was no difference in the average number of BI sessions each student group received which suggests more BI sessions may not differentially improve outcome.

Key Findings and Recommendations

The SBIRT Implementation Project represents an important investment of resources for supporting participating staff to integrate SBIRT into routine services with fidelity. This project was made possible through DPI grant funding, the DPI-DHS-WISH Center partnerships, and the outstanding participation of the school teams. Carefully compiled data based on delivery of SBIRT by 57 staff to 221 students provided a unique glimpse into the successes and challenges of implementing School SBIRT. The following were key findings in this report.

- **Students needed the services.** With the results of the initial GAIN-SS showing prevalent moderate-to-high risk behavioral health symptoms (see **Table 5**), participating students were clearly in need of Tier 2/3 intervention services.
- **Students were willing to discuss behavioral health concerns.** Students readily self-reported behavioral health symptoms and this observation is consistent with the clinical research that shows

adolescent self-report is forthcoming and reliable when behavioral health screening is administered by trained staff using best practices (e.g., start with engaging, listen for understanding, discuss confidentiality).^{27,28}

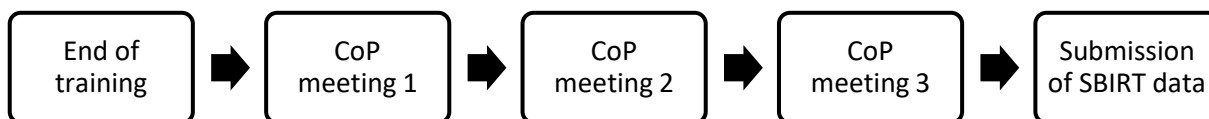
- **Staff demonstrated fidelity.** As shown in the **Table 1** logic model, delivering SBIRT as intended—that is, with fidelity—is critical for students to experience its anticipated benefits. Immediately following training, staff met or exceeded most fidelity standards in delivering BI (see **Table 2**); this finding was comparable to past BI fidelity reviews with school personnel.²² Staff self-assessment of BI practice (designed to support continued fidelity) showed a 37% completion rate.
- **Brief Intervention works.** Delivery of BI yielded a robust effect. Students showed statistically significant and clinically meaningful reduction of symptoms across all GAIN-SS domains (internalizing, externalizing, alcohol/drug, crime violence) regardless of the intervention focus (see **Table 6**). Additionally, students showed decreased frequency of problem behavior/symptom. It was notable that students in the improver group showed, on average, more symptoms in the initial GAIN-SS compared to the other outcome groups suggesting that the highest risk students can benefit from SBIRT. In this evaluation, most students (63.5%) showed improvement and this positive response to BI was comparable to a prior statewide evaluation in which 70.6% of students showed improvement.¹¹ In sum, these findings are consistent with the established literature on BI effectiveness with adolescents³⁰ and provide an important reminder that non-specialist personnel—that is, staff with no background in behavioral health—can learn SBIRT and effectively address behavioral health concerns in opportunistic settings.³
- **SBIRT is an effective Tier 2/3 intervention.** The positive student responses demonstrated in this evaluation make a strong case for “practice-based evidence”²⁹ of school SBIRT as a Tier 2/3 intervention. Although SBIRT was originally designed as a Tier 1 intervention³ (e.g., screening all grade-level students), the effectiveness of a universal screening approach can be limited because SBIRT resources are predominantly allocated to initial screening, thus little time and attention remains for providing BI services.⁹ In this project, at-risk students (Tier 2) and indicated high-risk students (Tier 3) were efficiently selected to receive initial screening so that staff could focus time on providing BI. Staff provided an average of 4 BI sessions (~80 minutes total time) and this “dose” of early intervention has great potential to substantially decrease the long-term risks that unaddressed behavioral health concerns can pose to adolescent development, school engagement, and learning.^{1,6,7,8}
- **Implementation was limited.** Although students benefitted from SBIRT, implementation was limited. Of the 133 staff who attended training, fewer than half attempted SBIRT delivery. Of the 57 staff who did, most (n = 35, 61.4%) delivered SBIRT to 1 or 2 students during the spring semester (see **Table 4**). Limited uptake suggests many implementation barriers existed. Although barriers were not directly assessed in this evaluation, previously identified barriers have included:¹¹ lack of staff time; lack of staff focus; competing demands; awkwardness in new ways of working with SBIRT; lack of teaming structure to efficiently identify students for SBIRT (e.g., SBIRT not on Tier 2/3 meeting agenda); lack of building-level administrator support, monitoring, or accountability. Yet, the implementation of SBIRT by participating schools is critically important to address unmet student behavioral health concerns.³¹
- **Implementation support following training matters.** Implementation support following initial training is critical for implementation success.^{18,19} The community of practice (CoP) meetings were designed to provide technical assistance and support to participating staff (see **Table 3**). Evaluation showed a robust CoP attendance effect, such that when staff attended two or three CoP meetings

(i.e., 66% or 100% rate of participation), significantly more students received SBIRT. Of the 57 staff who delivered SBIRT to at least one student, most attended most of these meetings. From this finding, CoP attendance by staff may be viewed as a proxy for delivering SBIRT.

To improve level of SBIRT implementation and engagement by participating staff, the following is recommended by project component:

- **Application.** Continue application process so that school administrators can make an informed decision about feasibility, fit, need, and capacity to implement SBIRT as an early intervention along a continuum of student mental health supports.¹ Consider offering informational sessions during the application period. A key message of such sessions would be that SBIRT implementation goes beyond initial training and requires dedicated time and resources. Consider tightening criteria for school selection based on application responses regarding capacity to implement.
- **Training.** Develop messages to deliver during training regarding what implementation is and why implementation is important. Example message: “It is important to note that simply choosing to implement an EBP is not adequate to meet the mental health needs of students. [SBIRT] must be continuously supported over time through various post-training, ongoing implementation supports in order to be implemented with consistency and fidelity (p. 14).”¹ During training, facilitate activities that explore and develop staff motivation for delivering SBIRT. Ensure messaging and activities are consistent across all training cohorts.
- **Implementation Planning.** Build in time for team-based implementation planning. Following successful application, introduce implementation planning at the beginning of project participation. For example, implementation planning could be part of the pre-training assignment, then brief discussion about the draft plan during training day 1 could be followed by an assignment that each team develops their plan prior to returning for training day 2. Plans should include how two-way communication will happen between the team and administrators to align school mental health policies and procedures with SBIRT implementation.¹ Communication should also be planned to inform families about the purpose and anticipated beneficial outcomes of School SBIRT.
- **Community of Practice and Data System.** Design and facilitate CoP meetings to recognize, appreciate, motivate, and monitor staff delivery of SBIRT. Incorporating the implementation progress measure dashboard (see **Figure 3**) is particularly important because “Teams monitor these data to ensure that students receive the evidence-based practices as intended... These data can inform specific implementation supports (p. 26).”¹ WISH Center should consider incorporating the dashboard as part of ongoing quality improvement. For example, school teams could use Plan Do Study Act (PDSA) to set an implementation goal (e.g., number of students to receive SBIRT by staff in the coming period) with strategies (Plan), execute the plan (Do), then examine dashboard results (Study) and consider goal/strategy revisions (Act). Within this approach, the period in-between meetings would be considered an improvement cycle (see **Figure 4**). A top priority should be engaging staff in regular CoP meeting attendance. As a parallel process, WISH Center could track attendance as a highly salient project process measure and use PDSA to improve staff attendance with strategies consistent with School SBIRT.³²

Figure 4. There are potentially four improvement cycles in the School SBIRT Implementation Project.



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