Getting Students the Help They Need with the Staff We Can Actually Find

SMART
School Mental Health Assessment Research & Training Center

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10-Minute Spark Presentation

Eric J. Bruns, PhD | UW SMART Center

GLE School Mental Health “Match”

Toronto, ON, Canda

June 1, 2026

A Solo Traveler

Administration and Policy in Mental Health and Mental Health Services Research
https://doi.org/10.1007/s10488-020-01080-9

ORIGINAL ARTICLE

Rates of Mental Health Service Utilization by Children and Adolesce in Schools and Other Common Service Settings: A Systematic Revie and Meta-Analysis

Mylien T. Duong[1] · Eric J. Bruns[2] ·

Accepted: 7 September 2020

Abstract
A meta-analysis was conducted to e
the general population and among t
mental health were compared to o
sented rates of mental health servic
with elevated symptoms or clinica
youth receiving care in each sector
other sectors are as follows: 7.26%
and 0.90% juvenile justice. For you
school-based mental health service
and 4.50% juvenile justice. School
general population and samples of y
are also provided in a range of othe
intervention development, and rese
point to the need for interconnectio

Prevention Science
https://doi.org/10.1007/s11121-022-01463-4

Effectiveness of a Brief Engage Strategy for High School Stude

Eric J. Bruns[1] · Kristine Lee[1] · Chayna Davis[1]
Cheryl Holm-Hansen[2] · Sharon Hoover[3] · Eliza

Accepted: 20 October 2022

Abstract
Schools offer an advantageous setting for the pr
youth. However, school mental health (SMH) s
efficiently delivered, with SMH practitioners (S
study evaluated the feasibility, acceptability, effi
solving, and triage strategy for SMHPs that aim
care. The study, conducted in 15 US school dis
schools and their participating SMHP(s) to eith
or services as usual (SAU; $N = 198$ students). SM
reported the strategy was feasible and well-align
cantly greater engagement in SMH at 2 months
reported significantly greater treatment completi

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School Mental Health
https://doi.org/10.1007/s12310-025-09745-2

ORIGINAL PAPER

Self-Reported Problems of Adolescents Seeking or Referred to School Mental Health Services

eda Liu[1] · Janine Jones[2] · Courtney A. Zulauf-McCurdy[1] ·
lizabeth M. McCauley[1]

Administration and Policy in Mental Health and Mental Health Services Research
https://doi.org/10.1007/s10488-025-01465-8

ORIGINAL ARTICLE

Behavioral Health Student Assistance Programs: Leveraging Non-Traditional Mental Health Providers to Address Workforce Shortages and Mitigate the Youth Mental Health Crisis

Eric J. Bruns[1] · Cassandra Ehde[1] · Larissa M. Gaias[1] · Bethlehem Kebede[1] · Christina McWherter[2] · Erin Wick[2]

Accepted: 26 June 2025

Abstract
Workforce shortages and other barriers have undermined efforts to address recent spikes in youth behavioral health problems. This study evaluates Washington State's Behavioral Health Student Assistance Program (BH-SAP), a novel approach to addressing the youth behavioral health crisis by using paraprofessional-delivered services in schools to expand the continuum of services available to youth. During the 2022-23 school year, 60 Student Assistance Specialists (SASs) delivered 3,218 prevention activities, provided group interventions to 1,158 students, and served 2,532 students with indi-

The U.S. Mental Health Workforce Shortage Is Severe This is True for School MH As Well

Data from WA State, U.S.A.

1:12,000

school social worker ratio
(rec. 1:250 — less than 1/50th)

1:1,100

school psychologist ratio
(rec. 1:500 — less than half)

78% vs 49%

MH providers white vs.
K-12 students white

Why it's hard to fix

- Poor salary-to-debt ratio deters recruits
- Graduates underprepared for school contexts
- Licensed clinicians do not fit school contexts
- Hardest to hire where need is highest

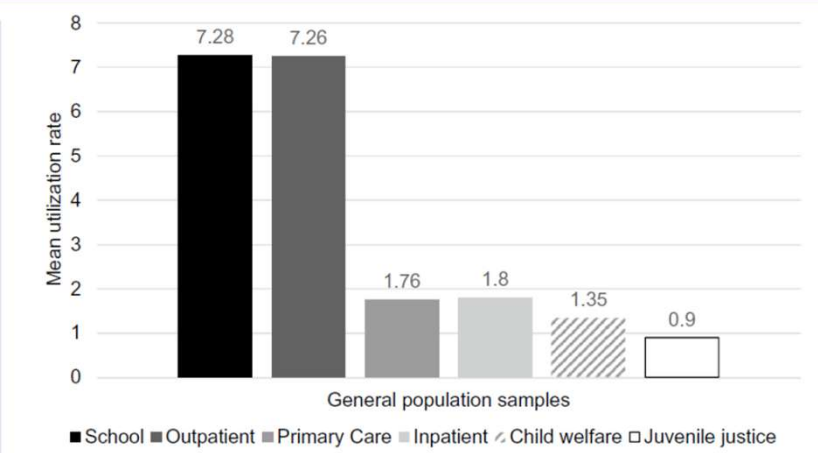
WA State Behavioral Health Workforce Assessment, 2017

Cultural mismatch is also a barrier

78% of WA MH providers are white — but only 49% of K-12 students are white. Language and cultural barriers further reduce access, especially for students of color.

And Yet… Schools Are Where Students Go for Help

Bruns et al. (2025) | N=455 students, 52 high schools, 3 states | doi:10.1007/s12310-025-09745-2

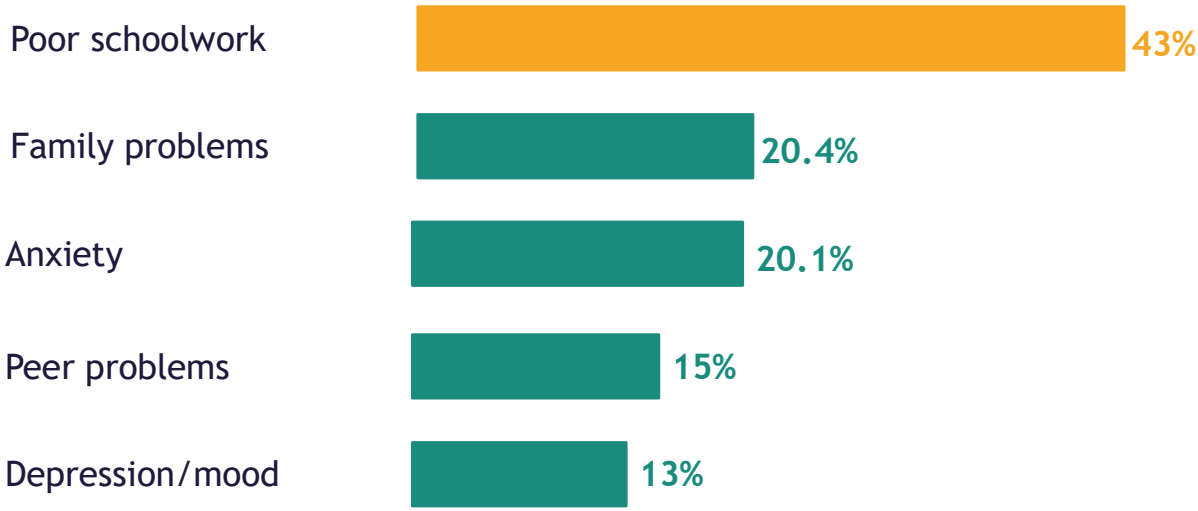


Schools are the single most common setting for youth MH services

Duong, Bruns et al., 2021

- Youth spend the majority of their awake hours in schools.
- School staff are trusted adults
- They notice when students are struggling

But what do students actually come in for?



The #1 reason students seek help is academic — not MH symptoms. Counselors and paraprofessionals make sense as first responders.

If Masters level practitioners are scarce…
And students' top concerns are academic and social —
And they trust school staff to help them…

What is the best strategy?
Do we really need a Master's clinician as first responder?

① Invest in Paraprofessionals

Train non-licensed staff on Tier 1-2 SMH with school- group- and individual-level EBP, structured rubric, and supervision

Example: WA State Behavioral Health Student Assistance Professional (BH-SAP) model

② Equip Staff Already in Every School

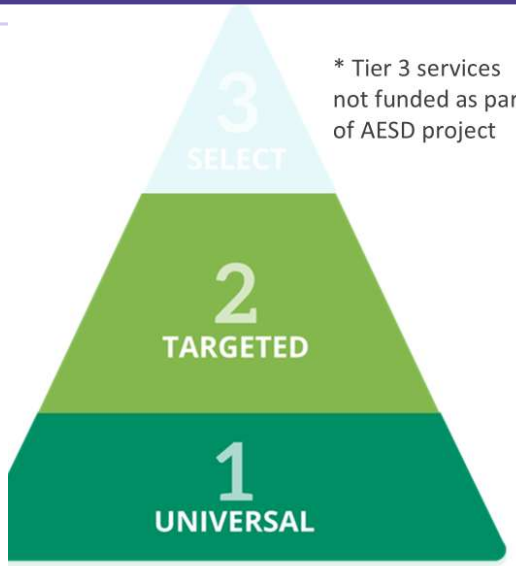
Train school counselors in brief, structured EBP that fits their role and aligns with the MTSS framework

Example: Brief Intervention for School Clinicians (BRISC) for school counselors

BH-SAP: Non-Licensed BA/AA Paraprofessionals in Schools

WA AESD model | Launched 2021 in 80 schools with U.S. COVID Recovery funds | Currently 20 schools via WA Legislature

What BH-SAPs Do



* Tier 3 services not funded as part of AESD project

- Non-licensed staff delivering Tier 1 universal prevention and Tier 2 targeted supports
- Often from same communities as students — reducing cultural & language barriers
- Supervised by licensed MH staff: extends the workforce, does not replace it

Program Standards Rubric

Quality is ensured through a structured rubric covering:

- Staff selection & hiring criteria
- Core training curriculum & competencies
- Ongoing supervision requirements
- Service documentation standards
- Fidelity monitoring processes

★ **Adherence to the rubric is associated with better student outcomes across sites**

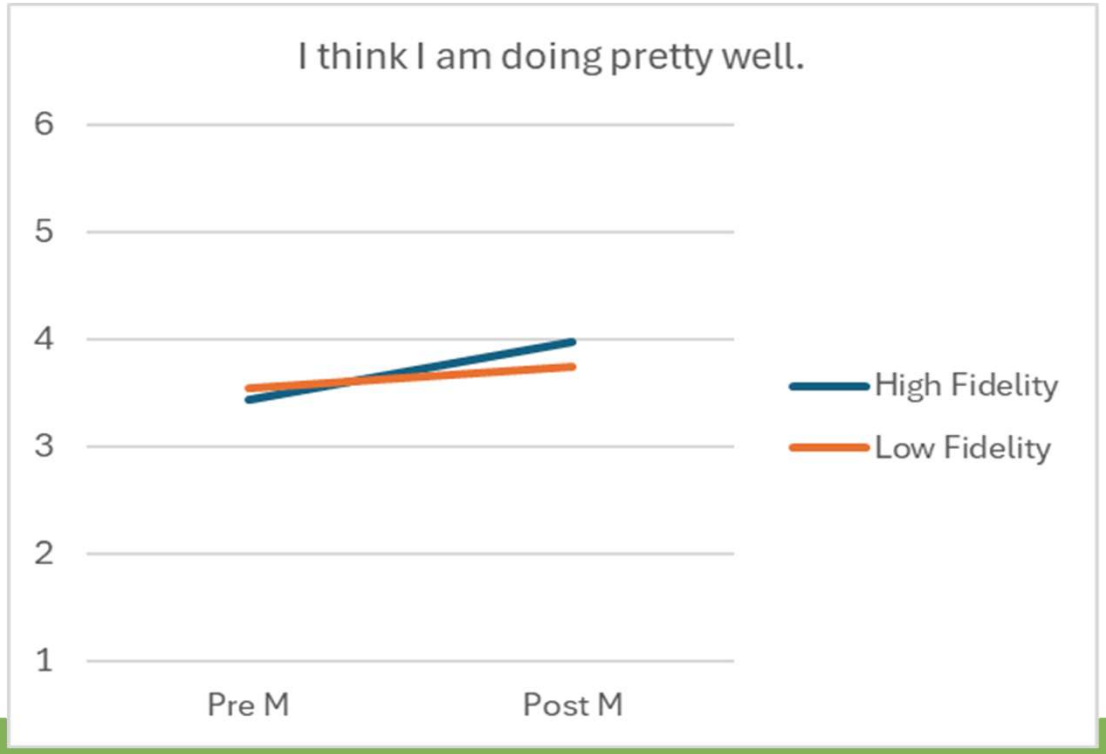
Sample BH-SAP Fidelity Indicators

Program Component
Participate in school building staff meetings
Provide classroom presentations on: Mental health (MH) and Substance use (SU)
Coordinate and implement universal MH and SU prevention campaigns
Participate in multidisciplinary team meetings to facilitate and coordinate referrals and supports
Facilitate or partner with Youth Prevention Club and coordinate activities for the school community
Lead or participate in parent and/or community MH / SU training
Implement group-based intervention curricula
Conduct MH/SU screening using standardized measure

Sample BH-SAP Fidelity Indicators

Program Component	Fidelity Indicators
Participate in school building staff meetings	Attend at least 3 staff meetings per year
Provide classroom presentations on: Mental health (MH) and Substance use (SU)	At least 1 MH and 1 SU presentation per year
Coordinate and implement universal MH and SU prevention campaigns	At least 4 days of MH / SU awareness activities per year
Participate in multidisciplinary team meetings to facilitate and coordinate referrals and supports	Staff participated in a minimum of 3 multidisciplinary team meetings per school
Facilitate or partner with Youth Prevention Club and coordinate activities for the school community	Staff recorded a minimum of 3 Youth Prevention/Leadership club meetings per school.
Lead or participate in parent and/or community MH / SU training	Staff recorded a minimum of 2 parent and/or community trainings.
Implement group-based intervention curricula	Staff conducted at least 1 evidence-based group
Conduct MH/SU screening using standardized measure	100% of referred students were screened

Higher Fidelity to the BH-SAP Model is Associated with Better Student Outcomes



BH-SAP effects are similar to licensed clinicians

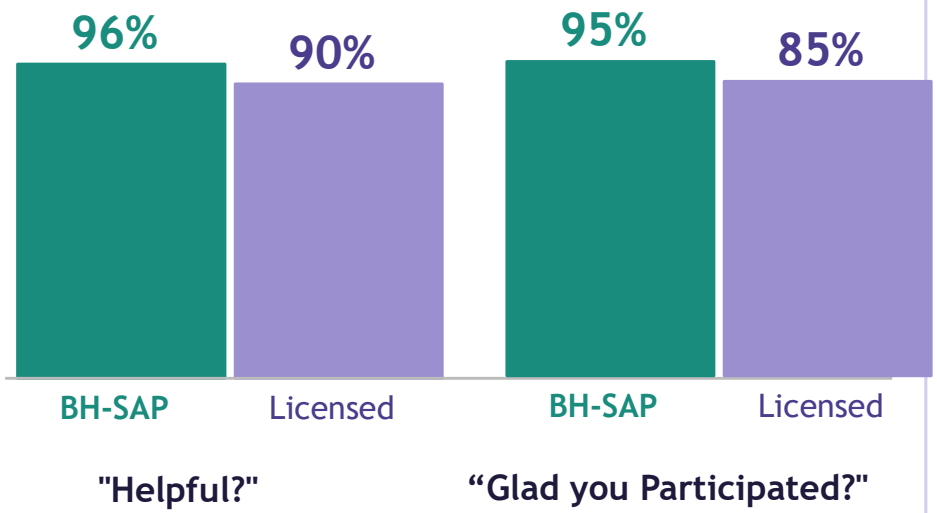
…and students like them more

Program evaluation | N=4,000+ students | 82% pre-post survey completion

Bruns et al., 2025

Student Satisfaction

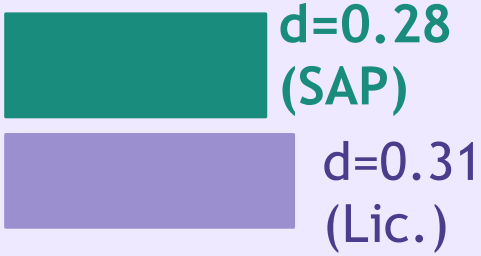
BH-SAP vs. Licensed Clinicians



BH-SAP Effect Sizes vs. Licensed Clinicians

Pre-post change on matched outcomes

PHQ-8 (Depression symptoms)



BRISC: Brief, Structured EBP Built for School Counselors

4 sessions • 15–30 min each • Tier 2 within MTSS • Appropriate for any MS/HS practitioner

The Four Sessions

1 — Engagement & Assessment

"What's going on?" — identify top problems

2 — Problem Solving

Student sets a goal; maps concrete steps

3 — Skills as Needed

Stress mgmt, realistic thinking, communication

4 — Review & Triage

Progress check → done, continue, or refer up

Why This Fits School Counselors

Role-appropriate

Problem-solving is what counselors already do — BRISC adds structure and evidence

Not “therapy”

Tier 2; does not require a license or parent release to deliver

Fits school schedules

15–30 min sessions- work during free periods, homeroom, lunch

MTSS-integrated

Results-informed triage to next steps fits RTI/MTSS framework

They are already there

School counselor is in every school — no new hire required

BRISC: What the Randomized Trial Showed

Multi-state RCT | N=457 students | 49 high schools | 15 districts | WA, MN, MD | Bruns et al., 2023

53%

treatment completion after 4 sessions

vs. 15% usual care

61%

student engagement in SMH at 2 months

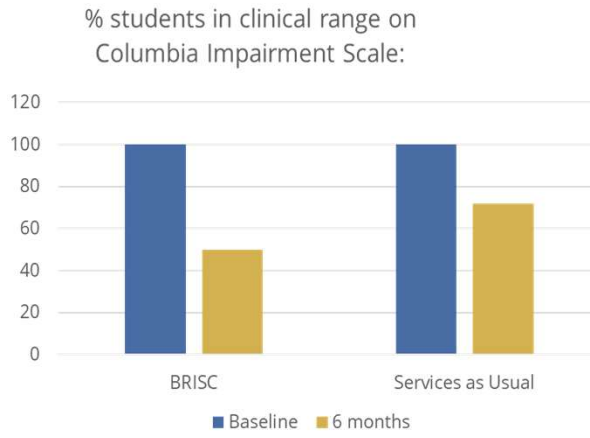
Compared to 29% for TAU

↓

student-rated top problem severity

at 2 and 6 months

Even though they complete services faster, **fewer BRISC students were in the clinical range after 2 and 6 months**



Clinicians rated BRISC highly:

- Motivation to continue using BRISC: 7.3/10
- Compatible with the school's mission: 3.3/4
- Own effectiveness using BRISC: 7.3/10

"BRISC promotes efficiency within school MH with no compromise to effectiveness." — *Prevention Science*, 2023

A Tiered Workforce Strategy: Aligned with MTSS Tiers

Each tier uses the least specialized staff sufficient to address student need

TIER 3 | Intensive

- Licensed clinicians & community MH partnerships
- for highest-need students requiring EBTs

TIER 2 | Targeted

- School counselors deliver BRISC (4 sessions, data-informed);
- BH-SAP paraprofessionals provide group and individual intervention with supervision

TIER 1 | Universal

- All staff trained in MH literacy & referral protocols;
- BH-SAPs lead group supports & skills programs;
- Counselors promote SEL school-wide

Key Principles / Big Ideas

- Prevention / School-wide strategies first
- Least-specialized staff first
- Clear role definitions
- Supervision ensures quality
- MTSS-integrated
- Free licensed clinicians for complex needs

Some Basic School MH Workforce Solutions

Invest

In paraprofessionals — structured rubric, clear training, adequate supervision.
BH-SAP outcomes match licensed clinicians. Students prefer them.

Equip

Existing school staff (e.g., counselors) with brief, structured, research-based, role-appropriate, MTSS-aligned strategies.

Study

How to use these strategies as a multi-tiered package.
Which models generalize across nations?
What does your country's version look like?
How do we build a comprehensive strategy?

How Are These Ideas Relevant to Your Community / Country?

UW SMART Center

smartcenter.uw.edu

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BRISC:
smartcenter.uw.edu/programs-services/brisc

BH-SAP/
aesd.net/student-assistance-program

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