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Abstract

Initial evidence suggests that school counselors can be trained in evidence-based prevention programs and treatments; however, the application of these interventions in the school setting is influenced by a variety of factors, including characteristics of the intervention, the provider, and the organization. Understanding and attending to these factors is crucial to promoting the successful implementation of evidence-based interventions in school settings. This study examined the initial feasibility and acceptability of a training and implementation package for Interpersonal Psychotherapy – Adolescent Skills Training (IPT-AST), a school-based preventive intervention for adolescent depression. Participants consisted of 33 school counselors from middle and high schools in six school districts in New Jersey who were invited to receive training in IPT-AST. Approximately six months following the training, participants completed 20-30 minute individual, semi-structured interviews regarding a) whether or not they ran IPT-AST groups, b) perceived barriers to and facilitators of implementation, and c) suggestions for improvements to the IPT-AST training package. Of the 33 counselors interviewed at six-month follow up, only one had implemented an IPT-AST group (with significant modifications), and two others had attempted to run a group together. About half of the participants (N=16) reported incorporating components of IPT-AST (e.g., communication skills, closeness circle), into their individual, group, or dyadic work. Participant responses highlighted numerous barriers to implementation of IPT-AST that generally grouped into six categories: 1) time, 2) support from school community, 3) fit with school priorities and needs, 4) logistics, 5) readiness for implementation, and 6) beliefs. The facilitators of implementation of IPT-AST groups, as reported by three participants, fell into similar categories: 1) support from school community, 2)
logistics, 3) readiness for implementation, 4) beliefs, and 5) provider characteristics. Implications for future training and implementation efforts are discussed.
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Introduction

Approximately one quarter of youth have experienced a mental health disorder during the past year, and about one third will experience a mental health disorder across their lifetimes; however, the majority of youth with current needs do not receive treatment (Merikangas, Nakamura, & Kessler, 2009). In one nationally representative sample of more than 11,500 households with children, 15-21% of youth reported mental health problems, with only 29-49% of them receiving services (Kataoka, Zhang, & Wells, 2002), leaving more than half of these youth in need. Studies have found that the majority of youth who access services do so in school settings, accounting for 70-80% of treatment-seeking youth (Burns et al., 1995; Farmer, Burns, Phillips, Angold, & Costello, 2003). This points to the vital role that schools can and should play in improving access to mental health care. Indeed, policy makers and consumers have increasingly recognized the importance of utilizing the school setting for mental health service delivery (Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007). For instance, the American Academy of Pediatrics (2004) endorsed the implementation of effective mental health services in schools as a means of improving access to care and enhancing service coordination. Among youth at risk for depression in particular, services provided in school settings have been found to be the most highly utilized across all ethnic and socioeconomic groups; this underscores the importance of school-based services in increasing accessibility for diverse populations (Lyon, Ludwig, Vander Stoep, Gudmundsen, & McCauley, 2013).

Despite this great potential that schools possess, research on the implementation of evidence-based interventions in school settings is still in its infancy. The intervention research cycle typically progresses from pilot to efficacy to effectiveness studies, and then moves to implementation and dissemination research. The efficacy of youth interventions for a variety of
conditions has been established (e.g., David-Ferndon & Kaslow, 2008; Eyberg, Nelson & Boggs, 2008; Pelham & Fabiano, 2008; Silverman et al., 2008; Silverman, Pina & Viswesvaran, 2008); however, much of this evidence comes from efficacy trials conducted under controlled conditions with highly trained clinicians and the ability to exclude patients based on research criteria (Weisz, Donenberg, Han, & Weiss, 1995). Fewer school-based effectiveness studies, which examine the effects of the interventions when delivered by community-based professionals, have been conducted. Generally, effectiveness trials have found less positive findings than efficacy studies, which has been attributed to differences in the level of care provided and to variability in implementation quality (Burns, 1999; Burns, Hoagwood, & Mrazek, 1999; Durlak & DuPre, 2008; Jensen, Hoagwood, & Trickett, 1999; Weersing & Weisz, 2002). This research-to-practice gap has paved the way for recent studies on implementation and dissemination, which focus on examining effective methods for training community-based practitioners and promoting successful uptake and utilization of efficacious programs in community settings, such as schools.

The following sections briefly review the depression prevention effectiveness studies that have utilized school personnel, other intervention studies that have investigated training packages for school-based mental health professionals, and the emerging literature on barriers and facilitators to effective implementation of interventions in school settings. The final sections review the efficacy of Interpersonal Psychotherapy-Adolescent Skills Training (IPT-AST; Young & Mufson, 2003), a school-based depression prevention program, and provide a rationale for developing and evaluating an IPT-AST training and implementation package for school counselors.
Leveraging the School Setting in the Prevention of Depression

A number of effective depression prevention programs have been developed, primarily based on cognitive-behavioral approaches (Horowitz & Garber, 2006; Stice, Shaw, Bohon, Marti, & Rohde, 2009). Some are universal interventions, which are provided to the entire population, while others are targeted interventions that are provided to a subsample with a known risk factor (selective prevention) or to individuals with subsyndromal symptoms (indicated prevention) (Gordon, 1983). Many of these depression prevention programs have been studied in school settings, in both efficacy and effectiveness trials. While these interventions have proven to be effective when delivered by research staff, delivery by school personnel yields mixed results. In particular, universal prevention programs implemented by school staff have found reduced or non-significant effects as compared to those implemented by research staff. For example, results from an effectiveness study of the Penn Resiliency Project (PRP), a cognitive-behavioral school-based depression prevention program, provided limited evidence for PRP’s effectiveness when the intervention was delivered by teachers, school counselors, and graduate students not associated with the research team. These effects varied by school, with the intervention having long lasting effects on depressive symptoms in two of three schools; however, the authors were unable to identify the source of these differential effects (Gillham et al., 2007). In addition, a PRP-based program implemented in the United Kingdom found that the intervention produced small, short-term effects on depression symptoms when implemented by school staff (mostly teachers), but these effects did not persist to one or two year follow ups (Challen, Machin, & Gillham, 2014). Finally, an effectiveness study for the Resourceful Adolescent Program (RAP) found no significant effect of the program on student depression
outcomes when delivered by school personnel, who were predominantly teachers (Harnett & Dadds, 2004).

Results from indicated and selective prevention programs are a bit more encouraging. For example, school psychologists have been found to effectively deliver a cognitive-behavioral prevention program to Icelandic adolescents at-risk for depression when provided with intensive training, regular phone supervision, and formal biweekly supervision (Arnarson & Craighead, 2009). Adolescents in the experimental group had significantly lower rates of first incidence of major depressive disorder or dysthymia as compared to assessment-only controls at post-test, 6-month (Arnarson & Craighead, 2009), and 12-month follow up (Arnarson & Craighead, 2011). Another effectiveness trial of a brief, cognitive behavioral group preventive intervention trained school staff (counselors and nurses) utilizing a four-hour workshop, reading assignments, and ongoing supervision that involved review of audio-visual recordings and provision of feedback via email. They found a significantly reduced onset of major depressive disorder as compared to brochure control and bibliotherapy conditions; however, effects were small or non-significant at six-month follow-up. Further, these effects were approximately half the magnitude of those found in efficacy research (Rohde, Stice, Shaw, & Briere, 2014).

These mixed findings point to the need to improve training efforts and address other barriers that may be impeding successful implementation of these programs in school settings. Given the extensive research supporting the efficacy of these programs, and the support for utilization of the school setting for service delivery, more work is needed to increase the impact and reach of these depression prevention programs.
Training School Counselors in Evidence-Based Interventions

Research has suggested the need to utilize school counselors to help increase access to mental health services in schools (e.g., Lockhart & Keys, 1998). School counselors have been identified as the most common type of school-based personnel providing mental health services, and they spend an estimated 52% of their time dedicated to providing these services (Foster et al., 2005). School counseling programs provide preparation in group counseling (98.4%) and counseling children/adolescents (64%), as indicated in a survey of American School Counselor Association (ASCA) members (Pérusse, Goodnough, & Noel, 2001); however, others are skeptical regarding school counselors’ level of preparedness for meeting the mental health needs of today’s youth (Lockhart & Keys, 1998). As such, it is important to better understand whether school counselors can in fact be trained to deliver evidence-based interventions, and how to best facilitate this process. Further, a study of school psychologists’ perceptions regarding their role in the prevention and treatment of internalizing disorders found that the large majority (68.1%) believe that depression prevention is fitting for their role; however, roughly half (49.4%) endorsed that they needed some additional training in this area (Miller & Jome, 2010). This suggests that school psychologists are ripe for training initiatives around the prevention of depression. In addition, given the limited evidence for the effectiveness of depression prevention programs when delivered by teachers (e.g., Challen, Machin, & Gillham, 2014; Harnett & Dadds, 2004), it seems fitting to investigate the use of other indigenous school staff for program implementation.

The studies that focus specifically on training school-based mental health professionals and school counselors in delivery of evidence-based interventions are limited. One study found that school-based mental health professionals (including school psychologists, guidance
counselors, school social workers, and a school psychiatrist) can improve their adherence to and
knowledge of cognitive behavioral treatment for childhood anxiety following training and
consultation (Beidas et al., 2012). Notably, these authors found no differences between training
conditions (workshop, workshop with active learning, and computer training) on therapist
adherence, skill, or knowledge.

Another study conducted a field trial of the Coping Power Program, an evidence-based
indicated aggression prevention program, and examined two training programs for school
counselors. The “Basic Training” condition involved a three-day training workshop and ongoing
once-monthly training calls, while the “Training Plus Feedback” condition also included
individualized technical assistance and individualized supervisory feedback. Counselors in the
Training Plus Feedback condition yielded positive student outcomes, as compared to treatment
as usual, while counselors in the Basic Training condition showed no differences from the
comparison group (Lochman et al., 2009). This study suggests the need for a robust training
package in order to promote successful implementation; however, these training methods are
time- and cost-intensive, and they may not be feasible for wide-scale dissemination, particularly
in the absence of grant funding.

One study examined school counselors’ (5 guidance counselors, 1 school psychologist) ability to deliver group CBT for social anxiety. Training consisted of 1) receipt of a treatment
manual containing outlines and procedures for each session; 2) attendance at a 5-hour interactive
workshop co-led by the treatment developer and a post-doctoral level psychologist; and 3) co-
leading a 12-session training group with a CBT-trained post-doctoral fellow with weekly
consultation. According to consultants’ ratings, school counselors were adherent to the treatment
(five of six counselors met the criteria of 80% adherence to the treatment protocol). In contrast,
ratings of counselor competence were more mixed. That is, ratings of global competence suggested high implementation quality; however, only half of the counselors met competency criteria for the individual techniques employed (Masia Warner et al., 2013).

Finally, studies that involve training therapists in school-based health centers provide additional evidence that evidence-based interventions can be incorporated into school settings. For instance, in a study of the acceptability and feasibility of the use of a modular psychotherapy system for youth anxiety and depression, therapists in school-based health centers who participated fully in the training were able to select appropriate students, track their use of treatment modules, and administer standardized measures to monitor symptom change (Lyon, Charlesworth-Attie, Stoep, & McCauley, 2011). Another study on the transportability of Interpersonal Psychotherapy for Adolescents (IPT-A) found that community clinicians in urban school-based health clinics could be trained to effectively deliver IPT-A to depressed adolescents when training included a manual, two half days of didactic training, and weekly supervision (Mufson et al., 2004).

**Factors Affecting Implementation**

While research has yielded encouraging results regarding the ability to train school-based personnel in evidence-based interventions, a number of factors impact effective dissemination and implementation. There is general consensus in the literature across many disciplines that factors affecting implementation fall into three categories: (a) characteristics of the program/innovation, (b) characteristics of the implementer, and (c) organizational characteristics (Forman & Barakat, 2011). The factors affecting implementation in school-based settings have been assessed utilizing a variety of methods. This includes 1) a systematic review of 21 studies examining the implementation of school-based programs with cognitive-behavioral (CBT)
components (Forman & Barakat, 2011); 2) interviews with evidence-based program developers regarding the factors perceived to be important to implementation of their programs in schools (Forman, Olin, Hoagwood, Crowe, & Saka, 2009); 3) interviews with implementers of Cognitive Behavioral Intervention for Trauma in Schools (CBITS), including site administrators and school-based providers (Langley, Nadeem, Kataoka Stein, & Jaycox, 2010); and 4) focus groups with school psychologists regarding the barriers and facilitators to providing mental health services in schools (Suldo, Friedrich, & Michalowski, 2010). A review of the factors affecting implementation described in these studies is detailed below, with organizational characteristics emerging as the most frequently cited.

**Program characteristics.** A number of program and training characteristics have been found to play an important role in the efficacy of implementation in schools. The use of standardized manuals, materials that actively engage students, intensive, high-quality training, and ongoing technical assistance/consultation were identified as important components to the training package (Forman & Barakat, 2011). Program developers also highlighted training package components as key elements of success, including good training (noted by 50% of those interviewed), good technical assistance (25%), and engaging the school in the planning stages of implementation (25%) (Forman et al., 2009).

**Provider characteristics.** A provider’s beliefs about the acceptability of an intervention impact successful implementation. For instance, school-based provider attitudes toward evidence-based practice have been found to have a positive relationship with adherence to cognitive-behavioral treatment (Beidas et al., 2012).

Personal characteristics of the implementer such as enthusiasm, warmth, self-efficacy, ability to handle ambiguity, and respect for students were identified by program developers as
markers of successful implementation (87%). Developers also highlighted good interpersonal skills (67%) and good teaching and/or implementation skills (62%) (Forman et al., 2009). For school psychologists, factors that affect involvement in mental health services include their desire to provide mental health services, their level of burnout, the size of their caseload, role strain, and their level of prior training, which includes level of knowledge, skill, and confidence to deliver these interventions. These person-centered factors were identified as the strongest facilitators to providing mental health services, while systems-level factors were cited as barriers to such activities (Suldo, Friedrich, & Michalowski, 2010). Finally, evidence suggests that new learning, which is outside of a trainee’s experience or requires the development of a more complex skill set, may be difficult to master (Fixen, Naoom, Blase, Friedman, & Wallace, 2005; Joyce & Showers, 2002).

Organizational characteristics. One key organizational characteristic found to affect implementation across multiple studies is administrator support (Forman & Barakat, 2011; Forman et al., 2009; Langley et al., 2010; Suldo, Friedrich, & Michalowski, 2010). Administrator presence during training activities and making public statements about the program can serve as facilitators (Forman & Barakat, 2011), while lack of support from school administrators has been found to be a barrier (Langley et al., 2010). Further, the majority of program developers (79%) specifically identified the principal’s leadership style as a facilitator of implementation (Forman et al., 2009).

The level of support from teaching staff has been identified as another factor affecting implementation. For instance, school psychologists noted that problems with school personnel, such as frustration with teachers, or teachers who are unsupportive or unaware of their services, served as a barrier to providing services. On the other hand, support from teachers and support
from the community were both acknowledged as facilitators (Suldo, Friedrich, and Michalowski, 2010). School-based clinicians implementing CBITS also highlighted lack of teacher support as a barrier (Langley et al., 2010). Other staff supports have been identified as facilitators, such as the use of regular school staff members and the presence of a local coordinator (Forman & Barakat, 2011). In addition, knowing someone else who is implementing the intervention (Langley et al., 2010) and the availability of consultation with other school-based mental health providers (Suldo, Friedrich, & Michalowski, 2010) are perceived as a facilitators of implementation.

The program’s fit with the school’s existing goals, policies, and programs, such as recognition by the school of the importance of mental health and prevention, and integration of the program into school activities are common factors that affect implementation (Forman & Barakat, 2011; Forman et al., 2009). Intervention developers also cited competing priorities in the school (29%) and the No Child Left Behind Act (29%) as barriers (Forman et al., 2009).

A variety of logistical barriers also affect implementation and provision of mental health services. These include time during the school day (Forman et al., 2009; Suldo, Friedrich, & Michalowski, 2010), funding for the intervention (Forman et al, 2009), space constraints (Suldo, Friedrich, & Michalowski, 2010), scheduling problems (Suldo, Friedrich, & Michalowski, 2010), and competing priorities (Langley et al., 2010).

**IPT-AST and Its Promise for Dissemination**

Interpersonal Psychotherapy – Adolescent Skills Training (IPT-AST; Young & Mufson, 2003), also known as “Teen Talk,” is an indicated school-based preventive group intervention for adolescents. IPT-AST is based on interpersonal psychotherapy for depressed adolescents (IPT-A), an effective treatment for adolescent depression (Mufson, Dorta, Moreau, & Weissman,
The results from two efficacy studies of IPT-AST are encouraging: adolescents receiving IPT-AST reported significantly fewer depressive symptoms, fewer depression diagnoses, and better overall functioning than youth receiving usual school counseling (Young, Mufson, & Davies, 2006; Young, Mufson, & Gallop, 2010). Further, the positive effects of IPT-AST may extend beyond depression. Adolescents in IPT-AST had a significantly greater reduction in anxiety symptoms compared to youth in school counseling (Young et al., 2012). Adolescents in IPT-AST also had significantly greater improvements in social functioning compared to adolescents in school counseling, and all participants showed improvements in school functioning, family functioning, and engagement in school (Young, Kranzler, Gallop, & Mufson, 2012).

Despite research on the efficacy of this school-based intervention, as well as the recent push to bring evidence-based interventions, especially depression prevention programs, into school settings, no study has examined whether school counselors can be trained to implement IPT-AST. The effectiveness study of IPT-A described earlier suggests that there is potential for training school-based personnel in IPT-AST, as community clinicians in urban school-based health clinics were found to effectively deliver IPT-A to depressed adolescents (Mufson et al., 2004). However, this study involved training mental health clinicians, not school counselors, and the training focused on an individual treatment for depressed adolescents, not a group intervention for those at-risk for depression. Further, the IPT-A study was an effectiveness study where there was a high degree of supervision and oversight of the school-based clinicians. To date, little is known about what is needed to successfully train school counselors to implement IPT-AST and the barriers and facilitators of sustained implementation outside the context of a research study.
Study Aims

The present study examined the acceptability and feasibility of an IPT-AST training program for school counselors (including school psychologists, school counselors, school-based clinicians, and social workers) as an initial step toward future efforts to implement IPT-AST in schools. Specific aims were as follows: a) to determine if a low-cost and minimal time commitment training package is sufficient for school counselors to run groups at their schools, b) to identify barriers to and facilitators of implementation, and c) to generate suggestions for improvement to the IPT-AST training package that would enhance future implementation efforts.

Method

Participants

Participants consisted of 33 school counselors (including school psychologists, school counselors, school-based clinicians, and social workers) from middle and high schools in six school districts in New Jersey who were invited to attend a one-day training workshop in IPT-AST conducted by Dr. Jami Young, a developer of the intervention. These districts represent urban and suburban areas, serving students of diverse backgrounds with regard to race/ethnicity and socioeconomic status. Participants were predominantly female (79%) and represented a variety of racial and ethnic groups (76% Caucasian, 9% Latino, 12% African American, and 6% Asian). This gender and racial/ethnic composition is similar to a nationwide sample of 5,300 school counselors, which was 77% female, and 75% White, 10% Latino, 8% Black, and 1% Asian (Bridgeland & Bruce, 2011). Participants in the present sample ranged in age from 25 to 70 years old ($M = 41.76$, $SD = 12.68$). The majority of participants (88%) received master’s degrees in various areas of counseling (61%), social work (12%), and school psychology (15%). Six percent of participants earned their doctorates (educational psychology and clinical
psychology), and six percent were in the process of receiving degrees (doctorate in clinical psychology and master’s in counseling psychology). In addition, 14% of those with master’s degrees were en route to receiving doctoral degrees. Several counselors (18%) had an additional advanced degree in a related field such as marriage and family therapy. Participants reported a range of years of experience in schools since receiving their degree (range: 0-30, $M = 9.89$, $SD = 7.54$), and years working at their current school (range: 0.25-35, $M = 7.08$, $SD = 7.32$). The participants for the present study ($N = 33$) did not differ significantly from those originally recruited at the training ($N = 38$) on any of the demographic variables, including age ($t(69)=.39$, $p=.69$), gender ($\chi^2 = 0.06$, $p=.81$), race/ethnicity ($\chi^2 = 1.58$, $p=.66$), degree received ($\chi^2 = 3.4$, $p=.49$), years of experience ($t(69)=.45$, $p=.65$), and years working at their current school ($t(69)=.51$, $p=.61$).

**Procedure**

School counselors from seven school districts in New Jersey were invited to attend a one-day training workshop in IPT-AST conducted by Dr. Young. These districts were selected because of their participation in the Depression Prevention Initiative, Dr. Young’s ongoing randomized controlled trial comparing IPT-AST conducted by research personnel to group counseling conducted by school counselors. The one-day training workshop was provided free of charge as a service to participating districts.

Data were collected as part of a larger study on the initial feasibility and acceptability of training school counselors in IPT-AST. Workshop attendees were notified of the study by email in advance of the workshop and were provided with additional information and consent forms the morning of the workshop. A total of 49 school counselors from six (of the seven) districts attended the training. Thirty-eight school counselors consented to participate in the larger study.
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(N=38), nine declined, and two arrived late and were therefore not recruited for the study, yielding a response rate of 81%.

Participants attended a five-hour workshop on IPT-AST theory and techniques led by Dr. Young and two other doctoral-level psychologists with experience running IPT-AST groups. The workshop included: 1) a discussion of the background and empirical support for IPT-AST, 2) instruction in early, middle, and termination phases of IPT-AST and core intervention techniques, 3) demonstrations of pre-group and group sessions, and 4) role play with supervision. The training was modeled after previous workshops on IPT-AST that Dr. Young has delivered.

School counselors who provided consent to participate in the study were asked to complete self-report measures prior to the start of the workshop. Select measures were completed a second time following workshop completion.

Following the workshop, participants were invited to join a listserv that would serve as a forum for logistical questions on implementation. School counselors had the option of signing up for the listserv and could choose to post and/or respond to questions from other participants regarding implementation of IPT-AST groups in their schools. School counselors also had the option of attending two hour-long consultation calls with Dr. Young, which occurred approximately two and four months following the training. These calls were designed to assist school counselors with clinical questions and application of IPT-AST techniques.

Approximately six months following the training, school counselors (N=33) participated in 20-30 minute individual, semi-structured interviews with the Principal Investigator in person or by phone regarding a) whether or not they ran IPT-AST groups, b) perceived barriers to and facilitators of implementation, and c) suggestions for improvements to the IPT-AST training package. Two counselors requested not to be contacted for the interview at the time of initial
consent, one refused to participate in the interview, and two did not respond to outreach from the Principal Investigator, yielding an 87% retention rate for the present study. Counselors who completed the interview were compensated with a $30 Visa gift card for their participation.

Measures

Data were collected on the day of the workshop on participant demographics, current job roles/responsibilities, perception of school climate, IPT-AST knowledge, intention to implement IPT-AST, confidence to deliver IPT-AST, and satisfaction with the training. See Table 1 for a brief description of the measures completed at each time point. A semi-structured interview guide for the individual interviews is located in the Appendix. Participant responses to the quantitative self-report measures were utilized as stimuli in the interviews, as appropriate, in order to elicit richer qualitative data. Data were also collected on the number of groups run and usage of the optional consultation and technical assistance components. The interview and frequency data are the focus of the present study.

Data Analyses

Each individual interview was transcribed and coded for common themes. An inductive analysis of the individual interviews allowed categories and meaning to emerge, utilizing a grounded coding system in which themes and patterns are determined by the data (Corbin & Strauss, 2008). The Principal Investigator reviewed each transcript to develop a codebook of relevant themes. The initial codebook listed themes reported in the school-based implementation literature and was later refined based upon the data. The Principal Investigator and a second coder then coded each transcript independently utilizing qualitative data analysis software (Nvivo). The coders met to discuss any discrepancies and arrive at a consensus. Inter-rater reliability was calculated utilizing Cohen’s kappa coefficient (Cohen, 1960). The average kappa
value for the codes utilized in the present study was 0.75, which is considered “substantial” agreement (Landis & Koch, 1977). Of the 57 codes utilized, 23 fell within the “almost perfect” range (over 0.81), 25 fell within the “substantial” range (0.61-0.80), 5 fell within the “moderate” range (0.41-0.6), 2 fell within the “fair” range (0.21-0.4), and 2 fell within the “slight” range (0.0-0.2). See Table 2 for a list of codes and kappa values. Given the lack of research in this area and the exploratory nature of this study, the use of qualitative data is appropriate, as the purpose is to develop a detailed and in-depth understanding of the barriers to and facilitators of implementation (Palinkas, 2014). This qualitative data also serves a pragmatic purpose, as it informs the components of future training packages.

**Results**

**Utilization of IPT-AST**

The majority (91%) of school counselors did not implement IPT-AST groups in their schools at 6-month follow up. Two participants attempted to implement a group together, and one participant implemented an IPT-AST group with significant modifications based on the cognitive functioning and needs of the students who participated. Despite these low implementation rates, about half of the school counselors (N=16) reported incorporating components of IPT-AST into their individual, group, or dyadic work. This included use of the communication skills (N=11), the closeness circle (N=8), role playing (N=7), scripting a conversation (N=4), linking affect to interpersonal relationships (N=3), assigning interpersonal work at home (N=3), conducting a communication analysis (N=2), and obtaining a mood rating (N=2).

Quantitative analyses were conducted to determine any significant differences between “implementers” (i.e., individuals who ran an IPT-AST group, attempted to run an IPT-AST
group, and/or incorporated IPT-AST components) and “non-implementers.” Implementation commitment immediately following the workshop was significantly higher among implementers ($M=4.8$, $SD=.53$) than non-implementers ($M=3.8$, $SD=1.2$); $t(17)=-1.05$, $p<.01$. Notably, the three counselors who ran or attempted to run IPT-AST groups reported implementation commitment at or above the implementers group mean ($M=5.15$, $SD=.23$). Differences in acceptability/efficacy ratings reported post-workshop were significant, with implementers reporting higher acceptability/efficacy ratings ($M=5.2$, $SD=.44$) than non-implementers ($M=4.6$, $SD=.98$); $t(17)=-0.6$, $p<.05$. Again, the three counselors who ran or attempted to run IPT-AST groups reported acceptability/efficacy ratings at or above the implementers group mean ($M=5.43$, $SD=.25$). Other variables did not reveal significant differences, including years of experience working in schools since completing graduate training ($t(31)=2.6$, $p=.34$), knowledge of IPT-AST following the workshop ($t(30)=-1.4$, $p=.81$), participant age ($t(31)=-0.46$, $p=.92$), hours per week spent counseling students when maximally active ($t(27)=6.3$, $p=0.10$), and school setting (middle vs. high school), $\chi^2(1, N=32) = 0.23$, $p=.63$.

### Acceptability of IPT-AST

In the follow-up interviews, school counselors generally spoke favorably about the intervention. The majority (94%) made positive statements about IPT-AST and its acceptability (Kappa=.90). The majority of counselors praised particular elements of the intervention, such as the closeness circle, the communication skills, and the opportunities for active involvement (e.g., role playing). For instance, one counselor stated, “The closeness circle I’ve used with a number of students, I think that’s been helpful. The structured interview is helpful in terms of identifying and exploring in further depth the relationships that they’re having difficulty with. Then I think just the prescriptive skills. It’s prescriptive enough that it helps them understand a little bit better
but it’s not overly prescriptive to the point where it’s one of those manuals where this is what you say kind of thing.” Others praised the overall rationale of the program (e.g., “The fact that relationships are so tied to a student’s mood day by day…and if that doesn’t happen then depression could set in. So I think it’s very valuable in terms of that also.”), as well as the focus on prevention (e.g., “But I liked the idea that…this is aimed at kids who are not already diagnosed with clinical depression but for kids who are at risk for developing depression”). A handful also specifically praised the intervention’s evidence base (e.g., “And again, seeing the outcome research it seemed like the students who had gone through Teen Talk were more resilient at the end than the students who had gone through a general group process. Of course I’d be willing to try that”). Some stated that the intervention was easy to understand and/or incorporate into their practices while others specifically noted that the intervention fit well with their prior experience and/or approach to counseling (e.g., “it’s similar to interventions I had done in the past so I felt it aligned well with that’’). Counselors applauded the program’s fit for the students (e.g., “Again I think it’s fitting with adolescent development. Getting peers to do the work for each other is critical. So I think right off the bat you know group work in adolescence is critical”). They also commented on observed or perceived benefit to students (e.g., “I think it was pretty successful. I think they got a lot out of it,” “I do think it would benefit our students wholeheartedly”). The majority of counselors (70%) provided praise of the IPT-AST manual (Kappa=.70). This generally included comments regarding the manual’s utility, organization, and thoroughness. For example, one counselor noted, “I think the package itself was pretty thorough. I know the binder had everything there that you could need. So I think that was very well prepared. You know whatever activities, descriptions, I think even the definitions in there. I
mean that was pretty thorough so I think anyone on any level could probably implement the program. I think everything is there that you would need.”

Fewer counselors (24%) made negative comments about the intervention and its acceptability (Kappa=.88). Criticisms included the lack of active involvement (e.g., “I think one piece that we did not love and I think it was kind of unanimous is that it was too much one-on-one in a group. I found and I think most of us found that group dynamics is what works well when they’re kind of all involved and part of the group and talking and sharing and figuring things out together”), the program’s need for modifications (e.g., for varying levels of cognitive functioning), the lack of contribution to the counselor’s existing skill set (e.g., “When you get a bunch of people who have been in the field 10, 20, 30 plus years, it was really kind of redundant. It was packaged differently but it wasn’t totally new and innovative”), and questioning the program’s efficacy for depression prevention (e.g., “So I don’t see that it’s only for depression… I’m not sure that I would feel that I’ve prevented depression by running the group I guess”).

Counselors also made statements regarding the perceived acceptability among parents, adolescents, and administration. A roughly equal number of counselors reported that students would or did receive the intervention favorably (18%, Kappa=.77) and unfavorably (22%, Kappa=.77). Those who commented on acceptability among teens noted the appropriateness for this age group (e.g., “And the issues that you can use it for you know are issues that are constantly facing our kids at all times. So you get the kids to do the work is really key”) and commented on how students received the intervention (e.g., “Because now that I’ve discovered that I’ve met some success with it I’m like oh I would like to make this a part of it because I think this is interesting. And the relationships—particularly with peers—become such a drive for
them. It drives them at this age.”) Those who mentioned an unfavorable receipt among students mentioned factors such as the format (e.g., “Yeah, they just want to talk about what’s going on. They’ll let us, we’ve used worksheets and information and they’ll listen but then they’ll be like ok can we just talk about—they always have something going on in their life that they want to spend time talking about”) and the stigma related to depression (e.g., “She told the girl she would be doing a group for interpersonal skills and it had to do with depression. And as soon as she heard the word she didn’t want to have anything to do with it”). Three counselors also commented favorably on acceptability among administration, citing features such as the program’s structure and low costs (Kappa=.43).

**Barriers to Implementation of IPT-AST**

Participants cited organizational, provider, and program characteristics that served as barriers to implementing IPT-AST. These factors have been grouped into the following overarching themes: 1) lack of time, 2) lack of support from the school community, 3) poor fit with the school’s needs and priorities, 4) logistical barriers, 5) readiness for implementation, and 6) provider beliefs. These barriers, as well as their relationships to one another, are described below and depicted in a data display (Figure 1).

**Time.** All participants cited lack of time as a barrier to implementation (Kappa=.88). This included organizational characteristics such as competing responsibilities, provider characteristics such as feeling overwhelmed, and program characteristics such as the time required for the intervention and its preparations, which often did not fit with the organizational demands. Specifically, 27 counselors (82%) mentioned competing responsibilities as a barrier (Kappa=.74). Counselors frequently noted the demands of large caseloads and varied job responsibilities (e.g., “So I think time is definitely a big barrier because it would be great if I
could just talk to kids all the time, but we have specific things that we must do. You know we have scheduling, we have case managing. We have to go to meetings, things like that. So that becomes—I think time is the number one barrier”). One counselor poignantly captured the dilemma of the school counselor: “I think a universal problem is that you’re fighting for time. And it’s time to do anything. Like even for things that are about their education decisions. I feel like that’s an ongoing professional struggle for school counselors for life.” Some counselors (24%) stated that they were overwhelmed by these responsibilities (Kappa=.69), which constitutes a provider characteristic related to time.

Associated with the idea of competing responsibilities was the reactive nature of the school counselor role, cited by 70% of participants (Kappa=.70). Many counselors described that the need to be flexible with one’s time and respond to crises makes it difficult to consistently implement interventions. For instance, one counselor stated, “Typically there is a big need to be flexible in your time. You have a student that shows up and you need to spend the next two hours with them because they are in crisis or whatever the issue might be. Or you have things that come up from a case management standpoint that require immediate attention. So that can kind of be difficult when you have things prescribed within your day.” Another counselor stated, “I think also counselors are sometimes forced to be in crisis mode all the time. They have to be reactive because their caseloads are huge. So they can’t spend as much time doing proactive, psychoeducational, developmental stuff.” Counselors even specifically cited how this bumps up against the proactive nature of a prevention group (e.g., “very rarely do I see a proactive approach to addressing issues of depression or suicidality or conflict resolution”) and/or the structure of a manualized intervention like IPT-AST (e.g., “I think that the kind of structure that’s associated with the program makes it very difficult”).
Another barrier related to time was scheduling difficulties, cited by 45% of participants (Kappa=.83). This demonstrated the interaction between an organizational characteristic (e.g., the structure of the school schedule and educational demands) with a program characteristic (e.g., the length of sessions). For instance, one participant noted, “I think there was some time constraints that were the big difficulty to implement, especially at a middle school level. You know the scheduling and pulling kids out of class. We don’t have a period at the end of the day where kids could come like a study type period. There are no afterschool buses. We would have to pull them out of class; that’s a problem if you have especially a long group. Or say you want to keep it weekly or biweekly it can be difficult to do that because you gotta watch what classes they’re missing.” Counselors at the high school level also noted these concerns (e.g., “I remember that being a problem too it’s long - so they would have to miss a full block of class, which the teachers don’t always like, and homeroom is only a half hour. Unless we have them eat lunch with us and did it but that’s kind of hard to be involved when you’re worried about everyone eating lunch”). Some counselors (21%) also noted that the lack of time for planning served as a barrier (Kappa=.61). This included the absence of common planning time within the counseling department and lack of time to coordinate the logistics of implementation.

**Support from school community.** The lack of support or buy-in from the school community, including administrators, teachers, students, and parents served as another organizational characteristic that emerged as a barrier in 73% of interviews (Kappa=.91). Specifically, administrators were perceived as an impediment to implementation by 36% of participants (Kappa=.79). This included the perception that administrators do not understand the role of counselors and/or the growing mental health needs of students, and statements regarding alternative priorities of administrators (e.g., “An administrator will not say—has not ever said—
well that’s their time to go to group. There’s no time built into the school day for a comprehensive school counseling program. There just isn’t…everyone’s focus is instructional time and instructional time only”).

Many counselors (58%) also noted a lack of support from teachers (Kappa=.77), as they may not permit students to leave class for a counseling activity. This was highlighted as a more global concern (e.g., “I would say it’s not specific to this intervention. It’s just that teachers don’t share students well. There’s no time, there’s way too much pressure in the classroom to keep the kids there”), and as a concern that may be more specific to IPT-AST (e.g., teachers are less likely to let students out for a prevention group where they aren’t seeing the impact yet). Counselors often connected this issue with demands of accountability and pressures from the state (e.g., “A lot of teachers believe that tenure can be pulled from them if they are not reaching these goals. So everybody has a lot of pressure right now and because of it they give us a hard time taking kids. So we try not to take them out of academic classes”). Still others acknowledged that this is not a global issue among all teachers (e.g., “Well let’s say we have a faculty of 150, I would say there are about 30 teachers, and we know who they are because they don’t even give the kids the passes…We know who’s supporting us and who’s not”).

At times the students are also seen as the impediment to successfully running a group or engaging in counseling activities. More than one quarter of participants (N=9) stated that students contribute to issues with consistency in attendance (Kappa=.73). For instance, students may choose not to attend (e.g., “some of our more, our higher level kids might not leave their AP and honors classes because they don’t want to miss the work,” “sometimes the kids don’t want to give up their lunch”), or they may be concerned about the stigma of receiving counseling, or participating in a depression prevention group. Parents were cited as a barrier to engaging in
counseling activities in 18% of interviews (Kappa=.68). The majority of these parents were described as placing academic needs above mental health concerns (e.g., “parents don’t always appreciate and value what we do as important enough for them to miss class”).

**Fit with school priorities and needs.** The program’s fit with the school and/or counseling department priorities and needs emerged as another theme, cited by 70% of participants (Kappa=.95). These barriers generally illustrate the intersection between organizational characteristics (e.g., school climate, school priorities) and program characteristics (e.g., depression prevention focus). For instance, 21% (Kappa=.89) noted that the school’s main priority is academics, which ultimately impacts the responsibilities of the school counselor (e.g., “I think they think mental health’s important, but they’re more concerned about who is going to college a little bit more than mental health”). Tied to this idea is the school community’s overall appreciation for and understanding of mental health and/or the school counselor role. Nine participants (27%, Kappa=.73) described lack of awareness among teachers, administrators, students, and parents of how mental health can affect academics (e.g., “I don’t know if they see the connection between if a kid is struggling emotionally, they’re not going to be getting into college or getting great SAT scores because this has to heal before any of that other stuff can happen”), and lack of awareness of the school counselor’s skill set in the area of mental health (e.g., “In terms of the profession itself, I think we’re still working really hard to educate students, teachers, and administrators about what school counselors do…None of [the job postings] care if we’ve run groups. They don’t care if we have good experiences in mental health issues…”). Further, 18% of participants (Kappa=.62) explained that their counseling department’s approach does not fit with the IPT-AST groups, which they viewed as more clinical in nature. For instance one participant described the supportive nature of school counseling (“you know counseling in
school is more supportive services...otherwise we refer out when it’s more of a therapeutic type group or therapeutic needs”), while another expressed discomfort with taking on a more therapeutic role (“I might feel uncomfortable having a therapeutic environment and being responsible for a student with a depression type of group”).

Linked to the theme of fit, particularly as it relates to the emphasis placed on academics and how the school community views the school counselor role, is the role of policy. Eight participants (24%, Kappa=.92) cited external pressures from the state which impact the overall climate and culture of the school. This is also related to the previously cited barrier of support from the school community, such as teachers’ willingness to let students out of class, and administrator support of mental health programming. For example, one participant stated, “I think there is a concern, especially at this time in public schools, about having kids taken out of class or missing class because there’s so much riding on the new evaluations and all that stuff. The teachers are really under quite a bit of pressure themselves now for students to achieve.” Counselors also cited how these new metrics of accountability affect how the school counselors themselves define and execute their roles (e.g., “I think it may also have been that a significant factor was all of the new requirements coming down from the state in terms of administrators having to spend their time and energy on new ways of evaluating staff and staff having to spend a lot of our time and energy figuring out ways to be evaluated”).

The final barrier that fell within the theme of fit was the lack of fit with the student’s perceived needs, noted by 18% of participants (Kappa=.78). These participants described how referrals are generated or how groups are formed, stating that these did not align with the target population for IPT-AST (e.g., “The things we were getting from counselors – see we rely on the counselors to refer students to us for like if we had an idea for a group...but the students that
were referred to me just didn’t fit for the manual”). Further, a related barrier was difficulties with recruitment, noted by 36% of participants (Kappa=.77). These counselors described not only the lack of fit with the referrals that came in, but also the difficulties in identifying and screening students for the program. The time required to identify appropriate students with subsyndromal symptoms of depression was seen as a barrier, particularly given the counselor’s typical means of generating referrals. These counselors also noted other barriers to recruiting students, such as stigma and competing priorities for the students/parents.

**Logistics.** Logistical barriers emerged in 61% of the interviews (Kappa=.95). These included organizational characteristics such as difficulties procuring space for a group (21%, Kappa=.93), administrative tasks required to run a group (9%, Kappa=.76), lack of afterschool transportation (6%, Kappa=.97), and lack of funding, whether for staff, training, or program materials (12%, Kappa=.97). Logistics also involved provider characteristics such as going on/returning from maternity leave (6%, Kappa=.89). In addition, 21% of participants (Kappa=.88) cited the timing of the training and/or the fact that their groups were already planned as a barrier. This represents the intersection between program characteristics (i.e., training timing), organizational characteristics (i.e., time and flexibility afforded to school counselors to implement additional groups), and provider characteristics (e.g., “it was just that I had done a lot of planning beforehand and that’s just my personality”). Finally, related to logistics are the previously mentioned barriers of scheduling difficulties, cited by 45% of participants (Kappa=.83), and difficulties with recruitment, noted by 36% of school counselors (Kappa=.77).

**Readiness for implementation.** About half of participants (52%) noted lack of preparedness to deliver IPT-AST as a barrier to implementation (Kappa=.80). This included
provider characteristics such as level of confidence to deliver the intervention and/or comfort in working with this population (33%, Kappa=.74), insufficient knowledge of IPT-AST (15%, Kappa=.16), and level of prior training and experience (21%; Kappa=.90). This included overall counseling experience, experience running groups, type of degree/training, and specific training in running groups. Organizational characteristics related to implementation readiness included the lack of a specific plan for or commitment to implementation and/or a departmental mandate to implement the program (24%, Kappa=.91). For instance, one counselor described the need for an implementation plan: “we should have collectively talked about how we were going to implement it or use it or try it,” while another emphasized the need for the program to be built into his/her job responsibilities (i.e., “It’s not necessarily where my bosses are allotting my time”).

**Beliefs.** Approximately half of the participants (48%) expressed beliefs that appeared to serve as a barrier to implementation (Kappa=.80). These included negative beliefs about the intervention, such as its level of engagement for students (e.g., “I think one group session was almost all, it felt like delivery of curriculum, and in term of attention, especially if I want my kids coming back, they’re not going to listen to me talk about skills, emotions, and feelings for a full 45-50 minutes without me getting them up, doing something, sharing, giving me feedback on what they think about things”), the manualized and structured nature of the program (e.g., “I feel like for the students that I’ve worked with manualized stuff is kind of difficult. It needs to be more where you can plug things in as it fits in the context of talking about other things that are going on for them more in the moment”), and the time required to implement the intervention. Participants also commented on their level of interest in providing mental health services and/or leading a clinically focused group (e.g., “I mean if I wanted to do therapy I would be a therapist
right? But I’m not, I’m a school counselor (laughs). I feel like there are defining roles and to put myself in a let’s have a therapeutic group specifically garnered to depression or to you know preventing depression that would kind of make me like ok well I don’t want them to see me as a therapist because I’m not”).

Other beliefs that served as barriers included the focus on depression (e.g., “with me a lot of my groups have a wide variety of kids and I wouldn’t want to focus it in that direction,” “the other thing that I find – and I think this is developmental in middle school – is sometimes when you get a lot of students together, especially if you have students who are clinically depressed – when they are 10, 11, 12, 13 years old it’s almost like sometimes they end up feeding off of each other and I don’t think that’s necessarily productive”), and the preventative nature of the program (e.g., “I don’t think it’s top priority necessarily. Because you know there is other more serious stuff like significant trauma and neglect are things we think about when we are worried about kids, or significant behavioral issues”).

Another common belief among counselors (42%) was that the training covered skills that the counselors already knew and utilized (Kappa=.84). In some cases this was cited as a barrier to attempting implementation (e.g., “some of the things were things that I did already…It’s just kind of a re-packaging of things that I’ve already learned in a different way”). In other cases counselors used that information to applaud and support their existing efforts (e.g., “So I recognized while we were going through the training that there’s a lot of elements of productive group work in general that were a part of the program which was comforting because when we went over your statistics about how the program was received, the outcome data, it was good to see that we were already, prior to the training, using some of at least the underlying core philosophies of the program in the group experience”). And in some cases, this familiarity
enhanced counselor acceptability and positive receipt of the training (e.g., “I’ve used the
closeness circle – I call it a social circle since I’ve been in my Bachelor’s training. So I think
there’s a cross reference across any discipline. Guidance counselors, anybody could work with
these”).

**Facilitators of Implementation of IPT-AST**

The factors that served as facilitators to implementation grouped into similar themes
noted above in the barriers section: 1) support from the school community, 2) logistics, 3)
readiness, 4) beliefs, and 5) other provider characteristics. Given that only a subset of
participants implemented or attempted to implement IPT-AST groups ($N = 3$), these factors will
be reviewed briefly, as well as depicted in a data display (Figure 2).

**Support from school community.** Participants noted support from members of the
school community, including administration and colleagues, as a facilitator (Kappa=.98). Two
participants (Kappa=.79) cited support from administrators as a facilitator to implementation
(e.g., “[Principal] is very creative and she wants the school to stand out. So I think any creative
ideas that people have she’s always open to it”). One participant noted the importance of support
from colleagues as it related to recruiting students for the group (Kappa=.71) and two cited the
benefits of working with a co-leader (Kappa=.74).

**Logistics.** Logistical decisions that served as facilitators (Kappa=.58) included
scheduling the group afterschool (Kappa=.59), encouraging attendance with snacks for the
students (Kappa=.89), and engaging in a myriad of recruitment efforts (Kappa=.52). These
recruitment tools included promotion on the school’s website, paper and pencil permission slips
sent home, pamphlets in the office, and a sign on the counselor’s door.
Readiness for implementation. Several factors contributed to the school counselor’s feeling of readiness serving as a facilitator. Two counselors (Kappa=.12) cited their degree and/or training, a provider characteristic (e.g., “I think some of it has to do with our training. I went to school for marriage and family therapy”). Other provider characteristics included confidence to deliver the intervention (Kappa=.64) and level of counseling skill (Kappa=.85), each mentioned by one participant. One counselor also cited the manual and materials provided at the training (Kappa=.50) as a factor that facilitated uptake.

Beliefs. Two participants (Kappa=.30) expressed positive beliefs about the intervention, which served as a facilitator to implementation. For instance, one stated, “I mean I prefer your program to others. You know I’ve seen so many that have worksheets and cookie cutter stuff. We don’t generally like those; we don’t use those. But this one had a lot of creativity.” This provider also commented on the ease of implementation and acceptability among providers with varying levels of expertise: “The other thing too is if someone is just starting out, it’s pretty easy to follow.”

Provider characteristics. In addition to beliefs and readiness factors, other provider characteristics emerged as facilitators to implementation (Kappa=.72). Two participants (Kappa=.32) mentioned their interest in providing mental health services and/or running groups. The participant who implemented a group cited a “fit it all in” philosophy despite the time pressures inherent in the job (Kappa=.97). Notably, the two who attempted to implement a group also mentioned this as a factor that would facilitate implementation if they were to attempt implementation again next year (e.g., “You make it work, you just kind of fit it in,” and “I can do it. I know I can do it I just have to make up my mind to do it, really. And I have to make time to do it. So more or less I have to really build it in to my schedule”).
IPT-AST Training Package

In the follow-up interviews, the majority of counselors (61%) provided positive feedback on the workshop (Kappa=.81). They praised features such as the interactive nature of the training, the format, the materials provided, the thoroughness and specificity of the content provided, and the academic setting in which the training took place. Counselors also offered suggestions for improvement such as incorporating more hands-on activities and experiential components, viewing and analyzing videos of real groups, improving the pacing of the session (e.g., breaking it up into two half-day trainings, leaving sufficient time for role plays at the end), including more breakout sessions, reducing the content on statistics and theory, increasing content on implementation, providing opportunities to plan for/troubleshoot implementation, and better differentiation in delivery of content (e.g., dividing up counselors based on years of experience or experience running groups). Some suggested that the training be held at the end of the year or the beginning of the year to maximize the likelihood of implementation. Other implementation suggestions included hearing from similar schools that have implemented the program (i.e., “I would want to hear from a school about the same size or similar with some of the same barriers to say we did this and it’s fine. Because I think that would give everyone a vote of confidence that they can do it and they worked through the barriers. And maybe you can do that in writing too and not have to have them live. But rather than do a demonstrated thing – if I saw a real school do that I think that would be powerful”), and working with other districts in their region to troubleshoot implementation (i.e., “For instance if you broke up the training into a regional thing so that, for instance, it would be really easy for us to consult with…someone who’s right in our general area that we might know professionals there already. So the likelihood of us picking up the phone to consult about how it’s going here or there or how they were able to
make it work might, that might be something else helpful to think about”). Other ideas thought to enhance the likelihood of implementation included more frequent reminders about the program following the workshop, utilizing a “pitch” during the workshop to show the “value demonstrated” of the program, and advocating for the program to school staff “above the counselors…just so that they can understand that this is something that is legitimate.”

Following the one-day workshop, few participants participated in other components of the training package. Three participants (9%) attended the first consultation call approximately two months following the workshop. The second consultation call, which was intended to take place approximately two months after that, was not scheduled because no counselors expressed interest in participating. All participants were invited to join the technical assistance listserv to receive additional support on implementation logistics. Seven participants (21%) joined the listserv; however, no counselors posted questions or comments. Despite the low utilization of training package components and the low implementation rates, over half of the counselors (52%) thought that the training package provided was sufficient (Kappa=.69). For instance, one counselor noted, “Oh yeah absolutely. For those who were interested in running the program, I think the model and the support you provided…was more than sufficient. I think it would be great. Absolutely.” Others (39%) thought that additional training was needed (Kappa=.88). Some suggested another workshop or “refresher” training to further cover the material. Others suggested a smaller group training following the larger workshop to help personalize the information and implementation plans, as well as including observation with feedback. In addition, one participant suggested that following up in person, rather than by consultation call or email, would be more effective.
Discussion

The present study evaluated the acceptability and feasibility of a training and implementation package for school counselors in IPT-AST, a school-based depression prevention program. Though school counselors generally reported high ratings of implementation commitment, intervention acceptability, and training satisfaction immediately following the training workshop (Haimm, Axelrod, Anderson, Natale, & Young, 2014), actual implementation rates were low. Of the 33 counselors interviewed at six-month follow up, only one had implemented an IPT-AST group (with significant modifications), and two others had attempted to run a group together. In contrast, uptake of components of IPT-AST (e.g., communication skills, closeness circle) was much more prevalent, with nearly half of the sample reporting use of techniques learned at the training in individual, group, or dyadic work. In addition, the majority of the positive statements made about IPT-AST were in reference to specific components rather than the program as a whole or its utility in preventing depression.

Those who implemented or attempted to implement an IPT-AST group or its components differed from non-implementers on implementation commitment and acceptability/efficacy ratings following the IPT-AST workshop. Although age was found to be a predictor of post-workshop implementation commitment at the trend level (Haimm et al., 2014), the present analyses did not reveal significant differences in age between implementers and non-implementers. There were also no significant differences between implementers and non-implementers on IPT-AST knowledge, years of experience in schools, hours spent counseling per week, and school type (middle vs. high school). Taken together, this provides fruitful avenues for tailoring future IPT-AST trainings to improve implementation commitment and the intervention’s perceived acceptability and efficacy. For instance, engagement strategies and/or
problem solving around plans for implementation might increase implementation commitment, and the intervention’s acceptability might be enhanced by the use of additional materials such as testimonials from other counselors and/or students. These changes, as well as other suggested improvements to the training package will be expanded upon below.

Overall, school counselors made positive statements about IPT-AST and its acceptability, although the majority of these statements referred to components rather than to the intervention as a whole. Fewer counselors had negative things to say about the intervention. Such comments were largely regarding the lack of contribution to the counselor’s existing skill set. These counselors stated that they already knew and applied many of the concepts, strategies, and techniques. Notably, just as the praise for the training/intervention rarely touched upon the importance of depression prevention, these statements regarding the redundancy of the program did not reference existing knowledge of depression prevention programs. This distinction highlights a potential change for future trainings in how the program is presented to trainees. That is, an emphasis on the value-added of the IPT-AST program, such as the aim of depression prevention and ways in which the techniques do in fact differ from previously learned material, will be critical to future dissemination efforts. Indeed, in discussing future directions for implementation science in school mental health, Owens and colleagues (2014) highlight the role of implementer motivation and perceptions and suggest that research examine the extent to which these can be targeted to enhance uptake, adherence, and outcomes.

Given the low implementation rates in the present study, discussion of barriers to implementation dominated the follow-up interviews. Participant responses highlighted numerous barriers that generally grouped into six categories: 1) time, 2) support from school community, 3) fit with school priorities and needs, 4) logistics, 5) readiness for implementation, and 6) beliefs.
The barriers that comprised these themes spanned organizational, provider, and program characteristics, the majority of which were previously cited in the school-based implementation literature (Forman & Barakat, 2011; Forman et al., 2009; Langley et al., 2010; Suldo, Friedrich, & Michalowski, 2010). As noted by Forman and Barakat (2011), these characteristics often interacted with one another. For instance, the reactive nature of the school counselor role (organizational characteristic) did not fit with IPT-AST’s prevention focus (program characteristic).

The facilitators to implementation of IPT-AST groups, as reported by three participants, fell into similar categories: 1) support from school community, 2) logistics, 3) readiness for implementation, 4) beliefs, and 5) other provider characteristics. Though interpretation of these findings is limited given low implementation rates, there are potential parallels to prior research, which found that person-centered factors were identified as the strongest facilitators to providing mental health services, while organizational factors were more frequently cited as barriers (Suldo, Friedrich, & Michalowski, 2010).

Despite the myriad of barriers reported, the large majority of counselors (27) mentioned groups that they had previously or currently run at their schools. This included boys/girls groups, peer groups, and groups targeting particular issues or types of students (e.g., LGBT, divorce, bereavement, oppositional behaviors, new students). This is supported by quantitative data from the School Counselor Activity Rating Scale (SCARS; Scarborough, 2005), in which counseling activities were rated, on average, as the activities that participants most frequently engaged in (M=3.88, SD=.46). This suggests a rather large discrepancy between the practices of the counselors around engaging in counseling activities and running groups, and the reported barriers encountered in running IPT-AST groups. One potential explanation is that although the
counselors report running groups, they may do so infrequently (e.g., one group a year) as compared to their other counseling duties. In addition, these groups likely differ from IPT-AST in their frequency and duration of sessions. It is also possible that they encounter similar barriers that impact their ability to implement these groups as intended. This question was not systematically addressed in the interviews; however, it did come up organically in some responses. For instance, one school counselor stated that one of her current groups was intended to meet monthly, but it had convened only three times over nine months of the school year.

In addition, some did acknowledge that a central barrier to running an IPT-AST group was that they had already committed to the groups that they would run for the year; however, this did not account for all participants. Thus, it is important to consider the interaction between organizational characteristics (e.g., time) and program characteristics (i.e., structured nature of the intervention, focus on depression) and/or provider characteristics (i.e., desire/interest to run this type of group). In other words, while school counselors may regularly run groups at their schools, their preference may be for groups that are perceived to require less planning and/or structure, and they may gravitate toward other topics, whether based on personal interests or the nature of the referrals. Indeed, over a third of participants noted recruitment as a barrier to running IPT-AST groups (i.e., lack of fit with the referrals that came in, time required to identify and screen students at-risk for depression, stigma). This suggests the potential need for a culture shift and additional support around recruitment strategies for a prevention program such as IPT-AST. Usual practices among counselors in the present sample typically revolved around reacting to incoming referrals (i.e., from teachers, administrators), and/or asking colleagues for students that they believed would be appropriate for a particular group. There is some evidence to suggest that these practices could change with additional support. For instance, one study found that in-
service training can be effective in changing school staff’s awareness and knowledge of adolescent depression (Valdez & Budge, 2012).

The present findings suggest multiple avenues for promoting uptake of IPT-AST. Further, the interactions between the cited barriers points to the importance of the compatibility or appropriateness of fit of the intervention to the context (Proctor et al., 2011). The mental health systems ecological model (cf. Southam-Gerow & McLeod, 2013), which looks at the interaction between client-level factors, therapist-level factors, intervention characteristics, organizational characteristics, and systems-level factors, helps to conceptualize means of improving implementation efforts at different levels. For instance, future training initiatives might target provider-level factors such as beliefs, knowledge, skill, and level of confidence; means of addressing these factors are discussed in greater detail below in the context of suggested improvements to the training package. Potential program changes that might promote implementation include adapting IPT-AST to involve shorter sessions that could be completed within a class period (e.g., 40 minutes). Such adaptations took place in select schools participating in a randomized controlled trial of IPT-AST given the constraints of the school schedule. In one school, the group was shortened to 45 minutes, which provides initial evidence that such adaptations are feasible. In addition, other group interventions adapted for the school setting have made similar changes (e.g., Masia Warner et al., 2013).

Organizational-level changes might include time built into the school day for social-emotional programming (i.e., to combat the difficulties encountered in upholding a consistent and protected block of time for the group) and more explicitly outlining the role of prevention in a counselor’s job description. Indeed, counselors highlighted support from administration and fit with the school’s overall priorities as barriers to implementation. Creating the expectation that
counselors would partake in preventive and proactive initiatives would counterbalance the reactive nature of the role that so frequently interfered with implementation of IPT-AST.

Similarly, enhancing buy-in from the school community (e.g., administrators, teachers) would further change the school culture to be more inviting to such a program. Research has shown that school clinicians are in fact able to surmount barriers to implementation when provided with necessary support from school leadership and peers (Langley et al., 2010). Such efforts might include meetings with key stakeholders about the program and its potential impact, and distributing materials about the program to school personnel. Owens and colleagues (2014) made a similar suggestion in their proposal for a research agenda on school mental health, stating that future research should consider how mental health activities may benefit other, largely academic, goals.

Finally, systems-level changes could potentially support such a sea change. For instance, Koller and Bertel (2006) argue that preservice training in preventative, strengths-based mental health is inadequate across disciplines (e.g., social work, school counseling, school psychology, teachers, administration) and requires a paradigm shift in graduate training and certification and licensing levels. There is also a lack of understanding among administration of the school counselor role. For instance, a survey of over 300 principals in the United States found that only 17% had any coursework exposing them to information on school counselor roles or comprehensive guidance programs; such a change in principal certification programs could help to promote the collaboration between school counselors and administration (Beesley & Frey, 2006).

Advocacy by organizations such as the American School Counselor Association (ASCA) could also help promote changes to the recommended roles and responsibilities of the school
counselor, as well as the training required at the graduate level. Currently, ASCA recommends that counselors spend 80 percent or more of their time in direct or indirect services to students, and they stipulate activities deemed appropriate (e.g., academic programming, individual and small-group counseling services, interpreting student records) and inappropriate (e.g., maintaining student records, providing therapy or long-term counseling to address psychological disorders, teaching classes when teachers are absent) (ASCA, 2012). As such, it would be within their purview to make recommendations to meet the growing need for school counselors to be equipped to provide mental health services in schools. In addition, the preventive and time-limited nature of IPT-AST would fit with the mental health-related activities already approved by ASCA.

Finally, given that nearly a quarter of participants in the present study noted the role of policy and its effect on the academic pressures felt within the school environment, advocating for the inclusion of social-emotional outcomes in assessment of student progress might facilitate the implementation of prevention programs like IPT-AST.

The reported barriers and explicit feedback on the training package also offer suggestions for training package changes that would target provider-level and organizational-level factors to promote implementation. Namely, counselors suggested changes to the IPT-AST workshop that might promote the acquisition of knowledge and skill (e.g., viewing and analyzing videos of real IPT-AST groups, including more breakout sessions and hands-on activities, breaking up participants based on experience to facilitate differentiation of content). Counselors also suggested the inclusion of additional training, such as a “refresher” course to increase knowledge and level of skill, and the use of ongoing observation with feedback. This is consistent with recommendations provided in the training and implementation literature (e.g., Lochman et al.,
Online training resources may provide another avenue for ongoing support, as these have also been cited as a promising component in training teachers to deliver an evidence-based preventive intervention (Becker, Bohenkamp, Domitrovich, Keperling, & Ialongo, 2014). In the present interviews, counselors also noted that changing the timing of the training, such as moving it to the end or beginning of the year, and providing frequent reminders to the counselors following the training might promote implementation.

Though there is room to enhance the robustness of the training package offered, which would both respond to counselor feedback and remain in keeping with recommendations in the training and implementation literature, it is notable that few participants utilized the supports that were in place. That is, only three participated in the first consultation call while none participated in the second, and none posted questions to the technical assistance listserv. Thus, it is also important to consider means of increasing commitment to the training program. As noted previously, better marketing the value-added of the program during the training might increase the likelihood of implementation. This includes conveying the value-added to the counselor’s skill set, and impressing upon trainees the importance of depression prevention whether through testimonials from other counselors/students, or other formats. Several participants stated that the portion of the workshop that presented efficacy research on the program was too long and not essential; it is possible that a greater focus on the potential benefits of a depression prevention program on both emotional and academic outcomes, rather than specifics regarding past randomized controlled trials, would be better suited to a population of school-based personnel. As previously mentioned, providing stakeholders, such as district, building, and department administration, with similar materials conveying the potential impact of the program on their students’ social and academic functioning, may help to shift the culture of the school and the
attitudes toward such interventions. Indeed, counselors spoke about the difficulty in finding time for program implementation and participation in training without administrator buy-in and support.

Counselors also noted the potential utility of focusing more on implementation during the training and at follow up. This included opportunities to meet in smaller groups to receive individualized feedback and develop implementation plans specific to their schools. Topics might include scheduling difficulties, means of obtaining buy-in from administration and other school personnel, and plans for identifying and recruiting students. One counselor also suggested utilizing the training to establish connections with counselors from other districts in their region so as to promote ongoing collaboration around implementation planning. Such revisions to the training package would be in keeping with one of Beidas and Kendall’s (2010) recommendations, in which they highlight the importance of identifying barriers to utilization of interventions in order to target these early on in training through problem solving.

Limitations

There are several limitations to the present study. First, the present sample included participants with a variety of roles in the schools, including school counselors, school psychologists, social workers, and school-based mental health professionals. The majority of participants were school counselors; however, the heterogeneity of the sample impacts the implications of the findings. Second, low implementation rates impacted the data collected and the interpretation of findings. That is, there were few participants who could comment on facilitators to implementation of the IPT-AST groups, which limits the utility and applicability of the findings. In addition, the large majority of the counselors did not attempt to run groups. Thus, the barriers identified must be interpreted within this context. In other words, had more
counselors attempted implementation, other barriers may have emerged more frequently, such as difficulties with student recruitment and uncertainty regarding competence to deliver the intervention. Finally, the number of counselors who reported implementing components, in place of the full group, was unexpected. Thus, the interview guide did not allow the present study to systematically address barriers and facilitators to implementation of these components as distinguished from barriers and facilitators to running the groups. In some cases, this muddied the interpretation of the counselor’s statements, and in other cases this represented a missed opportunity to gather additional information.

Another limitation is that the training package was not as robust as is recommended in implementation literature. Further, even though technical assistance and consultation were offered, few participants took advantage of these components of the training package. Taken together, these features of the study likely impacted the reported barriers, particularly around readiness for implementation. This may have also impacted the implementation rates.

Finally, the present study possesses limitations inherent in its qualitative methodology. For instance, a semi-structured interview guide was utilized; however, the content of the interviews and questions asked were variable based on the participants’ responses and the time constraints of the 20-30 minute time allotted. In addition, the data analyses were inherently subjective. The use of a second coder and calculation of Cohen’s kappa values enhanced reliability; however, given that codes were given equal weight regardless of the kappa level, the findings should be interpreted with caution.

**Future Directions**

The present study was an initial step toward determining the acceptability and feasibility of training school counselors to deliver IPT-AST. Future IPT-AST training initiatives should
apply the aforementioned changes to the intervention and the training package, which are
designed to overcome the reported barriers and leverage the reported facilitators. Research can
then determine the impact these changes have on implementation rates. Ideally, this research can
identify which training components are necessary and sufficient for a satisfactory level of
implementation, perhaps by comparing different training and implementation packages. Indeed,
investigators have asserted that the next generation of implementation science in school mental
health should begin to systematically manipulate conditions to promote implementation, rather
than simply examining the barriers and facilitators themselves (Owens et al., 2014; Proctor,
Powell, Baumann, Hamilton, & Santens, 2012). Future investigation should also examine
counselor adherence and competence to deliver the intervention following participation in a
robust training package to ensure treatment fidelity.

The present study provides initial promising evidence regarding the acceptability of IPT-
AST among school counselors; however, more work is required to overcome barriers to
implementation at program, provider, organizational, and systems levels. Such research is critical
in promoting the use of evidence-based practices in school settings, where the large majority of
children receive mental health services. This work also provides an avenue for shifting the
culture from one of reaction to prevention, which would help to reduce the incidence of
adolescent depression and promote social and academic functioning during critical
developmental years.
References


Koller, J. R., & Bertel, J. M. (2006). Responding to today's mental health needs of children,
families and schools: Revisiting the preservice training and preparation of school-based personnel. *Education & Treatment Of Children, 29*, 197-217.


Turner, K., Nicholson, J. & Sanders, M. (2011). The role of practitioner self-efficacy, training, program and workplace factors on the implementation of an evidence-based parenting


Table 1

*Measures Administered Pre- and Post-workshop*

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Pre-workshop</th>
<th>Post-workshop</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographics</td>
<td>Demographic data collected included participant gender, age, race/ethnicity, years of graduate training, type of graduate degree, years of experience in schools, years worked in current school, and current position.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>School Climate</td>
<td>Utilized a school climate measure from the Metropolitan Area Child Study (MACS, 2002). The school climate measure assesses three dimensions of school climate: negative relationships, relationship to administrative leadership, and experience of supportive climate. Several questions were adapted to make them more appropriate for use with school counselors.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>School Counselor Activity Rating Scale (SCARS; Scarborough, 2005)</td>
<td>The SCARS assesses the amount of time school counselors spend on various professional activities. An initial study of the scale provided support for a four-factor model with positive results on the validity and reliability of the scale (Scarborough, 2005). Two items were added for the present study to reflect frequent school counselor responsibilities not captured in the SCARS: (1) college advisement, and (2) psychological/vocational testing and report writing.</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Implementation Potential Scale (IPS)</td>
<td>The IPS assesses five factors: acceptability/efficacy, implementation commitment, administrator support, and organizational resources. Positive results on the validity and reliability of the IPS were reported in an initial study of the scale (Forman, Fagley, Chu, &amp; Walkup, 2012).</td>
<td></td>
<td>X X</td>
</tr>
</tbody>
</table>
Knowledge of IPT-AST techniques was assessed using a novel scale developed for this study to assess school counselor knowledge of IPT-AST theory and techniques. The questionnaire was adapted from a knowledge scale for IPT-A and was reviewed by two IPT-AST experts.

Self-efficacy was assessed using a single item, “How confident are you in conducting IPT-AST groups at your school?” rated on a 7-point scale. Previous work has found self-efficacy assessed by a single-item to be predictive of program use (Shapiro, Prinz, & Sanders, 2012).

Satisfaction with training was assessed using four items rated on a 7-point Likert scale from a study by Turner, Nicholson, and Sanders (2011). Items assess the quality of the training presentation, the amount of active participation provided, the quality of the course content, and overall satisfaction with training.
Table 2

**Qualitative Codes and Kappa Values**

<table>
<thead>
<tr>
<th>Code</th>
<th>Kappa</th>
<th>Range</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Beliefs about IPT-AST</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive beliefs</td>
<td>0.90</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Negative beliefs</td>
<td>0.88</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Praise of manual</td>
<td>0.70</td>
<td>Substantial</td>
</tr>
<tr>
<td>Acceptability among students (Yes)</td>
<td>0.77</td>
<td>Substantial</td>
</tr>
<tr>
<td>Acceptability among students (No)</td>
<td>0.77</td>
<td>Substantial</td>
</tr>
<tr>
<td>Already knew/utilized the skills</td>
<td>0.84</td>
<td>Almost perfect</td>
</tr>
<tr>
<td><strong>Barriers</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Time (theme)</td>
<td>0.88</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Competing responsibilities</td>
<td>0.74</td>
<td>Substantial</td>
</tr>
<tr>
<td>Overwhelmed</td>
<td>0.69</td>
<td>Substantial</td>
</tr>
<tr>
<td>Reactive</td>
<td>0.70</td>
<td>Substantial</td>
</tr>
<tr>
<td>Scheduling</td>
<td>0.83</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Planning time</td>
<td>0.61</td>
<td>Substantial</td>
</tr>
<tr>
<td>Support from school community (theme)</td>
<td>0.91</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Administrators</td>
<td>0.79</td>
<td>Substantial</td>
</tr>
<tr>
<td>Teachers</td>
<td>0.77</td>
<td>Substantial</td>
</tr>
<tr>
<td>Students</td>
<td>0.73</td>
<td>Substantial</td>
</tr>
<tr>
<td>Parents</td>
<td>0.68</td>
<td>Substantial</td>
</tr>
<tr>
<td>Fit with school priorities and needs (theme)</td>
<td>0.95</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Academics</td>
<td>0.89</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Understanding</td>
<td>0.73</td>
<td>Substantial</td>
</tr>
<tr>
<td>Departmental approach</td>
<td>0.62</td>
<td>Substantial</td>
</tr>
<tr>
<td>Policy</td>
<td>0.92</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Student needs</td>
<td>0.78</td>
<td>Substantial</td>
</tr>
<tr>
<td>Recruitment</td>
<td>0.77</td>
<td>Substantial</td>
</tr>
<tr>
<td>Logistics (theme)</td>
<td>0.95</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Space</td>
<td>0.93</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Administrative tasks</td>
<td>0.76</td>
<td>Substantial</td>
</tr>
<tr>
<td>Transportation</td>
<td>0.97</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Funding</td>
<td>0.97</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Maternity leave</td>
<td>0.89</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Timing of training</td>
<td>0.88</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Readiness for implementation (theme)</td>
<td>0.80</td>
<td>Substantial</td>
</tr>
<tr>
<td>Confidence/comfort</td>
<td>0.74</td>
<td>Substantial</td>
</tr>
<tr>
<td>Knowledge</td>
<td>0.16</td>
<td>Slight</td>
</tr>
<tr>
<td>Prior training/experience</td>
<td>0.90</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Commitment/department mandate</td>
<td>0.91</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Beliefs (theme)</td>
<td>0.80</td>
<td>Substantial</td>
</tr>
</tbody>
</table>
**IMPLEMENTATION OF IPT-AST IN SCHOOLS**

Facilitators

<table>
<thead>
<tr>
<th>Theme</th>
<th>Kappa Value</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support from school community (theme)</td>
<td>0.98</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Administrators</td>
<td>0.79</td>
<td>Substantial</td>
</tr>
<tr>
<td>Colleagues</td>
<td>0.71</td>
<td>Substantial</td>
</tr>
<tr>
<td>Co-leader</td>
<td>0.74</td>
<td>Substantial</td>
</tr>
<tr>
<td>Logistics (theme)</td>
<td>0.58</td>
<td>Moderate</td>
</tr>
<tr>
<td>Scheduling</td>
<td>0.59</td>
<td>Moderate</td>
</tr>
<tr>
<td>Food</td>
<td>0.89</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Recruitment</td>
<td>0.52</td>
<td>Moderate</td>
</tr>
<tr>
<td>Degree/training</td>
<td>0.12</td>
<td>Slight</td>
</tr>
<tr>
<td>Confidence</td>
<td>0.64</td>
<td>Substantial</td>
</tr>
<tr>
<td>Counseling skill</td>
<td>0.85</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Manual/materials</td>
<td>0.5</td>
<td>Moderate</td>
</tr>
<tr>
<td>Beliefs (theme)</td>
<td>0.3</td>
<td>Fair</td>
</tr>
<tr>
<td>Provider characteristics (theme)</td>
<td>0.72</td>
<td>Substantial</td>
</tr>
<tr>
<td>Desire/interest</td>
<td>0.32</td>
<td>Fair</td>
</tr>
<tr>
<td>“Fit it all in” philosophy</td>
<td>0.97</td>
<td>Almost perfect</td>
</tr>
</tbody>
</table>

Training Feedback

<table>
<thead>
<tr>
<th>Theme</th>
<th>Kappa Value</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workshop feedback, positive</td>
<td>0.81</td>
<td>Almost perfect</td>
</tr>
<tr>
<td>Training package sufficient</td>
<td>0.69</td>
<td>Substantial</td>
</tr>
<tr>
<td>Additional training needed</td>
<td>0.88</td>
<td>Almost perfect</td>
</tr>
</tbody>
</table>

*Note.* Classification of kappa values based on Landis and Koch (1977). 0-0.2 = Slight; 0.21-0.4 = Fair; 0.41-0.6 = Moderate; 0.61-0.8 = Substantial; 0.81-1.0 = Almost Perfect.
Figure 2
Facilitators of Implementation (N=3)

**PROVIDER CHARACTERISTICS**
- Desire/interest (N=2)
- “Fit it all in” philosophy (N=1)
- Beliefs (N=2)

**READINESS FOR IMPLEMENTATION**
- Confidence (N=1)
- Manual/materials (N=1)
- Degree/training (N=2)
- Counseling skill (N=1)

**LOGISTICS**
- Scheduling (N=1)
- Food (N=1)
- Recruitment (N=1)

**SUPPORT FROM SCHOOL COMMUNITY**
- Colleague (N=1)
- Administrators (N=2)
- Co-leader (N=2)

**Key**
- Organizational/Systemic Characteristic
- Program Characteristic
- Provider Characteristic
Appendix

Individual Semi-Structured Interview Guide

Introduction

• Thank you for taking the time to speak with me today for my doctoral dissertation research.
• You’ll be compensated for your time with a $30 Visa gift card after we complete the interview.
• The purpose of these interviews is to 1) find out if you ran IPT-AST groups at your school or incorporated IPT-AST elements into your work, 2) identify what you believe to be the barriers or facilitators to running those groups, and 3) solicit your suggestions for future trainings with school counselors.
• I will be recording our interview today so that your responses can be reviewed and coded by our research staff to determine important themes.
• All of the information you share will be confidential. No counselor or school names will be used in reporting any results of this study, and we will not share this information with your supervisor. In addition, all files will be labeled only with a participant number and securely stored.
• Before we begin, I want to remind you that there are no right or wrong answers – I’m here to learn about your experience as a member of our first IPT-AST training program, and I hope you will feel comfortable openly and honestly sharing your opinions so that we can make improvements in future trainings.
• Do you have any questions before we begin?

Great, let’s get started….

1. First I’d like to learn about your experience doing counseling with students. **Can you tell me about the current counseling work that you do?**

2. Did you incorporate any of the elements of IPT-AST (e.g. skills, closeness circle/interpersonal inventory) that you learned at the November training into your current work?
   a. If yes, can you please describe a time that you did so (in detail)?

3. Did you implement IPT-AST groups in your school?
   a. If yes:
      i. **How many students were in your group(s)?**
      ii. **What were the factors that facilitated your implementation of IPT-AST?**
      iii. **What were the obstacles you faced when attempting to implement IPT-AST?**
   b. If no: Did you attempt to run an IPT-AST group following the training in November?
      i. If yes, what were the obstacles you faced when attempting to implement IPT-AST? (Alternate wording if their survey indicated high intention to implement: “After the training, you said you were very
enthusiastic about running an IPT-AST group. I know so many things come up—can you describe what changed?)

ii. If no, **what were the main reasons you did not attempt to implement a group?** (Note: distinguish between level of desire and time during the day/agency to make decisions)

Based on what you described, it sounds like [repeat relevant factors affecting implementation] were the factors that most impeded/facilitated your implementation of IPT-AST. Did I capture that correctly?

2. Now I’m going to go through a list of other factors that research has identified as important to implementation. Please let me know how you think these factors affected your implementation of IPT-AST, if at all. (Note: ask about any topics that were not already mentioned above)
   a. **Provider characteristics**
      i. **Your own beliefs about IPT-AST**
         1. Can reference quantitative data here
      ii. Your level of desire to provide mental health services
      iii. **Other competing responsibilities/burnout**
      iv. **Confidence to deliver IPT-AST**
         1. Can reference quantitative data here
      v. **Level of prior training (including level of knowledge and skill)**
         1. Can reference quantitative data here
   b. **Organizational characteristics**
      i. **Support from colleagues** (e.g. administrators, teachers)
         1. Can reference quantitative data here
      ii. Knowing others who are implementing the intervention
      iii. **Program’s fit with school’s existing goals, policies, and programs**
         1. Note: bring in screening statistics from their school if they state that there is a low need for a depression prevention program
      iv. Integration of the program into school activities/curriculum
      v. **Logistics** (e.g., time, funding, and space)
   c. **Characteristics of IPT-AST itself**, such as the use of a manual, and materials that actively engage students

Now I’m going to ask some questions regarding the elements of the training package that we provided, which included the workshop that you attended, two optional consultation calls, and the technical assistance listserv, which was also optional.

3. Did you find this training package sufficient to support you in implementing IPT-AST? Why/why not?

4. Which elements of the training package were most helpful to you? Please provide specifics on the workshop, consultation calls, and listserv (if applicable).
   a. **If the person attended a consultation call:** Are there things about you or your district/school that facilitated your coming on the call?
5. **What changes or additions to the training package would you recommend?** Please describe changes to:
   a. Workshop
   b. Consultation calls
   c. Technical assistance listserve
   d. Additional components needed?

6. What has been helpful for you in the past in learning a new mental health intervention?

7. What has helped you in the past to implement new programs at your school?

We’re almost done with the interview. I just have a few more questions.

8. **Do you have plans to implement IPT-AST or its components in the future?**
   a. If yes, when? How do you plan to do so? What would need to happen in order for a group to get off the ground?

9. That covers all of the questions I had. **Do you have anything else to add that we didn’t cover already?**

I’d like to thank you again for your time and for sharing your thoughts with me. Would it be ok for me to get back in touch if I have any follow up questions or ideas to run by you? Also, can you please provide me with a mailing address so I can send you your $30 Visa gift card for participating in the study?

Address: