School Counselor Perspectives on Implementing a Modular Treatment for Youth

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ABSTRACT

Despite great advancements in the development of evidence-based treatments (EBTs) for youth mental health problems, few EBTs have been adopted by or successfully implemented in schools. This is of concern, as schools are the most common entry point for youth mental health services. Modular psychotherapies may be a particularly good fit for the school context given their flexible nature. This study examined the experiences of school counselors implementing of a modular therapy. School counselors (*n* = 20) were recruited from a larger randomized controlled effectiveness trial in five school districts. Counselors participated in semi-structured interviews, and content analysis was used to elucidate barriers and facilitators to successful implementation of the protocol. Barriers and facilitators fell into four broad categories, consistent with the Consolidated Framework for Implementation Research: (1) intervention components, (2) school setting, (3) school counselors, and (4) study-specific processes. School counselors generally found the flexible nature of the protocol to be a good fit for their students and emphasized the benefits of training and ongoing consultation. Counselors highlighted many logistical barriers specific to the school counseling setting (e.g., lack of time, space, and competing job demands). Findings underscore the need for the development, testing, and implementation of brief and flexible mental health treatments that are tailored through school stakeholder engagement.

Evidence-based treatments in schools

One in six youths (i.e., children and adolescents) experience a mental health disorder (Whitney & Peterson, 2019), yet 80% of youths with mental health needs do not receive services (S. H. Kataoka et al., 2002). Evidence-based treatments (EBTs) are a promising and potentially potent means of addressing an array of youth mental health problems (Southam-Gerow & Prinstein, 2014). Despite their widespread development and proliferation in recent decades (Weisz & Kazdin, 2017), few EBTs have been adopted by or successfully implemented in schools (Evans et al., 2013). While this research-practice gap is not unique to schools (Garland et al., 2010), it is an important gap because schools have become the most common entry point for accessing youth mental health services (Farmer et al., 2003; Green et al., 2013). Accordingly, widespread implementation of EBTs in schools may be one key to effectively reducing youth mental health

problems on a large scale (Evans & Weist, 2004; Masia-Warner et al., 2006).

Applying principles of implementation science to school-based EBT

The underutilization of EBTs is common across multiple health service settings (Morris et al., 2011). As a result, the field of implementation science has emerged to promote the systematic uptake of EBTs into routine practice (Eccles & Mittman, 2006; J. R. Weisz et al., 2014; Williams & Beidas, 2019). Broadly, implementation research seeks to determine how to successfully transport core components of interventions into professional practice, adapt interventions to the local context, and enhance organizational readiness for successful implementation (Rabin et al., 2008). Among the many useful implementation science frameworks in existence (e.g., Aarons et al., 2011),

the *Consolidated Framework for Implementation Research* (*CFIR*) offers five major domains across which to evaluate the implementation of interventions: (1) intervention characteristics (e.g., core components of the treatment), (2) outer setting (i.e., socioeconomic and political context surrounding the institution) (3) inner setting (e.g., organizational structure), (4) implementers (e.g., providers' motivation to implement the intervention), and (5) process (i.e., how the change process is executed; Damschroder et al., 2009). The CFIR might provide a useful tool for evaluating the implementation of EBTs within schools; however, to our knowledge, few if any studies have utilized it for this purpose. Thus, in the absence of a theoretical framework, the present study sought to examine barriers and facilitators to the implementation of a modular EBT in schools, and organized findings within the CFIR, when applicable.

Unique characteristics of school-based treatment

Schools pose unique challenges to EBT implementation, as most EBTs are developed in outpatient settings and designed to be delivered across weekly 50-minute sessions (A. R. Lyon et al., 2011). The school context for therapy is considerably different from many outpatient mental health settings and is widely variable both within and across schools (Fazel et al., 2014). For example, ratios of school counselors to students vary considerably, resulting in disparate caseload sizes (Christian & Brown, 2018). School counselors also face demands that many outpatient providers do not contend with (e.g., administering psychological testing, frequent consultation with teachers and school administrators; Mullen et al., 2017), which may make EBTs difficult to deliver as prescribed (Langley et al., 2010).

In a review of the emerging research on EBT implementation in schools, several barriers were identified, including school counselors' professional (e.g., inexperience with EBTs) and personal (e.g., attitudes toward EBTs) characteristics, high rates of turnover, and inadequate training and consultation, which were particularly salient in under-resourced schools (Eiraldi et al., 2015). In a qualitative study of school counselors delivering a cognitive behavioral intervention for trauma-

exposed youth, reported barriers to successful implementation included school counselors' competing job demands, poor caregiver engagement, difficulty finding time and space, and inadequate support from school staff (Langley et al., 2010). Lyon et al. (2014) conducted interviews with school counselors implementing the anxiety- and depression-specific components of a modular EBT. School counselors described the intervention as appropriate for and effective with most students, particularly those with mild to moderate internalizing concerns. They also shared concerns about the interventions' suitability for those with more severe problems, including trauma-related distress. However, the study did not make use of the EBT's trauma- or conduct-specific content. Moreover, the EBT was implemented within a school-based health center, a novel but sparsely utilized model (i.e., less than 2,000 nationwide; Juszczak et al., 2007) for providing physical and mental health care within schools (Brown & Bolen, 2003). In other words, relatively little is known about the implementation of comprehensive modular therapy in general, broadly representative school counseling settings.

Potential utility of modular EBTs in schools

Modular EBTs may be particularly well suited for the school setting, as they allow for flexibility in treatment *content* (i.e., "modules" consisting of therapeutic activities and their related procedures) and *coordination* (i.e., "protocols" for selecting the most appropriate content) to facilitate widespread applicability and usability (Chorpita et al., 2005; A. R. Lyon, Lau et al., 2014; Park et al., 2018). Whereas traditional EBTs encompass a specific protocol for one or more related disorders, modular approaches draw on commonly utilized components of multiple EBTs and are designed to treat an array of problems (Chorpita & Daleiden, 2009; Farchione et al., 2012; Pachankis et al., 2019). This diversity in treatment content may be especially advantageous in schools, wherein youths present with a wide variety of internalizing and externalizing health concerns and for whom comorbidity is common (Bearman & Weisz, 2015; Deighton et al., 2019). Modular EBTs provide greater flexibility in treatment coordination as well, with multifaceted

protocols that readily allow for changes in treatment content based on youths' shifting concerns and most pressing needs (Lucassen et al., 2015). Moreover, modular EBTs are designed to be flexible in duration as well as in session length and frequency (Chorpita et al., 2005), making them well suited to school environments in which time is at a premium.

Prior studies have found modular EBTs to be effective in reducing youths' internalizing and externalizing symptomatology when delivered partially or exclusively within schools. For instance, J. R. Weisz et al. (2012) conducted a randomized effectiveness trial of modular EBT in both community-based clinics and school-based settings. The intervention outperformed both usual care and standard EBTs (e.g., cognitive behavioral therapy, behavioral parent training) on both quarterly (Chorpita et al., 2013) and weekly (J. R. Weisz et al., 2012) outcome measures. More recently, a pilot test of the Brief Intervention for School Clinicians (BRISC; A. R Lyon et al., 2015), a flexible and modular intervention specifically designed for use within schools, was more effective than usual care in reducing students' symptoms of anxiety and depression (Bruns et al., 2019). The present study seeks to build on this existing literature by examining provider-level implementation of a modular EBT that addresses both internalizing and externalizing problems in school-based therapy.

Current study

The current study builds on extant research to further examine the experiences of school counselors' implementation of modular therapy for youths in schools. Specifically, we investigated the counselors' experiences implementing the Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC; herein "MATCH"). MATCH consists of 33 *modules* (i.e., specific treatment elements delivered within a single session; e.g., psychoeducation for anxiety) with four *protocols* (i.e., sets of related modules addressing a particular mental or behavioral health problem) for anxiety, depression, conduct, and traumatic stress (cf. Chorpita & Weisz, 2009 for more detail). MATCH is manualized in that it follows an orderly progression through modules, but modular in that it provides

school counselors with the flexibility to change their focus of treatment (e.g., from depression to conduct) when students' presenting problems change or more urgent concerns arise. The goal of the present study was to (1) investigate the experiences of school counselors delivering MATCH as part of an effectiveness RCT and (2) explore the barriers and facilitators to its successful implementation in schools.

Method

Participants

Participants included $n = 20$ (out of 30 invited) school counselors who were randomly assigned to the MATCH condition within a larger RCT comparing the effectiveness of MATCH and usual care therapy in schools, and who agreed to participate in an interview following study participation. They were between 24 and 60 years old ($M = 35.8$, $SD = 8.3$), predominantly White (70% White, 5% Black; 25% did not report race/ethnicity), and mostly women (90%). All had completed at least a master's degree (85% master's-, 10% post-master's-, 5% specialist's-degrees) in social work, mental health counseling, or another related field, and their professional titles included social workers (55%), counselors (20%), school psychologists (15%), and interns (10%). On average, participants reported 4.9 years (range: 2–16; $SD = 4.5$) of clinical training and 9.1 years (range: 0–30; $SD = 7.8$) of professional experience, with primary theoretical orientations of cognitive-behavioral (35%), psychodynamic (10%), behavioral (5%), systems (5%), or combinations thereof (40%).

Participants worked for one of five Boston-area public school districts (75%) or for community-based mental health agencies (25%) providing school-based care. The community-based mental health agency providers were contracted by the schools to provide individual counseling services for particular youths, and the agency was subsequently reimbursed by the family's insurance company. In all, participants in this study treated 62 students across 9 elementary schools, 8 K-8 schools, and 2 middle schools, and reported an average MATCH caseload of 3.1 students ($SD = 1.8$). Students were diverse with respect to age (7–14 years; $M = 10$, $SD = 1.9$), natal sex (60% male, 40% female)

and race/ethnicity (58% White, 8% Black, 3% Latinx, 5% Asian, 23% multiracial, 3% other). Languages other than English spoken by enrolled families included Spanish, Portuguese, Mandarin, and Arabic. Based on their primary presenting problems, as determined by standardized and idiographic assessments, students were initially assigned to treatment via one of four MATCH protocols (35% anxiety, 48% depression, 2% traumatic stress, 15% conduct). Although only a small percentage of students were assigned to the traumatic stress protocol based on their initial assessments, several endorsed a history of trauma and/or related symptomatology. The majority of these students also reported clinically significant elevations in internalizing or externalizing problem areas, and thus were assigned to the depression, anxiety, or conduct problem protocols. This comorbidity is consistent with research indicating that anxiety, depression, and conduct problems are common in youth with histories of trauma (Copeland et al., 2007).

Procedures

School counselors assigned to the MATCH condition completed six days of MATCH training and weekly in-person consultation with a MATCH expert (i.e., a master's or doctoral-level clinician with previous experience using MATCH) while delivering MATCH to one or more youth participants. As this study was part of an effectiveness trial, no adaptations or modifications were made to the MATCH protocol. Consultants listened to audio-recorded MATCH sessions prior to their meetings with school counselors, provided verbal and/or written feedback on treatment delivery, and assisted school counselors in session planning. School counselors and their consultants also had access to an online measurement feedback system, the Progress Assessment in Therapy (PATH), which provided data on students' response to MATCH based on brief, weekly web-based assessments completed by youth and their caregivers. These data were reviewed in weekly case consultations with school counselors to monitor treatment progress and guide decision-making. School counselors referred youths they were currently seeing in therapy for study participation, and eligibility was determined by clinical elevations ($t > 65$) in youth- or caregiver-reported mental or behavioral health problems on the Youth Self-Report or Child Behavior Checklist (Achenbach & Rescorla, 2001). Exclusion criteria included diagnosis of neurodevelopment or pervasive developmental disorders, eating disorders, and/or attention-deficit hyperactivity problems (if indicated as the primary reason for referral; but, students diagnosed with ADHD were included if treatment was indicated for other problems, such as aggression).

Data were collected via semi-structured interviews with participants following study participation. The interview protocol was developed by research staff actively involved in the larger RCT. The protocol was approved by the university IRB, and participants received 50 USD compensation for their participation. Interviews lasted between 1 and 1.5 hours, and payment reflected an RCT-wide compensation rate of 35 USD per hour of study-related activities outside of school hours. Interviews were conducted by trained research staff familiar with the MATCH protocol.

Interview questions explored participants' experiences delivering MATCH in schools, with a focus on factors unique to school settings, including clientele (e.g., "How well do you believe MATCH meets the needs, characteristics, age range, and diversity of your students?") and job demands (e.g., "How well did MATCH fit into the needs, expectations, and demands of your job?"). Participants also identified barriers (e.g., "What were some of the barriers to implementing MATCH as part of your practice?") and facilitators (e.g., "What aspects of the MATCH program did you find helpful?") to implementing MATCH. Further questions examined the utility of specific elements of MATCH (e.g., the treatment manual, modules, worksheets) as well as study-related procedures (e.g., training, consultation, online progress monitoring). Participants rated the helpfulness of these elements on a Likert scale ranging from 0 (*not helpful*) to 7 (*very helpful*) and responded to open-ended follow-up questions on each. Interviews were audio-recorded and later transcribed by research staff. Transcripts contained both linguistic (i.e., language) and nonlinguistic (e.g., laughter, sighs) communication in order to capture the content and context of participants' responses (Graneheim & Lundman, 2004).

Analysis

Qualitative content analysis was used to analyze transcripts, as it offers a systematic and objective means of classifying and interpreting data via categories of codes taken directly from the text (Schreier, 2012). This approach has been used previously to elucidate mental health providers' perspectives on the implementation of EBTs in community- (Hamm et al., 2015; Stirman et al., 2013) and school-based (Distel et al., 2019; Stein et al., 2010) settings. More specifically, conventional content analysis (CCA; Hsieh & Shannon, 2005), the approach-of-choice in the absence of theory and nascence of research (Elo & Kyngäs, 2008), was used. CCA draws directly on participants' responses to facilitate data analysis without imposing *a priori* categorizations (Hsieh & Shannon, 2005; Kondracki et al., 2002). That is, participants' own words serve as the basis for coding data. Similar codes are grouped into categories, which, when contextualized and richly described, foster new understandings of the phenomenon under study (Hsieh & Shannon, 2005). CCA is often used to report clinical perspectives on understudied practices (Fox et al., 2015; Picciotto & Fox, 2018), including school-based psychotherapy (Lyon et al., 2014).

Transcripts were coded by research staff (first, second, and fifth authors) assisting with the larger RCT. NVivo 12, a qualitative data analysis software program, was used to facilitate data management and analysis. Coders were supervised by a senior researcher (last author) experienced in qualitative methods, and the research team met weekly for two months until coding was complete. To begin, they developed the following research questions to guide analysis (Doody & Bailey, 2016): (a) What are the facilitators and barriers to implementing MATCH? and (b) What are the facilitators and barriers specific to the implementation of MATCH in schools? Prior to and throughout analysis, coders discussed biases that might impact their ability to code objectively. Because of the inherent subjectivity of qualitative analysis (Braun et al., 2015), researchers must be aware of how their knowledge and experience influence analysis (Elo et al., 2014; Erlingsson & Brysiewicz, 2017) and exercise caution not to ascribe new meaning to data (Graneheim & Lundman, 2004). Coders openly discussed potential biases before and throughout the coding process, and strove to bracket the impact of these biases on coding. Potential biases were related to coders' ages, races/ethnicities (i.e., all identified as White, but schools were racially diverse), prior exposure to interview data, familiarity with the larger study, and existing attitudes toward EBTs.

Before coding an individual transcript, each coder read through it entirely to gain a sense of the whole interview (Erlingsson & Brysiewicz, 2017). During the second reading of the transcript, codes (e.g., names or phrases) were added to relevant portions of text (e.g., sentences; Elo & Kyngäs, 2008). The first four transcripts were coded by all coders to develop an initial codebook. Subsequently, transcripts were coded independently, with codes modified or added to the codebook, as needed, to ensure that participants' perspectives were well represented. Codebook development and refinement occurred through a consensus building process (Hill et al., 2005), which involves coders meeting weekly to discuss discrepancies in coding through open dialogue. Consensus building is commonly employed in qualitative research, including previous studies with school counselors (Lyon et al., 2014). Unlike calculations of interrater reliability, it draws on differences in opinions to broaden the conceptualization of codes and interpretations of coders (Hill et al., 1997). Within the codebook, related codes were organized into broader categories and attached to exemplars (i.e., representative quotations; Hsieh & Shannon, 2005). No new codes emerged after 16 transcripts were coded, indicative of thematic saturation (i.e., the exhaustion of codes/categories; Saunders et al., 2017) and resulting in a finalized codebook. Transcripts coded previously were re-coded to reflect these revisions.

Results

Consistent with the implementation-focused nature of the study, categories of barriers and facilitators were organized to fit 4 of the 5 domains of the *Consolidated Framework for Implementation Research* (Damschroder et al., 2009), including the inner setting (school), intervention characteristics (MATCH), implementers (school counselors), and the implementation process (study-specific;

Table 1. Codes grouped by CFIR domains.

Domain	Code	% School Counselors (N = 20)	Exemplar Quotes
Inner Setting (school)			
Barriers	Time	95%	"I think we didn't exactly follow the flow chart of activities because we did have a lot of stuff that came up, and we did have to deal with that in the moment."
	Lack of student engagement	60%	
	Attending to crises	55%	
	Lack of caregiver involvement	45%	
	Counseling to classroom transition	30%	
	Interruptions	30%	
	Job Demands	30%	
	Complex student symptom presentations	25%	
	Lack of support from school personnel	15%	
	Student academic difficulties	15%	
	Low student insight	10%	
	Space	10%	
Facilitators	Student engagement	50%	"The student that I had, um, with MATCH, like, was very, like, she was very into it and she, so I definitely had buy-in from her and I think she even liked doing the homework."
	Caregiver involvement	50%	
Intervention Characteristics (MATCH)			
Barriers	MATCH worksheets	95%	"… when it got to some of the older kids, like seventh and eighth grade, um, some of them [worksheets] felt that they were a little immature or childish."
	MATCH protocols	70%	
	MATCH manual	60%	
	MATCH qualities	15%	
Facilitators	MATCH worksheets	100%	"It was really easy to have it all kind of laid out in a linear progression of what to do next, so that was really helpful to have that and not have to think about where to go from one place to the next."
	MATCH protocols	100%	
	MATCH manual	100%	
	MATCH qualities	100%	
Implementers (school counselors)			
Barriers	Inflexibility	5%	"I have one kid that I've been working with for a while, so it was a little hard to like switch over to MATCH. But, honestly I think that was more me than it was the kid, The kid adapted really quickly. It was just that wasn't what I was used to doing."
Facilitators	Adaptability	30%	"The skills, like being able to sort of like recognize your emotions and be able to label them I mean that's things like that I've done forever with kids."
	Experience	25%	
	Lighter caseload	10%	
Process (study specific)			
Barriers	Training	75%	"I just felt like I did not have an hour of time to give like once a week for consultation. It was like, that was just so stressful to me."
	Consultation	65%	
Facilitators	Training	100%	"I think having the consultation or supervision piece was really helpful and kind of talking through what was going well, maybe something that wasn't going well."
	Consultation	100%	

The percent column indicates the percent of counselors whose responses fit the designated code 12960.

see Table 1 for summary statistics and exemplar quotes). Although the CFIR has previously conceptualized "patient needs and resources" as specific to the outer setting (Damschroder et al., 2009), the present study identifies student qualities (e.g., treatment engagement) as relevant to the domain of inner setting because outer setting typically reflects client needs that are attributable to social context (e.g., socioeconomic and political factors). Because student qualities are proximal to the school context, they are considered as part of the 'inner setting" for this analysis.

Additionally, no counselors reported facilitators or barriers in the fifth domain: outer setting (e.g., socioeconomic and political context). Some overlap was found across barriers and facilitators, and thus they are separated below to facilitate interpretation. In order to contextualize our findings, we first describe information about clinical caseloads and the typical services provided by participating school counselors.

Caseload characteristics and services provided

To provide a context for better understanding the barriers and facilitators to MATCH implementation, counselors were asked to describe their overall caseloads and the typical services they provide. Active caseloads (i.e., students they met with regularly) ranged from 10 to 50 students, with up to 480 total

students for whom they provided monitoring and as-needed services. In describing their typical services, school counselors noted relatively short session lengths: "Maybe I'm supposed to see a kid for 30 minutes but they forgot or I'm chasing them down or I'm trying to find them and I only have 15 minutes." Half of the school counselors identified anxiety (e.g., social anxiety, test anxiety) as the most commonly reported problem in their overall caseload, with depression, post-traumatic stress, and behavioral issues (15%-30%) also of concern. School counselors (20%) also highlighted students' difficulties regulating emotions and developing social skills. Additionally, four school counselors (20%) indicated that their caseloads often included students who received specialized services for social-emotional or learning disabilities (e.g., Individualized Education Plans, 504 Plans).

School counselors reported using both individual (35%) and group therapy (35%). Individual therapy was common among participants employed by outside community agencies, while group therapy was more commonly practiced by those working directly for schools. As one school counselor reported: "It's more difficult to see students individually, so I opt to see students in small groups or even dyads." In addition to providing therapy, counselors' additional responsibilities included assessment, consultation, and case management (5%-10%).

Helpfulness ratings

School counselors were asked to rate how helpful they found four components of MATCH from 0 (not helpful) to 7 (very helpful): 1) the manual, 2) the worksheets, 3) the initial training, and 4) weekly consultation. Seventeen of the twenty counselors interviewed provided ratings for all of these components. The helpfulness ratings were high for the MATCH manual ($M = 6.35$, $SD = 0.63$), MATCH training ($M = 6.31$, $SD = 0.93$), and MATCH consultation ($M = 6.22$, $SD = 1.26$), with the MATCH worksheets receiving slightly lower ratings ($M = 5.89$, $SD = 1.81$).

Inner setting: school

Barriers
Time, space, and lack of institutional support.
School counselors identified several logistical and institutional challenges that problematized MATCH implementation. The majority (95%) reported time as a major constraint, including limited in-session time to meet with students as well as additional time required to prepare for sessions. Nearly one-third of school counselors (30%) reported that sessions were frequently canceled or interrupted by school activities (e.g., field trips), and 55% reported that even when sessions occurred as scheduled, students were often experiencing more immediate "crises" which led counselors to delay presenting MATCH content: "A lot of times I'd end up having another student [in session] … in an ideal world I'd still be able to do some of the MATCH stuff, but the reason I often had someone else [in session] is because they had just gotten into a fight." Several school counselors (30%) indicated that the time needed for students to transition between class and therapy further exacerbated these time constraints. Finally, 30% of school counselors noted that their additional job demands (e.g., IEP meetings) limited the time they had to devote to MATCH implementation. Issues regarding the lack of physical space to conduct MATCH sessions were raised by two (10%) of the school counselors: "Space was always an issue … we were either in the smallest space ever, or we were in a classroom that no one was using." Three (15%) school counselors also discussed feeling unsupported by other school staff in their pursuit of implementing MATCH and tracking student progress: "I wish that our teachers were more invested because I think we would have been able to see the impact in school … how do I treat them if I don't know if it's working or not?" Some (25%) school-employed counselors specifically reported that their role did not support individual therapy in general: "It's not what an administrator would be looking at when they evaluate you. I feel like a lot of our job is like, you know, putting out fires and helping make other people's jobs easier."

Student qualities.
School counselors discussed a range of student qualities as barriers to MATCH implementation. Most commonly (60%), they cited students' lack of treatment engagement, both in and out of session: "The activities we ask the students to do outside of our time together, that's a challenge in a school. Students don't want to feel like counseling is required. I think they preferred it to be a more relaxed break where they can talk to a trusted adult."

For 25% of school counselors, MATCH implementation was complicated by students' symptom complexity: " … kids come in with pretty complex array of concerns that don't always lend themselves well to just doing MATCH." Additional student characteristics identified as barriers included academic difficulties (15%) and low insight (10%).

Lack of caregiver involvement. Almost half of school counselors (45%) reported difficulties contacting or communicating with caregivers. These problems were exacerbated by language barriers between caregivers and school counselors and the fact that most caregivers worked during the school day, making them difficult to reach or meet with during the school day. Likewise, 45% cited challenges with caregiver engagement for specific MATCH protocols (e.g., conduct-related modules), reflecting caregivers' concerns regarding the appropriateness of content, wider stigma surrounding mental health treatment, and a lack of time and resources to participate in treatment. In particular, three school counselors (15%) reported that caregivers were reluctant to practice MATCH skills with their children at home.

Facilitators
Student qualities and job demands. Most school counselors (70%) reported that MATCH fit the needs, characteristics, age range, and diversity of their students: "I think it's a perfect match … I love that it can be adjusted for the age groups." Similarly, more than half (60%) reported that MATCH was well suited to the demands of their jobs: "I have a goal for what I'm working towards with the students, so I think in that sense it works really well with how I'm evaluated." Notably, all (100%) of the counselors employed by outside agencies (*n* = 5) reported that MATCH fit well with the demands of their job.

Student and caregiver involvement. Half (50%) of school counselors identified student engagement as integral to successful MATCH implementation, noting the importance of compliance (i.e., treatment attendance, homework completion) and adaptability (i.e., willingness to engage in a new intervention). Caregiver involvement was also considered important (50%), particularly in

helping children practice MATCH skills outside of the school setting: "The parents that were more into it and able to be supportive at home could do more of that follow up to ensure that it was getting done."

Intervention characteristics: MATCH

Barriers
MATCH protocols. School counselors reported infrequent utilization of the trauma and conduct protocols. Some (35%) found schools to be an inappropriate setting for treating trauma. For example, regarding the trauma narrative (a component of the trauma protocol), one school counselor said, "The visualization or reliving of trauma … is nothing I would ever do in school." Nearly half (45%) of school counselors had difficulty implementing the conduct protocol, which relies heavily on the behavioral training of caregivers: "I found the parent training to be a little challenging, just based on the fact that it was parent-only sessions and it can be challenging to get them in during school hours."

MATCH modules. A majority of school counselors (70%) described particular MATCH modules as harder to implement than others, with 35% highlighting components of the anxiety protocol. Specifically, they noted that building a fear hierarchy and completing exposures are difficult to implement in schools, particularly for kids with more generalized anxiety concerns. "I remember feeling like some of the anxiety modules weren't necessarily the best for the kids that I was working with in schools because it's usually hard to do the exposure-therapy kind of stuff."

MATCH materials. Sixty-percent of school counselors reported problems with the MATCH manual. Specific problems included the limited amount of options per module (e.g., only two "relaxation" strategies), difficulty navigating between protocols and finding specific modules, and the burden of using and transporting a physical manual. Almost all school counselors (95%) cited at least one element of MATCH worksheets as a barrier to implementation. Many (65%) suggested that worksheets were overly repetitive and not visually appealing to students, describing content as "too childish" for older

youths. As worksheets were primarily presented in English, school counselors shared concerns about treatment access and caregiver engagement. While counselors in this trial only had access to study materials in English, with the exception of caregiver handouts provided in Spanish, MATCH worksheets are available in other languages (e.g., German). Thus, this barrier should be interpreted within the context of the larger effectiveness trial. For those school counselors who did assign MATCH worksheets as homework, they reported low rates of completion by youths and their caregivers. School counselors had access to an electronic version of the MATCH manual. However, as they frequently reported logistical concerns, including insufficient time and space, accessing these materials during sessions may have been problematic within the school context, increasing their reliance on the physical manual.

MATCH qualities. Broader intervention qualities were also discussed as barriers to MATCH implementation, with 15% of counselors reporting one or more quality of MATCH as a barrier. School counselors found the length of modules to be a barrier to treatment delivery, noting the limited amount of time they had with students during sessions. Three school counselors (15%) questioned the age-appropriateness and cultural-relevance of content, suggesting that it did not always reflect the diverse backgrounds and lived experiences of students: "I think the one thing that MATCH maybe lacking in a little bit is in the cultural aspect. I work with a very high Latino population, and it's a different culture versus my Caucasian population." A quarter of school counselors perceived MATCH to be too structured to deliver effectively, noting that the intervention was often too rigid and did not allow for personalization or creativity. Similarly, 25% of counselors found MATCH to be "too demanding" or "challenging" to implement effectively, describing the process of planning for sessions as "overwhelming" when combined with the other demands of their jobs. Finally, school counselors who primarily provided group therapy expressed dissatisfaction that MATCH could not be implemented within that context.

Facilitators
MATCH protocols and modules. One-hundred percent of counselors reported that there were MATCH protocols and modules that facilitated implementation. School counselors reported that they most frequently used elements from the depression protocol, citing problem solving, relaxation, and cognitive restructuring as most beneficial to students. Of school counselors who utilized the anxiety protocol, psychoeducation was identified as a particularly helpful module that was easily deployed in a school setting and well received by students.

MATCH materials. One-hundred percent of school counselors reported that the MATCH manual was helpful to implementation; the vast majority (80%) found the manual to be clearly written and readily navigable, highlighting the utility of flowcharts to guide module selection and scripted dialogs with which to engage students in particular modules. The entire sample (100%) also noted helpful facets of MATCH worksheets, particularly their ease of access: "I appreciated literally being able to make copies of things if I wanted to use exactly what was in there." They described the worksheets as engaging for younger students, and found them helpful for reinforcing content.

MATCH qualities. All school counselors identified one or more quality of MATCH that aided in implementation. Specifically. school counselors described the flexible, modular, and skills-based qualities of MATCH as essential to implementation: "I think it is pretty flexible and worked with the student … just the fact that you could jump from module to module and really tailor it to the kid that you're working with." Although the structure of MATCH was identified as a barrier to implementation by a quarter of the counselors, 45% of counselors reported that its structured and organized nature facilitated MATCH delivery: "I think it was helpful just to have a bunch of structured activities and lessons for a variety of different needs."

Implementers: school counselors

Barriers

For one counselor (5%), inflexibility made learning and adapting to a new therapeutic approach problematic, more so than for students: "I have one kid that I've been working with for a while, so it was a little hard to like switch over to MATCH. Honestly, I think that was more me than it was the kid. The kid adapted really quickly. It just wasn't what I was used to doing."

Facilitators

School counselors described three personal and professional qualities that facilitated MATCH implementation. The most commonly identified characteristic was a sense of adaptability, which was reported by 30% of counselors and summarized by one counselor as follows: "Once I kind of got in the groove and realized I shouldn't or couldn't cram one full lesson into my 30-minute time slot with kids, learning how to adapt on my own fit really nicely." Secondly, 25% of counselors reported that previous experience with EBTs also contributed to successful implementation: "I knew CBT in other realms. I felt like MATCH made a lot of sense for where I was at as a clinician." Lastly, two counselors (10%) reported that self-described "lighter" and "less complex" caseloads eased the burden of implementation.

Process: study-specific

Barriers

Training. Most school counselors (75%) found at least one element of MATCH training unhelpful, with the most common complaint being that the trainings were too long. Some indicated that training lacked applicability to the school setting as clinical examples lacked complexity, and suggested that trainers lacked experience in, and understanding of, school-based therapy.

Consultation. Sixty-five percent of school counselors described at least one challenge related to their consultation with MATCH experts. Several (35%) reported problems finding time for consultation, citing their large caseloads and busy schedules. The length of consultation (averaging nearly an hour) was often described as burdensome, and many school counselors found the content of consultation to be repetitive or not pertinent to their cases. Two school counselors (10%) found that consultants' inexperience with school-based therapy precluded them from offering relevant guidance.

Facilitators

Training. All counselors (100%) identified one or more elements of training as helpful, and most commonly (65%) recounted their participation in role plays as key to their future implementation of MATCH. They also expressed appreciation for trainers' experience with the protocol, teaching, and presentation styles, as well as the use of videos to illustrate particular MATCH skills.

Consultation. All counselors (100%) identified one or more elements of consultation as helpful. The most beneficial component of consultation, as indicated by more than 75% of school counselors, was the opportunity to receive feedback on previous sessions with students. They highlighted the value of consultation as a conduit for feeling validated in their work and reported that consultants assisted in problem-solving and generating ideas for future sessions, particularly for challenging cases. For nearly half of counselors (45%), strong rapport with consultants maximized the benefits of consultation.

Discussion

The present study examined the experiences of school counselors implementing a modular EBT (i.e., MATCH) through qualitative analysis of semi-structured interviews. Using the *Consolidated Framework for Implementation Research* (CFIR; Damschroder et al., 2009) to guide interpretation, barriers and facilitators to implementation were grouped across four domains: (1) intervention (MATCH) characteristics, (2) inner (school) setting, (3) implementers (school counselors), and (4) the implementation (study-specific) process. Although broader outer setting factors are also relevant to implementation (e.g., Ruffolo & Capobianco, 2012), no counselors reported facilitators or barriers in this

domain. This may be because interview questions focused primarily on counselors' personal experiences implementing MATCH within individual school settings, leaving macro-level forces less salient (Lyon et al., 2014). Notably, factors specific to the inner setting (i.e., school) and the intervention itself were most prominent in our results. Key themes are highlighted below, and associated implications and recommendations for research and practice are discussed.

Acceptability of some depression components

Counselors reported that they most frequently used MATCH depression modules (e.g., problem solving, relaxation), which is consistent with the high prevalence of depression in participating youths. In other words, our findings indicate that certain components of EBTs for depression may be more acceptable to school providers than others. Indeed, it is also important to identify which components of EBTs real-world providers perceive to be clinically appropriate (Aarons et al., 2009). It may be particularly advantageous to integrate effectiveness and implementation research methods (Curran et al., 2012) in interventions studies for youth depression, as extant EBTs evidence relatively weak effects (J. R. Weisz et al., 2006).

Reluctance to use exposure-based techniques

Anxiety was the second most common presenting problem identified by school counselors, and they most frequently reported using psychoeducation and cognitive restructuring modules from MATCH's anxiety protocol. Exposure, a well-studied and effective tool for treating anxiety in youths (Kendall, 2011), was rarely used, as school counselors deemed it too challenging to implement within schools. These findings reflect previous research showing that, despite their effectiveness, exposure techniques are often underutilized and poorly received by clinicians (Deacon et al., 2013), highlighting a need to identify methods for increasing school counselors' buy-in to such practices (Becker-Haimes et al., 2017). A more streamlined and efficient approach to treating anxiety and related problems in youths (see Weisz et al., 2017) may be particularly

valuable in helping school counselors implement common elements of EBTs (e.g., behavioral activation) with proven efficacy as standalone interventions (J. R. Weisz et al., 2004).

Infrequent use of conduct and traumatic stress components

MATCH protocols for trauma and conduct problems were largely reported as a poor fit for the school context. Several school counselors expressed the belief that schools are not an appropriate context for trauma treatment, with particular concerns about implementing trauma narratives in schools. Interestingly, similar concerns were identified in a study examining the partial implementation of MATCH, which excluded training in the traumatic stress protocol (Lyon et al., 2014). However, programs specifically targeting traumatic stress using exposure and other evidence-based techniques in schools, such as *Cognitive Behavioral Intervention for Trauma in the Schools* (Jaycox et al., 2018) have been successful in engaging school counselors in implementing these treatments (Allison & Ferreira, 2017; S. Kataoka et al., 2011; Langley et al., 2015).

School counselors also noted that the MATCH conduct protocol was not a good fit for schools. The majority of this protocol is designed to be conducted with caregivers, and several barriers to caregiver involvement were noted, so it is unsurprising that the implementation of this protocol was challenging. As behavioral problems are a common reason for referral to school mental health services (Green et al., 2013), effective strategies for reducing behavioral difficulties in school therapy are greatly needed. Alternative targets for behavioral training, such as teachers or other school staff (Bradshaw et al., 2012; Hester et al., 2004; Reinke et al., 2008), may be one promising method of tailoring these existing EBTs in schools. Additionally, protocols that include options for treating conduct problems in the absence of caregiver participation may be particularly useful for schools (Weisz et al., 2017).

Logistical barriers in the school setting

School counselors reported several barriers related to school settings that hindered MATCH

implementation, most notably the lack of time, space, and institutional support, consistent with prior implementation studies (Langley et al., 2010; Lyon et al., 2014). These findings suggest the need for adaptations to EBTs which can be delivered in shorter sessions and in group rather than individual settings. Specifically, brief interventions that focus on core principles of therapeutic change may be particularly appropriate for school settings (Bruns et al., 2019; Weisz et al., 2017). The utilization of nontraditional service providers (e.g., teachers) represents another promising solution (Reinke et al., 2011), potentially alleviating the high demands placed on school counselors. As demonstrated by the current study, school counselors have unique insight into the specific needs of the populations they serve (Atkins et al., 2010). Thus, involving school counselors in the design and adaptation of EBTs may facilitate successful implementation. For example, community-engaged research practices have been employed to implement evidence-based prevention programs within public schools (Bradshaw et al., 2012) and may be especially beneficial in developing school-based interventions for youth of Color (Mulvaney-Day et al., 2006).

Training and consultation were generally acceptable

School counselors generally rated the MATCH training as very helpful and reported that trainers were knowledgeable in the MATCH protocol, but observed that trainers were unaware of the realities of school-based therapy. This finding underscores the importance of community-engaged research practices in intervention studies (Barkin et al., 2013; Mikesell et al., 2013). Discussions with key stakeholders before and during the implementation process can guide adaptations to intervention components to improve their fit within the school context. Although a small portion of counselors noted that their consultant's lack of experience in the school setting minimized the benefit of consultation, the overwhelming majority rated weekly consultation as very helpful in their implementation of MATCH. Taken together, these results suggest that MATCH implementation was facilitated by the combination of training and consultation, which is

consistent with several studies indicating that single trainings are insufficient to produce change in implementers' behaviors (Herschell et al., 2010). Given that ongoing consultation is a time-intensive and resource-heavy endeavor, an important area for future research is to examine what dosage of consultation is sufficient to produce desired student outcomes (Owens et al., 2014).

Limitations and suggestions for research

The current study was limited in a few key ways. First, the larger RCT was an effectiveness trial, not an implementation study nor a hybrid of the two. Accordingly, implementation outcomes (e.g., acceptability, feasibility) were not systematically assessed. The current study reflects an augmentation to the larger effectiveness trial design that was conceptualized and conducted after the RCT had begun in an effort to collect implementation outcomes. Future research would benefit from utilizing hybrid effectiveness-implementation approaches (Curran et al., 2012). In addition, data in the current study were obtained via semi-structured interviews, and thus responses largely reflected the questions that were asked. Future studies should consider using unstructured or less-structured interviews to identify other facets of implementation that may not arise in response to more specific interview questions.

Finally, only two-thirds of school counselors eligible for study participation completed the interview, which may have partially resulted from the ad-hoc nature of the study. In other words, future researchers should consider introducing these interviews and other methods of implementation data collection from the outset of the study.

Summary and conclusion

The current study examined facilitators and barriers to the implementation of a modular EBT in schools through the analysis of individual interviews with school counselors. Facilitators and barriers were found across four domains: intervention components, school setting, school counselors, and the study-specific process. Our findings have three important implications for research on the implementation of EBTs in schools. First, given the logistical barriers present in schools, brief interventions

consisting of a few core components may be more feasible for school counselors to implement. Second, community-engaged research with school counselors and other key stakeholders (e.g., teachers, administrators, caregivers) is central to sustainable implementation and consumer engagement. Finally, studies that integrate both implementation and effectiveness research may facilitate successful and expedient uptake of EBTs in schools.

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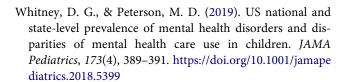
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