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## Multilevel Stakeholder Perspectives on the Implementation of Evidence-Based Interventions in a Large, Urban School District

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**Multilevel Stakeholder Perspectives on the Implementation of Evidence-Based  
Interventions in a Large, Urban School District**

A Dissertation

Presented in

Partial Fulfillment of the

Requirements for the Degree of

Doctor of Philosophy

By

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May, 2021

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## **Biography**

The author was born and raised in the Bronx, New York. She graduated from Hunter College High School in 2006 and received a Bachelor of Arts degree in Psychology and Anthropology with Honors from Wesleyan University in 2010.

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## Abstract

Despite evidence of equal or greater need for mental health services among youth from racial and ethnic minority (REM) and low-income backgrounds, these youth are less likely to receive treatment when it is needed. When they do receive care, it is typically not evidence-based. To address these disparities, advocates and scholars have promoted the use of evidence-based interventions (EBIs) in schools serving REM and low-income youth. However, challenges with the implementation of EBIs in schools have limited their uptake and impact in this setting, especially for this student population. Implementation science offers new ways of examining the process of bringing EBIs to schools in order to understand what factors contribute to or impede their success. This case study examines the implementation process for EBIs in the context of one of the nation's largest school districts using the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework. Interviews with 13 stakeholders in the school system (7 clinicians, 6 administrators) were used to understand: 1) which barriers and facilitators impact the implementation process across various stages, and 2) how student racial, cultural, and socioeconomic backgrounds impact the implementation process in elementary and middle schools. A hybrid deductive-inductive qualitative content analysis revealed several barriers and facilitators that appeared across different EPIS phases and that were endorsed by both clinicians and administrators. The results largely corroborated findings from prior implementation studies in schools, while filling in important gaps on administrator perspectives and the impact of student sociodemographic factors. Implications and recommendations for implementation programs in school districts are discussed.

*Keywords:* implementation science, mental health disparities, school-based mental health services

## **Multilevel Stakeholder Perspectives on the Implementation of Evidence-Based Interventions in a Large, Urban School District**

Despite evidence of equal or greater need for mental health services among youth from racial and ethnic minority (REM) and low-income backgrounds in the United States (Coley et al., 2018; McGuire & Miranda, 2008; Merikangas et al., 2010), youth belonging to these groups have historically been poorly served by the mental health system (Bringewatt & Gershoff, 2010; Marrast et al., 2016). Low socioeconomic status (SES) and REM status have long been predictors of decreased access to mental health services, increased dropout rates once services have been initiated, and the receipt of inadequate or ineffective treatment (Alegria et al., 2010; Malhotra et al., 2015). As a result, Black and Latino children, who are more likely to be from low-income backgrounds, are half as likely to receive treatment when it is needed compared to White children (Cook et al., 2013).

In the past few decades, schools have attracted significant attention and investment as treatment settings that can help eliminate these disparities (Paternite, 2005; Ringeisen et al., 2003), and have come to be considered the *de facto* mental health system for youth (Burns et al., 1995). The typical student spends approximately 75,000 minutes in school each year, far exceeding the amount of time spent in primary or specialty care settings (Lee & Gortmaker, 2012). Offering mental health services in schools can also circumvent some of the most significant barriers to care for REM and low-SES youth, including transportation difficulties, parents' busy schedules, and being uninsured or underinsured (Gudiño et al., 2009). Given these realities, public health and mental health experts have embraced schools as a key access point to mental health care for underserved youth.

The growing interest in mental health disparities and school-based mental health services (SBMHS) has happened concurrently with growing interest in evidence-based interventions (EBIs). EBIs (also known as empirically supported treatments, or ESTs) for mental health are loosely defined as psychological interventions that have demonstrated efficacy through clinical research, primarily randomized controlled trials (Chambless & Hollon, 1998). Advocates of EBIs in mental health treatment promote them as tools for improving the overall quality of treatments and outcomes for clients (Spring, 2007; Weisz & Kazdin, 2010).

Several federal policies and initiatives have been instrumental in promoting a mental health paradigm that integrates the goal of reducing mental health disparities with the provision of school-based services and EBIs (Atkins et al., 2010; Paternite, 2005). For example, the landmark U.S. Surgeon General's National Action Agenda on Children's Mental Health in 2000 outlined simultaneous goals of dissemination and implementation of "scientifically-proven prevention and treatment services" and elimination of mental health disparities on the basis of race/ethnicity and socioeconomic status, with action steps underscoring the potential of schools to reduce treatment gaps (U.S. Public Health Service, 2000). Nearly two decades later, in light of persistent mental health disparities for underserved youth, the American Psychological Association released a resolution that emphasized the importance of EBIs in effectively addressing their unmet need and the role of the school as an accessible mental health service setting (American Psychological Association, 2019). In sum, the provision of EBIs in schools offers well-recognized potential to address mental health disparities for low-SES and REM youth through both increased access to care, overall, and access to high-quality care, more specifically.

## **EBIs in Schools**

There are indications that SBMHS are successfully addressing treatment gaps for REM and low-SES youth (Weist et al., 1999). Studies comparing health care utilization of school-based and clinic-based services among low-SES and REM students have found greater engagement with and use of school-based services (Atkins et al., 2006; Juszczak et al., 2003). Similarly, Ali et al. (2019) found a greater likelihood of receiving mental health services solely through school for both REM and low-SES youth. There are also indications that mental health utilization disparities based on race are eliminated for youth when SBMHS are available (Cummings et al., 2010). However, significant barriers remain to meeting the mental health needs of underserved youth through EBIs in schools. These barriers arise from challenges related to EBIs in general, challenges related to the school context, and challenges in the use of EBIs for the treatment of REM and low-SES youth.

A major concern with regard to EBIs is the “research to practice gap” that consistently results in underutilization of research-backed interventions in “real world” settings, such as clinics and schools (Lee & Gortmaker, 2012). Among the factors contributing to this underutilization among mental health providers are difficulties accessing training for the EBIs, difficulty staying up to date with the research literature, and misconceptions about the relative effectiveness of EBIs compared to their preferred treatment approaches (Gallo & Barlow, 2012). In addition, even when EBIs are used in usual care settings, they tend to demonstrate weaker outcomes compared to those found in research settings (Santucci et al., 2015). The decreased efficacy of these interventions in usual care settings may be related to poorer training, decreased fidelity to the interventions, and less proficiency and skill while delivering the intervention (Beidas & Kendall, 2010; Bumbarger & Perkins, 2008).

Many of these challenges are heightened for EBIs delivered in the school setting (Kratochwill & Shernoff, 2003). Researchers have noted the difficulty with integrating and prioritizing SBMHS in general, and EBIs in particular, in a setting primarily responsible for the academic growth of students (Atkins et al., 2010; Paternite, 2005). Educational reforms related to the No Child Left Behind Act and the Individuals with Disabilities Education Improvement Act have taken priority and, despite shared goals, have not been well integrated with mental health reform efforts (Stephan et al., 2007). Dedicated mental health staff have a range of responsibilities in schools outside of the provision of mental health treatment, such as assessment, developing Individualized Education Programs, testing, and college and career counseling (Fan et al., 2018). As such, limited financial and staff resources in schools are primarily allocated to addressing academic barriers to learning and services targeting special education students, leaving little room for the provision of resource-intensive EBIs for the general student body (Stephan et al., 2007; Weist et al., 2012). Unsurprisingly, numerous studies have documented low rates of implementation (Evans et al., 2013; Hicks et al., 2014) as well as limited success rates (Kutash et al., 2006) for EBIs in schools.

EBIs face additional challenges in schools that serve predominantly REM and low-SES students. For example, the services and resources available in a school are largely dependent on the school's budget, which is primarily determined by the local tax base. As a result, schools serving low-SES and REM students tend to have fewer resources than those serving wealthier students (Darling-Hammond, 2004). Policies and mandates may also have differential impact for under-resourced schools. Several scholars have argued that No Child Left Behind (NCLB) has disproportionately burdened schools that serve REM and low-SES youth due to the penalties imposed for student underperformance (Darling-Hammond, 2007). While attempting to avoid

these penalties, these schools may be less likely to commit limited staff time and other school resources to mental health services. For these reasons, clinicians in schools serving low-SES and REM students may be asked to devote a greater amount of their time to non-clinical tasks, such as classroom instruction, to make up for staffing shortages (Eiraldi et al., 2015). In addition, mental health services in under-resourced schools are often characterized by fragmentation in care (Eiraldi et al., 2015), as providers are contracted from outside agencies to fill in service gaps.

Lastly, REM and low-income populations have been systematically underserved by EBIs. There is indication that when individuals in these groups receive mental health care, their treatment is less likely to be consistent with evidence-based standards of care (U.S. Department of Health and Human Services, 2001; Wang et al., 2000). And, although there is an abundance of EBIs for a variety of behavioral and emotional concerns in youth, experts have noted that only a handful of “evidence-based” interventions have been evaluated and shown to be efficacious with REM and low-SES youth (Pina et al., 2019). Interventions that may be well-supported in the literature for predominantly White and middle-class samples sometimes yield smaller or null effects for non-White and lower-income populations (e.g., Windsor et al., 2015). Furthermore, a meta-analysis of treatment outcomes for school-based services with predominantly REM and low-SES youth in urban settings found negligible effects (0.08) (Farahmand et al., 2011), suggesting that the interventions that have been evaluated in school settings may not be helpful for REM and low-SES youth.

Overall, these findings support the assertion that factors related to the delivery or implementation context may be critical to determining the impact of EBIs delivered in schools for youth (Rones & Hoagwood, 2000). In their review of over 500 studies examining outcomes

for child and adolescent prevention and promotion programs (including academic, physical health, and mental health programs), Durlak and DuPre (2008) found that treatment effects are two to three times greater for studies with careful and problem-free implementation.

Implementation factors appear to be especially relevant for understanding challenges related to the use of EBIs with REM and low-income students. As noted by Cabassa and Baumann (2013), efforts to eliminate mental health disparities for underserved populations would be strengthened by greater attention to client “language, cultural values, norms, and meanings, and their context” in implementation (p. 2). This may be even more important to consider when attempting to address the more complex treatment needs of students who have intersecting marginalized identities (e.g., racial/ethnic minority and low-SES). Thus, in order to understand why EBIs delivered in schools are not fulfilling their potential in serving REM and low-SES youth, it is necessary to more deeply explore the process of EBI implementation in the school setting with these populations.

In implementation research, qualitative inquiry is ideal for deep exploration of complex processes as it brings in key stakeholder perspectives to “describe what is happening and why” (Hamilton & Finley, 2019, p. 2). Gathering insights from clinicians and other decision-makers who play a role in EBI implementation can lead to a more nuanced understanding of the challenges and opportunities that arise when EBIs are brought into schools. Prior qualitative studies have helped to reveal school-based clinicians’ top challenges with implementing EBIs (e.g., Nadeem & Ringle, 2016) and administrator perspectives on student mental health needs (e.g., Iachini et al., 2015) that may have otherwise been difficult to capture using quantitative methods. Qualitative research can also identify implementation factors that are unique to the school setting (e.g., Locke et al., 2019). However, a minority of studies have used a qualitative



approach to explore the process of EBI implementation in schools, and even fewer have specifically considered the influence of student race, culture, and SES in this process. The present study is designed to address these gaps in the literature.

### **Using an Implementation Science Lens**

Implementation science is a rapidly growing field of study that “consists of scientific investigations that support movement of evidence-based, effective health care approaches...from the clinical knowledge base into routine use” (Rubenstein & Pugh, 2006). It is concerned with examining the factors and processes involved in introducing, integrating, and sustaining evidence-based practices in various healthcare settings (Bauer et al., 2015). While traditional clinical research prioritizes treatment-specific outcomes related to symptomatology or functioning, implementation research focuses on outcomes related to how EBIs are used, such as feasibility, acceptability, and sustainability, to name just a few (Rabin & Brownson, 2012). Implementation itself can occur in multiple settings (e.g., hospitals, community clinics, schools), involve multiple stakeholders, and typically takes two to four years to reach sustainment (Fixsen et al., 2009). Implementation science embraces the complexity of behavior and institutional change by attempting to account for the various factors influencing implementation outcomes.

Experts in EBIs and implementation research have pushed for more scholarship on the implementation of EBIs in schools due to the complexities of this setting (Forman et al., 2013; Lyon & Bruns, 2019; Owens et al., 2014; Paternite, 2005). For instance, the embedded nature of schools within districts results in an elaborate network of stakeholders at different organizational levels (e.g., direct service, school administration, district offices) who play different roles and have unique perspectives on the implementation process. Due to the diversity of mental health services offered in schools, providers of interventions may include dedicated mental health staff

(i.e., counselors, psychologists, and social workers), teachers, and paraprofessionals employed by the school, or clinic- or agency-based clinicians contracted by schools to supplement the existing mental health programs (Lyon et al., 2018). Also, the role of school administrators in creating an organizational climate and offering support to clinicians is thought to contribute to the success or failure of EBIs in schools (Rones & Hoagwood, 2000). The complexity of the school setting necessitates careful consideration of multiple individuals and factors that impact implementation.

There are a number of frameworks and models that have been developed to guide research on the processes, outcomes, and evaluation of implementation across various settings (Nilsen, 2015). Of these, the Exploration, Preparation, Implementation, Sustainment (EPIS) framework was developed to capture the factors most relevant to implementation in public service settings (See Figure 1; Aarons et al., 2011). The EPIS framework and its core concepts have been used both explicitly and implicitly in numerous implementation studies, highlighting the popularity and relevance of this framework for implementation research (Moullin et al., 2019). In the EPIS framework, the implementation process is divided into 4 phases (Exploration, Preparation, Implementation, and Sustainment), each of which is defined by the activities being carried out to support the intervention's adoption into the setting. The phases are proposed to occur sequentially, from an organization's initial recognition of an issue that needs to be addressed through preparation for and implementation of an innovation, and finally long-term sustainment of the innovation in the setting.

A key contribution of the EPIS framework is the emphasis on different factors impacting implementation at each phase of the process. These factors are conceptualized as primarily occurring in either the inner or outer context of the implementation setting (see Figure 1).

Aarons et al. (2011) proposed several inner context factors (e.g., organizational characteristics, leadership, and characteristics of individuals) and outer context factors (e.g., funding and patient/client characteristics) that are likely to influence the implementation process across public service settings. In addition, Aarons et al. (2011) proposed innovation (e.g., intervention, policy, procedure) and bridging factors that impact implementation. Commonly studied innovation factors are the adaptability of the intervention and its fit with the setting and client needs. Bridging factors have been included in the framework to recognize the interrelatedness of the inner and outer contexts (Moullin et al., 2019). Currently highlighted bridging factors within the EPIS framework are community-academic partnerships and purveyors/intermediaries between the inner and outer context.

A recent systematic review of studies in the implementation literature that cited the original EPIS framework paper indicated that out of 49 studies (of which 19 focused on mental health), only 4 used the EPIS framework to explore implementation in a U.S. school setting (Moullin et al., 2019). For this reason, relatively little is known about implementation of interventions in schools within the EPIS framework. However, the extant literature on school-based implementation suggests that using the EPIS framework would be especially illuminating for understanding the impact of factors that serve as barriers or facilitators to implementation. Further, research on EBI implementation in the child welfare system has found that barriers and facilitators to implementation vary in impact and importance across stages of implementation (Lambert et al., 2016), suggesting that factors in the school context should also be explored for each stage.

## **The EPIS Framework in the School Context**

For school-based programs, the inner context of schools is typically operationalized as the school itself and the adults who work there, while the outer context refers to processes and conditions at the district level and beyond (e.g., state and national policies) (Lyon & Bruns, 2019). The variety of individuals who are part of the inner context (e.g., principals, teachers, and dedicated mental health personnel) is a complicating factor unique to implementation research in schools (Owens et al., 2014). Funding decisions related to dissemination and uptake of evidence-based interventions are an example of a critical outer context factor at the district level, while mandates for the provision of social and emotional learning services are examples of outer context factors at the state and federal levels (Lyon & Bruns, 2019). The complexities of the school system result in a unique combination of potential barriers and facilitators to EBI implementation that are likely to vary across EPIS phases. Although there is a dearth of school implementation research using the EPIS framework, the general school-based implementation literature suggests factors that may be especially relevant in each phase.

***Exploration Phase.*** Aarons et al. (2011) describe the Exploration Phase of implementation as the period during which there is recognition of a need for some kind of intervention and different options are explored. Across implementation studies using EPIS, the Exploration Phase has been the least examined phase, both explicitly and implicitly (Moullin et al., 2019). For EBIs in schools, the exploration of new approaches to mental health service needs can be initiated by policies (at the federal, state, or district level) as well as by clinical research through funding and development of EBIs. In addition, professional organizations for clinicians can encourage or require EBI training and education (Aarons et al., 2011). Lastly, client and community advocacy can spur the implementation of new programs to address student needs. As

such, the perspectives of non-clinicians at the school- and district-levels may be especially important for understanding how EBI implementation is initiated in schools.

***Preparation Phase.*** After the Exploration Phase and the decision is made to adopt an intervention, the next step according to the EPIS framework is to develop a plan or strategy for how to integrate the intervention into the school setting. Prior research has found that even when clinicians are excited about an EBI and commit to delivering it, challenges with preparing for implementation can result in the EBI never being delivered (Nadeem et al., 2018). The Preparation Phase should include identification of potential barriers and facilitators and a plan to address them, as well as a plan for implementation support for providers (Moullin et al., 2019). Similar to the Exploration Phase, the decisions made as part of the Preparation Phase may be impacted by a number of initiatives and perspectives both within and outside of the immediate school setting (Aarons et al., 2011). Policies and mandates may make certain interventions more accessible to implement, regardless of the evidence base (Aarons et al., 2011). Funding opportunities can also be very influential in determining which interventions are most feasible within a school. Lastly, as part of the Preparation Phase, implementers must procure resources such as space, food, and technology (Walsh et al., 2015). When implementation in a school is occurring as part of research, the intervention developer and/or funding agency may play a large role in these decisions (Forman et al., 2009). Otherwise, preparation may be the responsibility of the individual(s) delivering the intervention in the school.

***Implementation Phase<sup>1</sup>.*** The Implementation Phase is the period during which the intervention is initially carried out. The majority of implementation research focusing on child and adolescent mental health has focused on the Implementation Phase (Novins et al., 2013).

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<sup>1</sup> In this manuscript, a capitalized “Implementation” refers to the EPIS phase, while the lowercase “implementation” refers to the overall process of which the Implementation Phase is a part.

Forman et al. (2009) interviewed 24 developers of behavioral and mental health interventions used in schools to understand barriers and facilitators to implementation from their perspectives. The most commonly identified facilitators were support from teachers and principals, support from other administrators, and good training. Program developers also highlighted the involvement of principals as potential facilitators or barriers to implementation. Intervention developers reported that funding, lack of time for program delivery during the school day, beliefs about the program among school staff, and competing priorities in schools, particularly related to meeting academic standards and expectations are the primary implementation barriers (Forman et al., 2009).

***Sustainment Phase.*** As Aarons et al. (2011) note, there has been relatively little examination of the Sustainment Phase of intervention implementation. Similarly, Owens et al. (2014) identified further study of sustainability in school settings as critical for the advancement of implementation science in school mental health. Sustainability broadly refers to the continued implementation of an intervention (in at least some form) after the initial funding and/or research support is removed. However, there is no single definition of the term as the goals and parameters of continued implementation often differ based on the type of intervention and the setting. Intervention developers have described sustainability as difficult to study and a “twilight zone” (pg. 33; Forman et al., 2009). Stirman et al. (2012) conducted a review of sustainability across healthcare settings and examined the factors most commonly mentioned in the categories of innovation characteristics, context, capacity, and processes and interactions. The most commonly cited influences on sustainability for mental health interventions in each category were fit and ability to modify the intervention (innovation), leadership and setting characteristics (context), workforce (e.g., staffing; capacity), and training, education, and ongoing support

(processes and interactions). In addition, the availability of funding is often perceived to be critical for, or even synonymous with, sustainability (Scheirer, 2005) as the initial research support typically includes financial resources that may not be available in the Sustainment Phase of a program. These practical realities may be especially influential for sustainability of interventions in under-resourced schools.

In sum, while the literature on school-based implementation suggests potential barriers and facilitators in each phase of the implementation process, this area is understudied and the factors impacting implementation in this setting are not well understood. Given that a major contributor to the complexity of implementation in the school setting is the variety of individuals involved, it is likely that the factors considered most influential for implementation differ both by a person's role and by the EPIS phase. Thus, an examination of barriers and facilitators to implementation of EBIs in schools is incomplete without understanding the perspectives of stakeholders at different organizational levels of the school system.

### **Stakeholder Perspectives on Implementation**

Studies that explore multiple stakeholder perspectives within the same implementation setting demonstrate that individuals with different roles at different organizational levels can hold similar and differing views on the implementation process. For example, Beidas et al. (2016) interviewed intervention developers, agency leaders, and system leaders about barriers and facilitators to EBI implementation in the context of a large public mental health system. They found general agreement across stakeholders, with some variation related to the aspect of implementation most directly related to their respective roles. Massey et al. (2021) had similar results in their study of barriers and facilitators to implementation for the Safe Schools/Healthy Students Initiative in several states. Although this study did not focus on specific EBIs, it is one

of the few studies to examine perspectives on school-based implementation across different organizational levels (clinicians, local agency leaders, principals, and state agency leaders) and document areas of similarity and difference between them (Massey et al., 2021). This study is also notable in that it examined changes in barriers and facilitators over a three-year implementation period. The study authors found that many factors remained salient across the three years, but noted changes in the emphasis and form that the barriers and facilitators took over the years (Massey et al., 2021). Such an examination of multilevel perspectives across time for EBI implementation in schools has not yet been conducted. The review below presents the extant qualitative literature documenting perspectives from school clinicians and administrators on the EBI implementation process.

***Clinician Perspectives.*** The majority of qualitative implementation research in schools has focused on the perspectives of the individuals directly delivering interventions. Clinicians working in schools have described it as a setting in which they benefit from teamwork, sometimes feel isolated, have varied responsibilities and unpredictable schedules, and work with diverse student concerns (Lyon et al., 2014). Several studies have provided insight into clinician perspectives in different phases of the implementation process. For example, Lyon et al. (2013) asked participating and non-participating school clinicians about their decision to participate in training for a modular psychotherapy EBI. They found several factors influencing the initial decision to participate such as time constraints and scheduling, the perceived utility and fit of the EBI with school, documentation requirements, general attitudes toward training, emotional responses toward training, and social connections and influences (Lyon et al., 2013). These themes illustrate the many considerations that go into decision-making by clinicians in the early phases of the implementation process.



Most research on school clinician perspectives has focused on the Implementation Phase. Corteselli et al. (2020) asked elementary and middle school clinicians about barriers and facilitators to implementation of the Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC). The top barriers endorsed by clinicians in the inner context were time, lack of student engagement, attending to crises, and lack of caregiver involvement, while facilitators were student engagement and caregiver involvement (Corteselli et al., 2020). The MATCH worksheets, protocols, and manual were endorsed as both barriers and facilitators related to intervention characteristics, and training and consultation were endorsed as both barriers and facilitators related to the study process (Corteselli et al., 2020). It is unclear whether these factors impacted all phases of the process or if they were only relevant to the Implementation Phase. In a study examining implementation of the CBITS trauma intervention in middle schools, both successful implementers and non-implementers described the following barriers to implementation: competing responsibilities (and its resulting time constraints), lack of parent engagement, logistical barriers related to session space and scheduling, and lack of support (and buy-in) from administrators and teachers (Langley et al., 2010). Two key differences among implementers and non-implementers were that implementers knew colleagues who were also implementing CBITS and they worked in schools with funding specially allocated toward implementation.

With regard to EBI sustainment, a qualitative study that also examined CBITS implementation in middle and elementary schools found that barriers for clinicians were job instability, administrator priority on academics, lack of district support, challenges with parent engagement, lack of time during the school day, and competing responsibilities (Nadeem & Ringle, 2016). In contrast, they shared that experiences of success with the intervention and

logistical support from school staff and administrators contributed to sustainability (Nadeem & Ringle, 2016).

Importantly, research suggests that clinician attitudes toward EBIs can change over time. A systematic review of the general literature on therapist training found that therapist attitudes toward an EBI improve after receiving training and delivering the intervention (Beidas & Kendall, 2010). And, in a qualitative study of frontline workers in the delivery of the SafeCare child welfare intervention, study authors noted that initial clinician perceptions of rigidity in the protocol appeared to change over time, though some clinicians remained “anxious” about delivering the intervention correctly while providing care consistent with their values (Willging et al., 2015). Examining clinician barriers and facilitators across EPIS phases can help to clarify whether attitudes or perceptions of EBIs change throughout the course of implementation.

***Administrator Perspectives.*** As leaders and more stable members of the school ecosystem, school administrators may be key to promoting a vision for the school that includes the use of EBIs. Likewise, district administrators play an important role in establishing priorities, funding, policies, systems, and procedures that facilitate EBI implementation in schools. A qualitative study examining school administrator, district administrator, and teacher perspectives on implementation found several aspects of leadership, climate, and stakeholder behavior that contributed to implementation success for school-wide EBIs in elementary schools (Locke et al., 2019). Participants in this study highlighted the importance of distributed leadership, capitalizing on existing teams, prioritization of EBIs, information sharing, and increasing opportunities for observation and feedback, all of which were implementation factors that emerged as unique to the school setting (Locke et al., 2019). Several studies have highlighted the importance of leadership buy-in and support for the success of intervention implementation (Aarons et al.,

2016; Ault-Brutus et al., 2014). In a large study examining sustainability of district-wide EBI implementation models in middle and elementary schools across several states, district leaders, school leaders, and school personnel indicated that intervention models that demonstrated beneficial outcomes, were compatible with district and school priorities, and had more support from district leaders were more likely to be sustained (Yu et al., 2012). In contrast, greater complexity of an intervention model, limited funding, staff turnover, and competing initiatives were reported as hindrances to sustainability (Yu et al., 2012). Nonetheless, school administrators appear to appreciate the need for mental health interventions in schools as demonstrated in a study where principals overall rated behavioral/mental health as their schools' highest need (Iachini et al., 2015). Of note, about half of principals reported great need for "training or information about diversity issues" (Iachini et al., 2015).

Overall, administrator perspectives on EBI implementation are relatively understudied compared to clinician perspectives. Given the findings highlighted above, it is clear that a full understanding of the implementation process in schools requires gathering perspectives from clinicians on the ground as well as other key stakeholders. With this in mind, the present study uses a qualitative approach to explore perspectives from clinicians (who deliver EBIs) and administrators (who participate in decision-making for EBI implementation).

### **Stakeholder Perspectives on Race, Culture, and SES in Implementation**

Although implementation science aims to improve treatment outcomes across settings and populations through understanding the conditions that facilitate this process, research in this area has not traditionally focused on issues of equity (Brownson et al., 2021). As such, implementation studies do not typically examine how sociocultural factors impact the implementation process even though doing so may be critical for understanding why EBIs do not

achieve the expected outcomes when implemented in settings that serve REM and low-income populations (Cabassa & Baumann, 2013). Given the diversity of students attending public school, understanding how best to serve the needs of REM students has been identified as a priority research area in school-based implementation science (Forman et al., 2013).

Unfortunately, while little is known about clinician and administrator perspectives on the implementation process across EPIS phases, even less is known about the extent to which they consider student race, culture, and SES during implementation.

Few studies have examined how school-based clinicians consider their clients' racial/ethnic and socioeconomic backgrounds during implementation. One exception is a study that found that middle and high school clinicians perceived greater challenges with engagement and appropriateness of a modular therapy with their non-White students (Lyon et al., 2014). In addition, for the CBITS intervention, which includes a parent component, clinicians reported barriers to parent engagement related to family SES, such as transportation difficulties, homelessness, scheduling conflicts from parents having multiple jobs, and lack of childcare (Santiago et al., 2013). In a survey study where school psychologists were asked to rate 10 potential barriers to EBI implementation in terms of their seriousness, "EBIs not culturally appropriate for all clients" was rated 9<sup>th</sup>, suggesting that concerns about cultural fit for students may be outweighed by the many other barriers that clinicians encounter in schools (Hicks et al., 2014). In another important study, Gamble and Lambros (2014) sought to understand school clinicians' perceived barriers and potential facilitators to providing services to REM students in urban schools. Cultural factors were the most commonly reported barriers, and these included stigma and language barriers (Gamble & Lambros, 2014). The most commonly reported potential facilitators for their work were designated staff in school to provide services, more

time, and greater family involvement (Gamble & Lambros, 2014). Taken together, the current literature suggests that the ways in which school clinicians consider student background in EBI implementation varies greatly across clinicians and schools.

Research on EBI implementation in other settings has more deeply explored clinician perceptions of fit between EBIs and diverse clients. In an examination of perception of EBIs among American Indians participating in a “tribal gathering,” participants indicated greater favorability of programs where “there was a perception that family tradition and culture was valued and could be incorporated into the curriculum and implementation process” (Walker et al., 2015). Likewise, clinicians providing substance use treatment to American Indians/Alaska Natives described modifying interventions to fit the needs and cultural backgrounds of their clients (Moore et al., 2015) and Lau et al. (2017) found that some therapists (e.g., Latino, less experienced) modify interventions to match the needs of their clients. In a study that interviewed clinicians and site investigators for implementation of a mental health empowerment intervention found that client background (majority Latino) was a key consideration in the decision to adopt the intervention (Ault-Brutus et al., 2014), and logistical concerns related to transportation and childcare emerged as implementation challenges. These findings mirror perspectives documented in the general psychotherapy literature that indicate varying levels of comfort with and acceptance of EBIs among therapists, especially for REM and low-income clients. More research is needed to understand whether and how perspectives on the use of EBIs with students of different racial/ethnic and socioeconomic backgrounds impact the implementation process for school-based clinicians, and whether these perspectives differ through EPIS phases.

Research on implementation in under-resourced schools has tended to highlight features of the setting, rather than low-income background of students, that impact the implementation

process. For instance, in under-resourced schools, factors such as experience and burnout are thought to be especially important in a clinician's decision to adopt an intervention (Eiraldi et al., 2015). There is also indication that the fragmented mental health system in under-resourced schools makes it difficult for all stakeholders to collaborate on implementation (Eiraldi et al., 2015; Owens et al., 2014). A lack of coordination among the mental health team can be a significant barrier to ensuring that services align with student needs and school culture, as documented by Farahmand (2013) in a study that considered both setting and student factors in implementation. In that study, interviews with clinicians and youth recipients of school-based interventions in a large urban school district revealed several implementation challenges that can be broadly categorized as 1) challenges related to socioeconomic backgrounds of youth, and 2) challenges related to financial resources available to the school (Farahmand, 2013). In the first category, clinicians and youth mentioned factors such as trauma and stress experienced by youth, high rates of absences due to suspensions, mental health stigma, and poor fit of the program to student needs. Some of the school-level factors that came up in the interviews were overcrowding, school closings, staff burnout, and staff turnover. It is unclear how clinicians see these factors impacting the different phases of the implementation process.

There have been very few studies exploring administrator perspectives on implementation related to student race, culture, and SES. In one qualitative study, superintendents of rural school districts reported receiving support from school boards for student mental health services, but found insufficient financial and personnel resources (O'Malley et al., 2018). The superintendents also reported budget constraints as the most common barrier to implementation of school-based supports in their districts (O'Malley et al., 2018). Direct quotes from the superintendents demonstrated their perceptions that "a pervasive

philosophy among adults and children that life, their circumstance, and opportunities are hopeless” and a “desire for no government oversight or ‘interference’ in our community” are barriers to mental health service provision (pp. 800-801; O’Malley et al., 2018). Such perceptions of client treatment preferences likely impact stakeholder decisions in the implementation process across phases and merit further exploration.

Although their study did not examine student race, culture, and SES, a study by Green and colleagues offers insights into how administrators may approach implementation for students with marginalized identities. Green et al. (2018) conducted interviews with school administrators to understand their perspectives on the implementation of interventions for sexual and gender minority youth, with a focus on the Exploration and Preparation Phases. Factors that impacted their decisions included a mix of generally endorsed implementation factors for school-based services as well as factors specific to the population being served, such as the overall political climate, stigma and discrimination in the community, lack of sensitive mental health resources in the community, and staff knowledge and training (Green et al., 2018).

Interestingly, prior studies suggest that when implementation research explores issues of race or culture, there may be greater divergence in perspectives across stakeholder groups. For example, a study examining perspectives on the use of EBIs with American Indian and Alaska Native populations found variability between and among agency administrators and service providers on factors that impede implementation of EBIs with this population (Walker et al., 2015). Another study examining implementation of EBIs for substance abuse among American Indians and Alaska Natives found differences and similarities across stakeholder groups when they asked program administrators and clinicians to define and discuss EBIs (Moore et al., 2015). One third of both groups expressed concerns about the cultural relevance of EBI’s overall

for native populations (Moore et al., 2015). On the other hand, clinicians had a more accurate understanding of what an EBI is (i.e., intervention found to be effective through research) compared to administrators.

In sum, the inclusion of multiple perspectives appears to be especially important for examining how student racial, cultural, and SES background influences implementation in schools. However, little is known about clinicians' perspectives on the impact of these sociodemographic factors on implementation, and it appears that no prior studies have explored administrator perspectives in this area. These represent major gaps in the literature given the important role that administrators play in the implementation process and the disparities in outcomes for EBIs implemented in schools with low-SES and REM youth.

### **EBI Implementation in a Public School System**

The present study utilizes a case study approach to gather perspectives from clinicians and administrators on the four EPIS phases of implementation for EBIs within the context of one of the largest school districts in the country. Given the great variability in the implementation context across school districts (Vona et al., 2018), a case study approach is appropriate for uncovering the factors impacting the implementation process in a particular district. The district<sup>2</sup> examined in the present study predominantly enrolls students from economically disadvantaged (77%) and REM (90%) backgrounds. It has also historically experienced high rates of segregation by student race and income, which has resulted in a longstanding pattern of overrepresentation of the city's REM and low-SES youth in the city's most under-resourced schools.

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<sup>2</sup> References to the specific district where the study was conducted, as well as official terms for the offices and structure of the support systems used, have been changed or omitted to protect the confidentiality of this study's participants.



In recent years, several events have occurred contemporaneously to create a unique SBMHS context for youth in the city. First, half of the city’s public mental health clinics, which were key providers of mental health services to REM and low-income populations, were shut down due to budget cuts. At the same time, several dozen school closings for “underperforming” schools primarily targeted schools serving REM and low-SES youth. Advocates and researchers have documented the negative impacts of school closures on students and staff, including feelings of loss and isolation.

About one decade ago, the district initiated an agenda of promoting social and emotional learning for the city’s most vulnerable students through a newly established department focused on social and emotional learning (SEL). The SEL department (SELD) sought to promote the implementation of SEL into a multi-tiered system of support (MTSS) within the district. MTSS is a model for addressing student needs across academic, behavioral, and social-emotional domains using a prevention-based strategy that incorporates evidence-based assessment and intervention (Averill & Rinaldi, 2011). It includes three “tiers” of support: Tier I interventions that are universal and are intended for all students in a school, Tier II interventions that are more targeted and are typically delivered in group format, and Tier III interventions that are intensive and individualized supports. One of SELD’s core objectives is focused on implementing EBIs at the Tier I and II levels. Since its inception, SELD has supported the implementation of several Tier II EBIs designed to address various mental health concerns, such as trauma and anxiety, for elementary and middle schools. All Tier II EBIs are manualized and time-limited, lasting from several weeks to several months. The EBIs implemented at the Tier II level are the focus of this study.

SELD's approach to Tier II EBI implementation intends to proactively mitigate or reduce common barriers to implementation success. At the start of every school year, the department emails clinicians a list of Tier II EBIs that they can apply to bring into their schools, sometimes providing extra encouragement to particular clinicians given known student needs in their schools. SELD then reviews the applications and determines which clinicians and schools will be offered training in the intervention. Notably, clinicians who are selected for a Tier II EBI receive training and support at no cost to them or their school. During the Implementation Phase, clinicians are invited to participate in optional professional learning communities (PLCs), which function as clinical group supervision meetings.

It is important to note that the Tier II EBIs offered by SELD are not the only group mental health interventions implemented by the district school-based clinicians. Clinicians are also free to create and provide their own group curricula. In addition, several community agencies partner with schools to offer Tier II interventions for students, either training school clinicians to deliver them or delivering them using their own staff. These outside interventions may or may not be evidence-based. For the sake of brevity, only those Tier II interventions that are provided to elementary and middle schools through SELD's Tier II programming will be referred to as Tier II EBIs in this study.

In order to increase coordination of all SBMHS within the school building, the district has encouraged schools to create SEL committees that are comprised of clinicians and other interested staff members. The development of these committees is facilitated by special district staff, who will be referred to as "sector liaisons." Within the school district, schools are organized into over a dozen sectors defined both geographically and by grade level. Each sector is assigned a sector liaison, whose role is broadly defined as a liaison between SELD, school

clinicians, and school administrators. In addition to supporting SEL committees, sector liaisons can play a key role in Tier II EBI implementation by encouraging clinicians and schools to apply for these interventions and troubleshooting problems that arise in the process.

SELD recently initiated a pilot implementation of its first Tier II EBI depression intervention for students in elementary school. In partnership with the intervention developer, a hybrid effectiveness-implementation trial of the intervention was launched in the district beginning in 2017-18. The university-based research team trained and supported school-based clinicians in the delivery of the depression program during their first year in the trial. In the second year of the trial, clinicians were given the opportunity to deliver the intervention again with continued clinical consultation (through PLCs) but less support and involvement of the research team. Informal conversations with various stakeholders throughout the pilot implementation process for this depression intervention inspired the present study.

### **Rationale and Study Aims**

The school setting holds promise as an access point for REM and low-SES youth to receive high-quality, evidence-based mental health interventions. However, persistent challenges with the implementation of EBIs in schools indicate that there's a need for qualitative research to better understand the implementation process from the perspective of the stakeholders responsible for its success (i.e., clinicians and administrators). It is especially important to understand their perspectives across the different phases of the implementation process (exploration, preparation, implementation, and sustainment) as outlined in the EPIS framework. Lastly, special consideration for unique barriers and facilitators of the EBI implementation process related to youth race, culture, and SES is needed. While some implementation studies have gathered perspectives from different stakeholders in the school context, and some studies in

non-school contexts have explored the impact of client race/ethnicity and socioeconomic status on implementation, no multilevel examination exploring the impact of student race/ethnicity and socioeconomic background has occurred in the school setting. The present study will address this gap in the literature through examination of the Tier II (group-based) EBI implementation process for elementary and middle schools in the unique context of a large, urban school district.

This study aims to answer two primary research questions:

1. What barriers and facilitators do clinicians and administrators describe in the implementation process for district-sponsored Tier II EBIs within their school district across phases of implementation outlined in the Exploration, Preparation, Implementation, Sustainment (EPIS) framework?
2. How are the race/ethnicity, culture, and SES of students considered by clinicians and administrators across EPIS phases?

### **Method**

A case study approach was used, as described by Creswell and Poth (2018). The case study differs from other popular approaches to qualitative inquiry through the emphasis on understanding an issue within a bounded system (the case). For the present study, the “issue” being examined is the implementation process for district-sponsored Tier II EBIs in elementary schools, and the case is the large, urban school district. Data for this study were collected using semi-structured interviews with district clinicians and administrators to learn more about their perspectives on the implementation process for Tier II EBIs.

Interview data were analyzed using hybrid deductive-inductive qualitative content analysis and the framework method. A hybrid analytic approach is useful when the researcher is

interested in building on a previous framework or theory while allowing unexpected insights to emerge from the data (Fereday & Muir-Cochrane, 2006). As a more deductive approach, directed content analysis was used to better understand stakeholder perspectives and experiences using pre-established codes from the EPIS framework. This type of content analysis helps to “validate or extend conceptually a theoretical framework or theory” (Hsieh & Shannon, 2005, p. 1281), and as such is an appropriate method to answer research questions related to the EPIS framework. It was also important to use inductive content analysis to allow for new themes and codes to emerge within each EPIS phase to capture barriers and facilitators. This approach is especially valuable when there is limited knowledge on a topic, as is the case for research examining clinician and administrator perspectives on implementation in schools, the impact of student race, culture, and SES in implementation, and this particular district implementation context.

### **Recruitment and Participants**

This study was approved by the Institutional Review Board of DePaul University as well as the school district’s research review board. The target sample for this study consisted of elementary school-based clinicians who previously delivered a depression intervention as part of the pilot trial in the district as well as district administrators at the school (principals, assistant principals) and district levels (sector liaisons and SELD staff) who were involved in decision-making around Tier II EBI implementation. Participants were recruited using purposive and maximum variation sampling to ensure that participants had some familiarity with Tier II EBIs and that there was a diversity of perspectives captured in the sample. Purposive sampling is a strategy that entails recruiting participants who have greater familiarity with the phenomenon being studied (Palinkas et al., 2015). In this study, purposive sampling specifically restricted

participant recruitment to clinicians in elementary schools who previously delivered the Tier II depression intervention, administrators in these clinicians' schools, and sector liaisons for these schools. SELD staff were also recruited based on their involvement in supporting the implementation of the depression intervention.

Maximum variation sampling seeks to increase the diversity of perspectives on the phenomenon being studied (Palinkas et al., 2015). Publicly available data on the percentage of economically-disadvantaged students in the district's schools were used for maximum variation sampling. Specifically, participant recruitment attempted to capture perspectives from clinicians and school administrators who worked in elementary schools across the socioeconomic spectrum. In this large district, the schools are clustered into several geographic sectors. Given socioeconomic segregation patterns in the city, these sectors often have distinct profiles with regard to student race/ethnicity and household income levels. To maximize diversity in the schools represented in this study, participant recruitment focused on two of the three sectors included in the depression intervention trial. One of these sectors, Sector B, differed from the other two sectors because its schools served students from predominantly higher-income households. In the present study, participant clinicians were recruited from two schools in Sector B that had between 10 and 15% students identified as economically-disadvantaged. This study also recruited participants from Sector A, which included schools that served predominantly students from low-income households. The three schools in this study from Sector A had over 85% of enrolled students identified as economically-disadvantaged by the district.

Participant recruitment began with a focus on the clinician subsample because they already had a relationship with the research team through working on the larger depression intervention study trial. Clinicians were recruited from a pool of 14 clinicians and eight schools

across Sectors A and B. Of these clinicians, seven delivered the depression intervention in both years of the trial and seven clinicians delivered it only in the first year. In an attempt to increase variability of experiences with EBIs, clinicians were partly recruited based on whether they delivered the depression intervention in the second year of the trial, so that some clinicians in this study have delivered this EBI twice and others only once.

The present study included 13 participants, of which seven were clinicians and six were administrators. Of the eight clinicians invited to participate in the study, seven completed interviews (four clinicians from Sector A, two from Sector B, and one who worked in both sectors in different years of the trial). After clinicians were recruited, the administrators (school principals and assistant principals) from their schools were invited to participate. In total, 17 administrators were invited to participate and six completed interviews (three each at the school and district levels). Due to staffing changes, only the sector liaison from Sector B was available for recruitment during the study and this person agreed to participate. Lastly, three SELD staff participants who had previously worked with the research team were invited to participate in this study, and two ultimately participated.

Examination of data saturation conducted throughout the early coding process indicated that conducting additional interviews would have been unlikely to result in new themes and codes, suggesting that 13 interviews were sufficient for this study (Saunders et al., 2018). The participants were racially/ethnically diverse with six Black, six White, and one Latina participant. All clinicians were women and four administrators were women. Table 1 presents demographic characteristics for the clinician subsample. All participants were assigned initials to protect privacy. To protect participant confidentiality, limited demographic information is presented about the administrators who participated in this study and they are referred to using

gender-neutral pronouns. The initials assigned to district-level administrators were R.P., A.K., and G.S., and for school-level administrators V.G., H.H., and J.M.

### **Interview Procedures**

All participants were invited to participate via email and/or phone call using contact information collected through their involvement in the initial trial or publicly available contact information on their school websites. Once participants indicated interest in participating, they were scheduled for an interview. Signed informed consent for all participants was obtained through email communication prior to the interview or at the time of the interview. The majority of interviews (n = 9) were conducted over the phone, and the remaining (n = 4) were conducted in person. Interviews were audio-recorded and varied in length from 45-90 minutes, with an average interview length of 75 minutes. All participants received a \$30 gift card for their participation.

Participants were asked about their experiences with the implementation of Tier II EBIs while serving in their current role using topic guides created for this study. Topic guides were modeled after the EPIS framework and include sections related to each phase of implementation. The interview topic guides included a mix of closed-ended and open-ended questions about the participant's role and responsibilities, their involvement in decisions about interventions in schools, and their perception of factors that make interventions harder or easier to implement in schools. One guide was created for the clinicians, who have direct experience with the delivery of Tier II interventions in schools, and another guide was created for the administrators. Questions included on the clinician interview guide were developed from previous conversations, interviews, and focus groups with clinicians. A sample question asked of clinicians during the section on the Preparation Phase was "*What factors make it harder to bring*



*an intervention to your school?"* The administrator interview guide included many of the same questions, with modifications to accommodate their non-clinical roles. Additional questions were included after consultation with a former sector liaison who was not interviewed for this study. A sample question asked of administrators during the section on the Sustainability phase was *"What factors make sustainability more likely?"*

After the first clinician and administrator interviews were completed, the guides were modified to include fewer questions. They were also modified to include introductory statements clarifying that one of the study foci was related to the impact of student racial/ethnic and SES background on implementation. Questions specifically addressing this focus were also added for each section of the interview guide and were asked of all subsequent participants. For example, participants were asked the following question in the section on the Exploration Phase: *"In what way does student SES/income affect their mental health needs in school?"* And, in the section on the Implementation Phase, they were asked *"In what ways do the racial/ethnic or cultural backgrounds of students impact the delivery of interventions?"* These changes were made after the interviewer observed that some participants did not readily address this topic without prompting.

### **Analytic Approach**

A team of four coders (three undergraduate students and the lead researcher) contributed to interview transcription and initial code refinement. The undergraduate students were trained and supervised by the lead researcher. After verbatim transcription of all interviews, the transcripts were transferred to NVivo where the team applied initial codes for the deductive portion of coding. Given that deductive coding is used to build on the literature, coding of the data began with a priori codes generated from the EPIS framework. After initial development of

a codebook with codes, definitions, and examples for the deductive codes, the team performed several iterations of coding, reliability testing, and discussion to assess the clarity and applicability of codes. This process resulted in a final set of deductive codes that included the following codes within each of the four EPIS phases: Neutral (Descriptive), Barrier, Facilitator. Codes were also created for Race/Ethnicity, Culture, and SES. The lead researcher, who was also the only full coder, coded every interview using the deductive codes established by the team before transitioning to inductive coding. Deductive and inductive coding were completed in separate NVivo files to minimize the influence of both coding processes on each other.

An inductive conventional content analysis approach was used by the lead researcher to generate codes and themes not captured in the deductive codes (Hsieh & Shannon, 2005). These codes were used to generate themes among the barriers and facilitators for each EPIS phase. Although the EPIS framework includes factors at the inner and outer contexts that are thought to influence implementation, this study allowed factors (i.e., barriers and facilitators) to emerge entirely through inductive coding. The codes were generated using an iterative process that entailed careful and repeated readings of selected interview transcripts and analytic memoing by the coder. The coding process began with descriptive and process coding (Saldaña, 2016) for a clinician interview. The coder then used these codes to guide coding of a second clinician interview, which resulted in refinement of initial codes and the addition of new ones. The first clinician interview was then re-coded using the new set of codes. This process of testing and refinement continued for the first four clinician interviews and was then repeated for the first four administrator interviews. Once the final codes were clearly defined and demonstrated applicability across interviews, all transcripts were coded using the final set of inductive codes by the lead researcher. The deductive and inductive coding files were then combined in NVivo,

allowing the researcher to see the inductive codes that were present within each phase and whether they were coded as “barrier” or “facilitator” within the phase. Analytic memoing was used to reflect on patterns among the codes, resulting in a categorization of codes that generated the final themes of barriers and facilitators.

Finally, the framework method was used to facilitate analysis and presentation of results (see Figure 2). The framework method is a strategy for organizing data according to “cases” and codes (Gale et al., 2013). The cases may represent individual participants or categories of participants, such as clinicians and administrators in this study (Gale et al., 2013). The final product of a qualitative analysis facilitated by the framework method often includes a table that visually organizes codes and themes across the “cases.” The framework method is compatible with both inductive and deductive analytic methods. For the present study, a table was created that was structured according to the deductive codes with eight rows presenting barriers and facilitators separately for each of the four EPIS phases. Columns for clinicians and administrators contain cells summarizing key themes around barriers and facilitators across EPIS phases that emerged through inductive coding. The final column contains barriers and facilitators specifically related to student race, culture, and SES.

## **Results**

Broad themes derived from the interviews and illustrative participant quotes are presented below, organized across the EPIS phases (Exploration, Preparation, Implementation, and Sustainment). Each phase section contains subsections for barriers and facilitators, which are further subdivided to separately present themes from clinicians and administrators. Each subsection presenting barriers or facilitators is capped with a presentation of findings specifically related to student racial, cultural, and socioeconomic background. Table 1 presents the barrier

and facilitator findings across clinicians and administrators to facilitate comparisons. Of note, the themes from the administrator subsamples (school principals/assistant principals and district administrators) were largely consistent with each other and are thus combined below. The few instances of disagreement will be highlighted. Likewise, themes were overall consistent across participants from Sectors A and B, but differences are highlighted when they occur.

### **Exploration Phase**

During the Exploration Phase participants assessed student needs, explored intervention options, and made decisions regarding Tier II EBI adoption. Clinician **barriers** were *limited resources* (time, staffing), *taking initiative*, and *changes and instability*, and **facilitators** were *teamwork*, *buy-in*, *knowledge/data*, and *greater resource availability* (time, materials, staffing). Administrator **barriers** were *lack of knowledge/data*, *lack of buy-in*, and *limited resources* (budget, staffing), and **facilitators** were *taking initiative*, *knowledge/data*, *buy-in*, and *teamwork*.

### ***Exploration Phase Barriers***

***Clinicians.*** Clinicians shared that limited resources related to time constraints and limited staffing made it challenging to carry out Exploration Phase activities. Time constraints were the most commonly described barrier. **B.H.** shared that “crazy” schedules interfered with assessing student mental health needs because the school’s SEL committee did not spend the full time allocated in meetings to discussing student needs. Concerns about limited time were especially important when clinicians were exploring options and deciding whether to bring in a Tier II EBI. Several clinicians shared their perception that Tier II EBIs were time-intensive and “a lot of extra things have to go into it” (**A.L.**), especially when their implementation occurred as part of a research study.

Many clinicians shared that the constraints on their time prevented them from adopting Tier II EBIs, even when they perceived them to be a good fit. **K.P.** expressed a desire to do more intervention work but being unable because there was “not enough time in the day” to do so while also fulfilling her other duties in the school. Limited staffing was also often endorsed as a barrier closely related to time constraints, as clinicians who were solely responsible for mental health services in the school had limited time for Tier II EBIs. **B.E.** shared that it was difficult to bring on Tier II EBIs because she needed flexibility in her schedule to attend to unexpected needs that arose throughout the day. Overall, clinicians had to balance their students’ mental health needs with the reality of these limited resources, which **A.L.** summarized as “that element of ‘well would it even be worth it?’”

When faced with limited resources and emergent student needs, clinicians reported taking initiative to serve their students, which sometimes meant turning to homegrown interventions or partnering with outside agencies rather than implementing the district’s Tier II EBIs. Clinicians generally expressed openness to any intervention that could meet student needs even if it was not officially sponsored by SELD or recognized as “evidence-based.” **B.M.** stated that her objective was “to see what works best” for her students. **B.E.** shared that she actively considered all interventions available to her, including those she was already trained in or could obtain training in. Clinicians sometimes found interventions through community agencies that partnered with schools to offer their own programming outside of the district Tier II EBIs offered by SELD. Others took initiative to create their own group interventions if they could not find one that fit their needs. Notably, several clinicians reported not having experience with evidence-based or manualized interventions prior to working with the district’s Tier II EBIs.

Another important set of barriers for clinicians in the Exploration Phase concerned changes and instability. High staff turnover meant that some clinicians found themselves assigned to different schools from one year to the next, which made it harder to know their students well. Even within the same school, unstable schedules and shifting responsibilities from year to year made it difficult to plan and make the decision to adopt an intervention at the start of the school year. Some changes in responsibilities were due to changes in district policies related to staffing and roles, as described by one clinician:

I didn't know how much I would get to do this year because we didn't have a case manager until October, which doesn't sound that late but in order to transition that person in, get them adjusted to the system...and I am still running meetings. (**B.H.**)

Within schools, changes and instability required flexibility from clinicians on a yearly and even daily basis. Many clinicians noted that this was often incompatible with the structured nature of manualized Tier II EBIs.

***Administrators.*** The most common barrier for administrators during the Exploration Phase was a lack of knowledge/data. District administrators shared that a lack of knowledge about mental health at the district level resulted in a focus on misbehavior instead of socioemotional needs, though this has been changing in recent years. **G.S.** acknowledged that there used to be a greater emphasis on discipline to address behavioral challenges, with little understanding of mental health challenges underlying those behaviors. This emphasis on misbehavior over mental health, contributed to less exploration of mental health needs and potential EBIs to address them. Similarly, **H.H.** reported greater attention to the students with behavioral outbursts in their school. With regard to Tier II EBIs, school administrators reported being aware of them but lacking “strong knowledge of them” (**J.M.**) and knowing “very little

about what the offerings from [the district] are” (V.G.). School administrators also noted a lack of data available to them regarding the efficacy of the Tier II EBIs offered by SELD, which in turn led to another barrier: lack of buy-in. H.H. perceived Tier II EBIs as being “off the shelf” and not well matched to their students, which contributed to the use of homegrown interventions in their school. School administrators overall expressed ambivalence about adopting Tier II EBIs because they were not confident that they would have positive outcomes for students. This was an important difference between school- and district-level administrators, as the latter group was more knowledgeable and confident in the positive impacts of EBIs.

Similar to what clinicians shared, administrators described limited resources as a barrier in the Exploration Phase. However, administrators differed in how they saw resource availability impacting Tier II EBI decision-making. R.P., a district administrator, noted that schools with more financial resources had greater flexibility in choosing whether to use interventions provided by the district or by an outside vendor. However, H.H., a school administrator in a well-resourced school, shared that costs associated with interventions can still be a deterrent to adopting them. Further, this administrator shared that having greater staffing resources gave them greater ability to use homegrown interventions, such as lunch groups and check-ins, rather than Tier II EBIs in their school.

### *Exploration Phase Barriers Related to Race, Culture, and SES*

Participants identified several barriers to the Exploration Phase related to student racial, cultural, and SES background. Clinicians and administrators alike indicated that inequities related to student background presented a challenge to identifying student mental health needs. B.H. noted that students of color and from lower SES homes were less likely to reach out for support both inside and outside of school. K.P. also explained that students from higher SES

families are more likely to have referrals for mental health services from outside of school to alert school clinicians to their needs, whereas lower SES students were less likely to have had any contact with an outside therapist for treatment or evaluation. With regard to exploration of Tier II EBIs, **B.M.** noted that schools in the wealthier part of the city had more resources. With fewer resources and money, she noted that clinicians in less wealthy parts of the city “have to work a little harder, try to balance.” **K.M.** noted that she chose to implement a grief intervention that was not sponsored by the district because there were no Tier II EBIs that could meet this need for students who were experiencing the loss that comes with the incarceration of loved ones.

Bias also emerged as a barrier in the Exploration Phase related to student background. **J.M.** noted that a lack of diversity in school leadership was a barrier because administrators were less understanding of the needs of students of color in their school and focused more on the needs of White students. Relatedly, **H.H.** stated that understanding the role of race, culture, and SES on mental health needs of students was an area of growth for them, noting that their student body was diverse but school staff were predominantly White. Some clinicians appeared to conflate race, SES, and academic abilities. **K.P.**, when asked about the impact of student background on intervention success, shared a concern that students’ academic abilities in certain schools could be a barrier.

District administrators noted barriers related to lack of cultural relevance. **R.P.** shared a desire for more culturally relevant Tier II EBIs and noted that some clinicians preferred homegrown interventions because they saw Tier II EBIs as not culturally relevant.

There’s lots of schools and [sectors] who ascribe to “we rather have something that’s more homegrown because it’s tailored, and it’s targeted, and it’s specific to our kids.” Culturally relevant interventions is huge in some of our



communities... “I want something that is specific to my demographics, to my communities, to the students that I’m servicing.” (R.P.)

A.K. also shared that in the past there was an intervention that was not added to SELD’s Tier II EBI portfolio because it lacked data demonstrating effectiveness with urban youth of color.

Lastly, participants reported that mental health stigma among communities of color sometimes kept students and families from sharing mental health concerns with clinicians. K.M. elaborated on beliefs she has encountered among her students’ community:

Culturally that’s a belief in our community. That you work out your own problems, or you just pray about ‘em and go to church. You don’t really seek- traditionally seek out mental health services.

### *Exploration Phase Facilitators*

*Clinicians.* Most clinicians endorsed teamwork and the buy-in required for teamwork as important facilitators in the Exploration Phase. Almost all clinicians described communication from SELD as a key facilitator for learning about the Tier II EBIs being offered. However, the most impactful teamwork and buy-in seemed to come from school administrators and teachers. B.H. noted that “everybody is identifying students that need supports” in the school. Clinicians reported that discussions with other school staff, especially administrators, helped them think through the intervention options and decide what was most appropriate and feasible for their school. Buy-in from school administrators also indirectly facilitated the decision-making process by contributing to administrator trust and encouragement for clinicians to bring in Tier II EBIs.

Knowledge/data were also key facilitators according to clinicians. Some shared that increased knowledge about student mental health helped district leadership contribute to the identification of student needs. K.P. noted that working for many years in her school also helped because she was known by students as “the person they come to.” Many clinicians learned about

Tier II EBI options by reaching out to other clinicians and staff and browsing the district's website. **T.S.** shared that she sought to be "trained in as many as I could." Some clinicians shared that having empirical evidence for an intervention's effectiveness helped them make the decision to invest their limited resources into a Tier II EBI.

Lastly, greater resource availability was an important facilitator for making the decision to adopt a Tier II EBI. Specifically, clinicians noted that having more time, greater availability of materials, and greater staff support all contributed to their choosing a Tier II EBI. **K.M.** indicated that interventions provided by SELD were more appealing because they allowed her to serve her students more efficiently, without having to take the time to develop her own curriculum. Relatedly, positive changes in the number of staff and increasing time availability for programming made it easier to choose to bring in Tier II EBIs:

Some of the interventions take two people to deliver. So now it's gotten a little easier that we have more time in the school. Before, we would just go to the school, um, two days maybe, and out of that two days one day would be devoted to parent interviews, special ed meetings...So then you don't have a lot of time to do other interventions. (**B.M.**)

**Administrators.** Administrators shared that taking initiative was a facilitator to the Exploration Phase, especially for assessing student mental health needs. **J.M.** arranged meetings with groups of students to learn more about "what's going on" with them emotionally and socially. **V.G.** sought out clinicians in the school, did their own reading, and attended workshops on their own to understand more about their students' mental health needs. At the district level, SELD took initiative to support schools with identifying appropriate Tier II EBIs. Their efforts included talking with school administrators about school priorities and sending out targeted communication to encourage schools to pursue interventions likely to be a good fit.

I target those schools to receive an additional touchpoint to say ‘hey, don’t forget this application is due on this date.’... I might not go on-site and help them with that application. But there might be another school...I will go on-site...and I will help them complete that application... ‘Cause I know that they need more hands-on support. (G.S.)

Knowledge/data were also key facilitators, especially for increasing buy-in for Tier II EBIs at both the district and school levels. **R.P.** explained that the district transitioned to a “whole child, whole community” model that helped to balance student socioemotional and academic needs. District administrators increased knowledge and buy-in among other district leadership by holding meetings and trainings “in order for them to have an appreciation of the intervention” and collaborate effectively with SELD, according to **A.K.** Buy-in and support for Tier II EBIs in the district were also facilitated by data showing trends in suicidal ideation and behaviors. Data was also used by SELD to identify and choose Tier II EBIs to bring into the district. Tier II EBIs were brought in on the basis of “any science or evidence behind the intervention and the level of effectiveness that it’s demonstrated” (**A.K.**) Other factors contributing to intervention adoption were perceived feasibility, ease of implementation, a local developer who could assist with implementation, and the intervention being based in cognitive behavioral therapy.

Teamwork was a facilitator that helped school administrators overcome their lack of data or familiarity with relevant data about student needs. District administrators took initiative to help schools understand their own school-level student data to help them make more informed decisions about Tier II EBIs that may be a good fit. One school administrator highlighted how teamwork helped their staff understand student needs beyond the data:

I think that the principal can lead that work and be the one to be asking the questions but I think the data can come from a variety of sources in the building and it should be a team looking at it... So I think if you talk through it

with the team, you'll get a more global perspective on what's going on in your building. (H.H.)

V.G. shared that they synthesized different perspectives from school stakeholders to identify “trends” among students and priorities for intervention to “meet the needs of multiple kids.”

### ***Exploration Phase Facilitators Related to Race, Culture, and SES***

Participants did not report many facilitators related to student race, culture, or SES during this phase, but mental health knowledge did emerge as an important facilitator. K.P. reported that higher SES families tended to show greater attention to mental health because “when you're not worried about your basic needs you start to think more about happiness.” G.S. noted that increased training and knowledge about trauma helped school staff understand that student aggression and anger may stem from “high levels of trauma.” V.G., who came from the same community as their students, noted that they had a better understanding of their needs because they grew up in the neighborhood and “I kinda lived a lot of this so I can recognize the signs.”

A concern for cultural relevance was another important facilitator for Tier II EBI adoption. While several clinicians reported that they looked for universal interventions, K.M. expressed greater interest in culturally tailored interventions “because there's just a lot of cultural implications” in the mental health needs of her students. Cultural relevance was also a facilitator of intervention adoption at the district level, along with evidence of efficacy with diverse youth.

### **Preparation Phase**

The main activities of the Preparation Phase for clinicians were applying for and getting approval for training, completing training, and preparing for potential barriers and facilitators that could impact the Implementation Phase. Clinician **barriers** were *lack of buy-in, lack of teamwork, competing priorities, competing responsibilities, and limited resources* (time, training

spots), and **facilitators** were *buy-in, teamwork, greater resource availability* (time, materials). During the Preparation Phase, administrators approved schools and clinicians to receive training, provided the training, set up systems of support, and prepared for potential barriers and facilitators that could impact the Implementation Phase. Administrator **barriers** were *limited resources* (time, staffing, budget), *competing priorities, competing responsibilities, and lack of buy-in*, and **facilitators** were *data, buy-in, teamwork, and taking initiative*.

### ***Preparation Phase Barriers***

***Clinicians.*** The most common barrier for the Preparation Phase was a lack of buy-in. Poor buy-in to the benefits of Tier II EBIs among school administrators sometimes resulted in difficulty getting their approval and support. **B.E.** did not think her school’s principal “truly believes that some of these interventions are needed.” This poor buy-in contributed to a lack of teamwork, which was another major barrier reported by clinicians. **B.M.** reported that this was especially consequential given that teachers were often more interested in academic outcomes for their students and were thus less likely to cooperate with Tier II EBI planning.

Limited resources were another major barrier, especially limited time as it related to balancing competing priorities and responsibilities for both students and clinicians. According to clinicians, initiation of the Implementation Phase for Tier II EBIs happened very soon after completion of training. With this tight timeframe, clinicians generally had little time to prepare for intervention delivery. Limited time among both clinicians and students presented challenges. On the student side, timing challenges were typically related to difficulties with balancing competing priorities of students’ academic and mental health needs. Clinicians shared that it was difficult to find a time for Tier II groups that would not pull students away from important academic subjects. On the clinician side, timing challenges were typically related to balancing

Tier II EBIs with competing responsibilities in the school. **T.S.** shared that she would like to run more Tier II EBIs but was unable to because of other duties in the school that limited her time.

Several clinicians reported that getting the opportunity to train for a Tier II EBI was not guaranteed due to SELD's limited training spots. **A.L.** shared that she was told by SELD to only apply for trainings if she was certain that she could deliver the intervention that year. However, she found herself "almost reluctant" to apply for more trainings because she could not guarantee that she would be able to deliver the intervention. For clinicians, it was sometimes difficult to predict their ability to implement an intervention due to the many changes that occurred from year to year as noted in the section on barriers of the Exploration Phase.

**Administrators.** District administrators described several barriers related to balancing student needs with limited resources, especially time, staffing, and budget. It was challenging to balance their desire to spread resources equitably among schools while wanting to offer new interventions to schools who had already demonstrated capacity to implement successfully. Limited time among district administrators meant that they could not attend to the implementation needs of all schools, with **G.S.** acknowledging: "there are schools that I haven't even stepped foot in this year." Setting up systems of support for implementation was hindered by insufficient staffing and time needed to offer tailored guidance about Tier II EBIs to each school and sector. **G.S.** likened attempts to establish this structure to "building the ship while it's floating." Similarly, limited time negatively impacted SELD's ability to collect and review data assessing school readiness when deciding which schools would be approved for Tier II EBIs.

District administrators noted that competing priorities and responsibilities made it difficult for schools and clinicians to balance limited resources with Tier II EBIs. **R.P.** acknowledged that school administrators typically did not want their school clinicians to be out

of the building for several days to attend trainings. Competing priorities were challenging for clinicians to balance even when inside the school building, which district administrators attributed to a lack of clarity and collaboration among related district departments when it came to “ownership” of Tier II work.

Any pushback we get from psychologists or social workers is not because they don’t believe in doing the interventions, it’s because their first obligation, legally, in their role, is to [Individualized Education Program] minutes. (G.S.)

The district’s limited training resources combined with schools’ limited budgets were perceived by district administrators to contribute to schools ultimately using homegrown interventions.

Lack of buy-in was another major barrier described by district administrators. They reported that school administrators were not always bought in to the importance of Tier II EBIs, which sometimes impeded preparation. More directly, district administrators shared that low perceived buy-in among school administrators was a factor that negatively impacted a school’s likelihood of being approved for Tier II EBIs. A district administrator shared their observation that clinicians sometimes experienced low buy-in themselves as they learned more about an intervention during training:

A complaint that we get from some clinicians is just their discomfort with CBT interventions and kind of manualized interventions that are scripted. And not having a whole lot of comfort with that and wanting to be, I guess, more authentic in their implementation of interventions. (A.K.)

### ***Preparation Phase Barriers Related to Race, Culture, and SES***

Clinicians did not describe much impact or influence of student background in the Preparation Phase. Participant **K.P.**, when asked about potential barriers related to student SES, acknowledged that “it hasn’t been something that I’ve considered...and maybe that’s the luxury

of being in a school where most of my students are of higher socio-economic status.” Participant **B.E.** indicated that she anticipated challenges related to absences but was not sure if this was related to student background.

District administrators shared concerns about bias as a barrier related to student background. Specifically, they noted that there was a pattern of schools in wealthier, Whiter neighborhoods being approved for more anxiety and depression interventions while schools in poorer communities of color were more often approved for trauma and anger-focused interventions. This was posited to result from a combination of trends in what schools were applying for as well as perceived student needs for each school by SELD.

I think that we tend to associate communities of color with needing more trauma types of groups and interventions. And...trauma impacts and affects everybody, not just students of color, not just our poor students, not folks that live in the hood, right?... In communities of color...it has to be everything but anxiety, right? Or it has to be everything but depression. (**R.P.**)

**A.K.** reported that clinicians shared concerns about the cultural relevance of Tier II EBIs during trainings. According to them, these clinicians were raising concerns voiced by their students.

### ***Preparation Phase Facilitators***

**Clinicians.** Buy-in was a key facilitator for the Preparation Phase. Most clinicians shared that getting principal approval for Tier II EBIs was made easier when principals had some buy-in to the interventions. **B.M.** stated that their principal “knows that the kids are going through a lot of emotional things at home” and “gives us all the support that we need to do everything...she wants the groups to happen.” **A.L.** shared that her school’s principal was “not upset about the kids missing class.” Sometimes principals had buy-in for the clinicians themselves rather than for the interventions. Clinicians shared that their administrators respected their roles as “experts”



and gave them autonomy to make decisions about interventions. School administrator buy-in also helped clinicians balance their clinical and other responsibilities. For example, **K.P.** shared that her administrators removed certain duties to free up her time for Tier II EBIs. Buy-in from school administrators seemed especially important for promoting teamwork in the school, which was itself another important facilitator. Clinicians identified sector liaisons, school administrators, and teachers as especially important collaborators. A couple of clinicians noted that administrator buy-in helped with teacher buy-in.

Most clinicians reported that an important facilitator was greater resource availability, specifically time and program materials. **K.P.** shared that “teachers are also very supportive, allowing me the time to meet with students and really believing in the value of it.” Having program materials accessible and the intervention protocol manualized were also facilitators for preparation as they reduced the time and effort needed for preparation.

***Administrators.*** Administrators highlighted the importance of data in facilitating Preparation Phase activities, starting with the school approval process. Given limited training spots for Tier II EBIs, district administrators carefully considered which schools and clinicians should be approved for training. This decision-making process was facilitated by the availability of school and district data and teamwork with other departments involved in mental health.

We’re looking at a bunch of different data sources to determine if this intervention is a good fit for this school...schools who have leadership buy-in, schools who have [SEL committees], schools who have some sort of system and structure in place for referring students... that lets us know “ok this school can or will support a Tier II intervention.” (**R.P.**)

Data also helped district administrators understand school needs and set up systems of support. For example, **G.S.** worked with schools to review their data (e.g., discipline data and attendance) and help them plan to address student socioemotional needs with Tier II interventions in mind.

Buy-in and teamwork with several stakeholders were also endorsed as facilitators. For district administrators, getting buy-in from other district department leaders was key to getting the funding needed to set up systems of support. They also advocated for clinicians to have time and materials to deliver interventions. Among school administrators, trust and buy-in into their staff facilitated their approval of Tier II EBI implementation. They generally trusted clinicians to make decisions about interventions and were reassured by clinician buy-in as a sign of their likely commitment to successful implementation.

It's usually if you're interested in it and you feel like it's something that will definitely work for and with our students, we'll take a stab. (J.M.)

V.G. shared that they saw Tier II EBIs as an opportunity for clinicians to get more training but was not convinced that the interventions resulted in benefits for their students.

Administrators reported taking initiative to ensure that school and clinician needs were met in the Preparation Phase. School administrators used leadership to help clinicians navigate limited time and staff resources. V.G. helped secure a vacant classroom to use for counseling and set clear expectations about times that clinicians can pull students for interventions. District administrators attended school SEL committee meetings and created professional learning communities (PLC's) to support schools with establishing these systems of support for implementation. They also took initiative by proactively responding to potential barriers that could arise in the Implementation Phase. For example, they established a system where principals had to first approve their clinicians for Tier II EBI training before SELD could approve them. This was done to ensure lack of buy-in from administrators would not later impede implementation. Stipends and other funding from the district also acted as incentives and mitigated potential barriers related to limited staffing and funding resources. Principals were also

perceived by district administrators to facilitate the Preparation Phase by taking initiative to resolve resource issues in their schools and simply “making it work.” Schools where clinicians or administrators took greater initiative to ask for help generally received more support from SELD.

### ***Preparation Phase Facilitators Related to Race, Culture, and SES***

Clinicians and administrators reported very few facilitators for the Preparation Phase related to student background. A contributor to the lack of facilitators endorsed was a tendency of participants to talk instead about the Implementation Phase or to speak vaguely about broader student needs when asked about student background. Some clinicians also shared a more neutral perspective on the impact of background on anticipated barriers and facilitators, like **B.M.** who responded to a question about anticipated facilitators by stating: “I think all the programs that they use across [the district] is beneficial to everybody no matter who you are.” However, district administrators noted that a focus on equity within SELD facilitated the approval of Tier II EBIs at low resource schools. Also, a clinician indicated that she used the training as an opportunity to ask about an intervention’s fit with students from lower income backgrounds.

If it doesn’t seem like it’s addressing student concerns, I always need to know what the connection is. Like how does this apply to them...Just making sure that it’s realistic as to what our kids face on a daily basis. (**K.M.**)

### **Implementation Phase**

The main activities of the Implementation Phase for clinicians and administrators were completing the referral and assessment process, delivering the Tier II EBI, and assessing the implementation process. Clinician **barriers** were *lack of buy-in, limited time, competing responsibilities, competing priorities, and changes and instability*, and **facilitators** were *buy-in, teamwork, emotional support, greater resource availability (materials), and taking initiative*.

Administrator **barriers** were *lack of knowledge/data, limited time, competing responsibilities, and changes and instability*, and **facilitators** were *buy-in, teamwork, systems of support, and emotional support*.

### ***Implementation Phase Barriers***

**Clinicians.** Lack of buy-in from stakeholders represented a barrier in several areas. For example, clinicians reported that it was sometimes difficult to get buy-in from students to participate in the groups, with **B.H.** stating that buy-in “is the hardest thing to get from a kid.” **B.M.** acknowledged that poor buy-in among students sometimes stemmed from stigma regarding mental health issues, which could make it harder to complete the eligibility assessment process pre-intervention. Getting buy-in from parents to let their children participate in Tier II EBIs appeared to be an even greater challenge for clinicians, and sometimes required additional time and effort. **T.S.** shared that she had to be “tactical” with parents and “plan for extra time for communication” in order to get their approval. Clinicians also reported difficulties with getting buy-in from staff, especially teachers:

If a kid is missing a day...we talk to the teacher, “Can you let them make up the work?” ... it works out a lot in our favor sometimes, but some teachers, they hard to bend. (**B.M.**)

Obtaining buy-in from multiple stakeholders was time-consuming, which exacerbated another general barrier endorsed by clinicians: limited time. Limited time availability emerged as a barrier in concert with three other major barriers: competing responsibilities, competing priorities, and changes and instability. With regard to competing responsibilities, a common barrier was the length and number of intervention sessions. **A.L.** explained that the time commitment for intervention delivery included the set up before the session and administrative

tasks after the session, which was a “big chunk of time commitment that can be difficult if other things are going on.” Clinicians noted that EBIs that required additional work outside of session delivery were especially challenging.

I’m thinking of this specific intervention that I’m doing right now, like “you have to go get this specific color construction paper and you need to make this one into an octagon, you need to make this one into a circle, you need to make this one into”- like okay, I have to do arts and crafts before I can start this. And I have to go find all of these materials, and I have to put it all together which takes longer than the actual group takes. **(K.P.)**

Some clinicians finished group sessions with students but were unable to finish other intervention components. **B.E.** reported deciding not to initiate delivery of an intervention when she was unable to find “a co-facilitator or someone to kind of help lessen the load” because the additional component of student interviews required a greater time commitment. **A.L.** noted that the overall time commitment needed to deliver one Tier II EBI meant that she could only feasibly deliver one at a time, despite having training in others.

Clinicians had difficulty managing the competing priorities of student mental health and academic needs. Limitations on student time often resulted in scheduling challenges and many clinicians reported tension with teachers as they tried to find a group session time that would not interfere with schooling. **B.M.** stated that teachers might be less cooperative with Tier II EBI scheduling because of their own pressures: “[the district] gotta test to make sure that you’re on grade level, you’re making progress. So, it’s just the teachers get graded on whether the kids make progress.”

Changes and instability in schedules and school needs also presented a barrier. These changes made it difficult to stick to the schedules of Tier II EBIs, forcing sessions to be canceled or other changes. As **B.E.** shared, sometimes “things happen” in the school that force clinicians

to skip a week for the intervention, prolonging treatments already perceived as taking a long time. **K.M.** identified timing as the “biggest barrier” for this reason. Even though she tries “not to make it reactive,” her role sometimes requires her to respond to crises (e.g., student mental health crises, phone calls from parents) during the day that interrupt Tier II EBI delivery. In some cases, this challenge was compounded by a lack of other staff to provide support. As **B.E.** explained, being the only clinician in the school meant that she was “constantly prioritizing [her] time throughout the day.”

Due to the barriers described above, SELD’s attempts at support were sometimes burdensome and not well-received. Clinicians shared that finding the time to communicate with SELD and complete documentation tasks was difficult given their time constraints. **K.P.** shared that Tier II EBI implementation requires many check-ins and emails, which could be “annoying.” **B.M.** noted that doing multiple Tier II EBIs increased the demands “because everybody wants to come do a training, do this meeting, do that and ugh, it gets crazy when you’re doing two or three interventions at the same time.”

***Administrators.*** Administrators reported minimal involvement with the activities of the Implementation Phase, which contributed to a commonly cited barrier: lack of knowledge/data. School administrators primarily received updates on the implementation process through local school SEL committee meetings or through direct conversations with clinicians. However, they indicated that they were generally uninformed about the implementation process and could therefore not assess how well it was going. **V.G.** expressed strong interest in having more involvement or information about the implementation process with a “clearer system of outcomes and expectations.” School administrators indicated most concern about not knowing whether and how Tier II EBIs were making an impact in the school.

District administrators acknowledged their typically greater focus on understanding the implementation process rather than the clinical impact of Tier II EBIs. Despite more contact with clinicians to check in about implementation, they lamented their lack of data. It was difficult for them to determine “the level to which folks are adhering to the design and core components of the intervention” (A.K.). R.P. shared that SELD was sometimes unaware when clinicians were delayed with implementation. As a result, they sometimes missed implementation challenges that clinicians were facing: “I found out at the end when it’s too late to get them the support that they needed to actually be able to implement.”

Most school and district administrators identified the confluence of clinicians’ limited time, competing responsibilities, and changes and instability as a significant barrier. For example, district administrators recognized that clinicians had limited time in the day to deliver the intervention due to their many responsibilities. Several administrators expressed recognition of clinicians often having to attend to crises in the school building, which sometimes conflicted with scheduled group sessions. H.H. noted that with so many competing responsibilities and cancellations “instead of having a weekly group maybe you have it once a month.” This administrator also shared a concern that their school’s clinician “overextends herself as it is.” G.S. noted at least one instance where several session cancellations by the clinician resulted in a group never being fully delivered once it was started. They also shared that even when interventions are delivered to completion, they may not be delivered with full fidelity due to time constraints. Beginning Tier II EBI implementation later in the academic year was also a barrier because it led to more delays and interruptions with holidays and testing.

### ***Implementation Phase Barriers Related to Race, Culture, and SES***

Clinicians and administrators identified several barriers related to student background in the Implementation Phase. Cultural stigma against mental health treatment meant that clinicians had to work carefully to get parental consent for students to participate in the programs. **K.P.** shared that she had to “convince parents that mental health is actually something that’s important to work on.” **V.G.** similarly stated that stigma around therapy and “a really natural distrust of all things therapeutic” was a barrier to parent buy-in and allowing students to participate.

Barriers related to student background also emerged during intervention delivery. **K.P.** shared concerns about the lack of cultural relevance or appropriateness of Tier II EBIs:

I feel like a lot interventions are made by White people. I don’t know if I’m right or not, but I feel like sometimes the language can be a little...what’s the word I’m looking for. Rigid? Or formal? And so there are times when I feel like this is not the kind of language that students would- is going to connect with. And that may be related to their cultural background. (**K.P.**)

**V.G.** also thought of Tier II EBIs as designed for White and middle-class students and was concerned that they were not received well by students for this reason. Other clinicians were more definitive in their belief that some Tier II EBIs had components that were not culturally relevant for their students and would be confusing if delivered as written. **B.E.** reported that she began an intervention and was unable to finish it because it did not appear to be effective for her students due to a lack of cultural relevance. District administrator **R.P.** shared that the vignettes and language in manuals were not always appropriate for students of different backgrounds.

**R.P.** noted that biases can lead to the over-referral of students of color to Tier II EBIs.

So as segregated as the city is, is as segregated as our schools are. But if, in fact, you’re in a diverse school and the only students that are being referred to Tier II interventions are students of color, that’s a problem. (**R.P.**)



### *Implementation Phase Facilitators*

*Clinicians.* Having buy-in from different stakeholders was a commonly endorsed facilitator, especially as it contributed to teamwork. Clinicians shared that teacher buy-in to the interventions helped ensure that students could attend the groups regularly. Buy-in from administrators seemed to be especially helpful with balancing student academic and mental health needs and overcoming barriers related to time and scheduling. **K.M.** shared that administrators helped “encourage the teachers to be flexible.” Clinicians noted that principal buy-in was also important for reducing the pushback from teachers when sessions went past schedule. With regard to teamwork, several clinicians reported that having another co-leader for the group was helpful for Tier II EBI delivery.

Sometimes you’re glad when there’s two people ‘cause when you get stuck, they can help. They can come on the point that you don’t know, that you’re stuck on. So with them saying that they want two clinicians to do it, that’s helpful. (**B.M.**)

On the other hand, some clinicians liked their independence and having less pressure and responsibility to report to somebody during implementation. **A.L.** shared that it can be more challenging to coordinate with a co-leader.

Emotional support emerged as a factor unique to the Implementation Phase. Clinicians shared that it was not just material and logistical support from stakeholders that was helpful, but also their encouragement. Emotional support seemed to be especially helpful as clinicians were often solely responsible for carrying out implementation activities. It was also appreciated in light of the unique demands of manualized interventions, such as adhering to the protocol and evaluating the intervention outcome. For **B.H.**, having an intervention assistant present during group sessions to assist with some of these components “was like having a partner, which

alleviated a lot of stress.” **T.S.** appreciated encouragement from district administrators because clinicians “need the extra little support too.”

As previously reviewed, clinicians reported experiencing several barriers during the Implementation Phase related to balancing Tier II EBIs with limited time and competing responsibilities. Greater resource availability made it easier to find and maintain this balance. Clinicians indicated that having manuals available made Tier II EBIs easier to implement because less preparation was needed before each session. Having materials provided also made them easier to implement because it saved clinicians time that would have otherwise been used to procure or create them. **K.P.** stated that “when they are scripted for you it’s fantastic.”

Clinicians also facilitated implementation for themselves by taking initiative. **K.P.** coordinated with teachers to schedule the weekly group sessions for alternating times each week so that students would not repeatedly miss the same subject. Some clinicians took initiative by buying intervention prizes for the students with their own money to overcome barriers related to limited financial resources. This was a helpful strategy for increasing student buy-in. Similarly, several clinicians mentioned balancing the Tier II EBI protocols with their students’ specific needs by making small modifications with language in their delivery to increase buy-in.

**Administrators.** Administrators also emphasized the importance of buy-in and teamwork. Principal buy-in was identified as a facilitator because they could provide space and other material support for implementation. With regard to teamwork, school administrators noted that they sometimes helped clinicians with getting parent buy-in. **V.G.** shared that “certain parents...might only trust me” and so they would get involved in those conversations. Teachers sometimes helped make referrals and track student progress. District administrators perceived that having a co-leader for Tier II EBI groups made them easier to deliver because they provided

“accountability” (A.K.). G.S. worked with clinicians to help them understand school data so that they could rely less on referrals from others in the school.

Systems of support, such as the SEL committees and PLC meetings, were key facilitators of teamwork. SEL committee meetings helped with generating referrals for the intervention groups because they provided a system that could reduce the likelihood of “over-referring students” or not referring enough, as explained by R.P. SEL committee meetings were also helpful for providing school administrators with updates. PLC meetings offered opportunities for clinicians to troubleshoot various issues with program implementation and may have also helped with accountability. Their structure was seen as particularly helpful by district administrators because they required clinicians to leave the school to attend them. This ensured that the typical disruptions of the day would not distract clinicians.

I think having that “I have to go and step away” is valuable as opposed to jumping on a call. ‘Cause when you jump on a call, guess what? Nobody cares that you on the phone. (R.P.)

District administrators also highlighted emotional support and encouragement as facilitators of implementation for clinicians. One noted that sometimes clinicians needed reassurance that they could implement and deliver Tier II EBIs well.

I’m just like, you don’t need me- you just need me to make you feel like you know what you’re doing. And yes, you are totally on the right path. I didn’t even think about that. Good job. And that makes them feel like, “OK, good I can keep going.” (G.S.)

Another administrator elaborated on this idea by stating that it was important to celebrate clinicians because building these relationships and connections was key to intervention success.

### ***Implementation Phase Facilitators Related to Race, Culture, and SES***

There were few facilitators described overall for the Implementation Phase based on student background, and none endorsed by administrators. Some clinicians reported taking initiative to modify the vignettes and language in the protocol in order to better fit their students and their experiences. **K.M.** noted that “kinship” with her students based on a shared background made it easier to get their buy-in for participation in Tier II EBI groups.

### **Sustainment Phase**

The main activities of the Sustainment Phase for both clinicians and administrators were assessing the continued need for and fit of the Tier II EBI in schools and ensuring its continued delivery. Clinician **barriers** were *changes and instability, lack of buy-in, and limited resources* (time, materials), and **facilitators** were *buy-in, knowledge/experience, and greater resource availability* (time, materials). Administrator **barriers** were *changes and instability and limited resources* (materials, budget), and **facilitators** were *taking initiative*.

### ***Sustainment Phase Barriers***

***Clinicians.*** In discussing barriers to sustainment, clinicians described essentially having to redo many of the activities of the Exploration, Preparation, and Implementation Phases each year. Thus, a major barrier to sustainment described by clinicians were changes and instability that shifted the balance between available resources and mental health needs from year to year. Clinicians shared that some barriers to sustainment were related to district leadership instability.

[The district] loves to change things so we get so used to after a while ‘oh, this is the greatest thing ever,’ ‘no no this is the greatest thing ever now.’ So there is some concern over that. (**K.M.**)

Tier II EBIs offered by SELD changed each year along with who was eligible to apply. Changes in school staffing and clinician responsibilities sometimes thwarted attempts at redelivering a Tier II EBI. For example, **B.E.** transferred schools mid-year and intended to implement a previously implemented Tier II EBI in the new school but found that “there was a lot of stuff going on in my building” with regard to more pressing student mental health needs and had to divert resources to those areas. Another clinician acknowledged that as new priorities emerged in student needs, limited resources in the school meant that previously implemented Tier II EBIs would have to be discontinued to make room for new ones:

If there’s an issue that I know is something that’s coming up over and over again and it needs to be addressed or it’s becoming a focus in the school, I may stop doing a previous intervention and start a new one. But I can’t keep adding more interventions to my plate. (**K.P.**)

Changes from year to year also made it difficult to determine how much time and effort would be needed to find eligible students for these programs as noted by **A.L.**, who shared that “this year was hard for me to find kids.”

Many barriers from previous phases also impacted sustainment, such as lack of buy-in and limited resources. However, during the Sustainment Phase it was clinicians’ own lack of buy-in that was a challenge. As clinicians explored intervention options for their students, prior negative experiences and perceptions of poor effectiveness or fit of a previously implemented Tier II EBI reduced the likelihood of sustainment. **B.M.** shared that she discovered one Tier II EBI was too challenging clinically due to the nature of the students referred, which dissuaded her from delivering the intervention again. In addition, whereas clinicians described the availability of intervention materials as a facilitator during the initial implementation year, *not* having them represented a barrier to sustainment in subsequent years for several clinicians. **B.H.** noted that

she wanted to deliver a Tier II EBI again, but without having the materials provided for session activities she was unsure how to proceed. Not having enough time overall continued to be a barrier for clinicians during this phase.

***Administrators.*** District administrators also emphasized the negative impact of changes and instability on sustainment of Tier II EBIs. Staff turnover, in particular, was cited as a barrier to ensuring that schools had interventions that sustained from year to year. This was especially challenging for sustainability of Tier II EBIs because training occurred for staff not schools, raising the question of whether sustainment should be conceptualized at the level of the clinician or of the school. District administrators acknowledged that clinicians moving to a new school could discover different mental health needs that could render a previously implemented intervention inappropriate for the setting, effectively restarting the implementation process. Some administrators noted that even when clinicians stay in their school, their responsibilities may change from year to year and result in no longer being able to balance program requirements with competing responsibilities.

As with clinicians, limited resources were reported as barriers by administrators. **R.P.** acknowledged that the decrease in support and materials provided for interventions after the pilot implementation year was a barrier for clinicians but that it was “not something we have the capacity to sustain.” They explained that SELD did not have the resources to provide this continuing support or even monitor sustainment across schools. School administrators mentioned cost as a potential barrier to sustaining interventions.

### ***Sustainment Phase Barriers Related to Race, Culture, and SES***

Neither clinicians nor administrators reported any barriers to the Sustainment Phase related to student background. This may reflect the general perception shared by participants that

factors important for sustainment were primarily considered during the initial implementation year. It may also reflect a sentiment articulated by one clinician that their focus was more on general student mental health needs rather than student background when considering which interventions to sustain.

In our field, we don't want to make too much more work for ourselves to be honest. And I know that there is a need for like depression and anxiety... I'm kind of like right in the middle because SES, or race or ethnicity of our kids could very closely relate to the needs that they present. (A.L.)

### *Sustainment Phase Facilitators*

**Clinicians.** In general, clinicians expressed strong buy-in to most Tier II EBIs and a strong desire to deliver them again despite the barriers. **T.S.** stated that she would deliver a particular Tier II EBI again “just knowing that I would have the same challenges.” A key facilitator to this level of buy-in and sustainment was prior experience with successful delivery of the intervention. The perception of prior student buy-in to a particular intervention also contributed to clinicians' own buy-in. Another facilitator was a clinician's perception that an intervention would remain relevant for students' mental health needs generally. As **K.P.** put it, there was a strong appreciation for interventions that were “not gonna go out of style.”

Greater knowledge/experience with a Tier II EBI were also important facilitators. For many clinicians, having delivered a Tier II EBI once with support contributed to greater confidence and ease with subsequent deliveries. In particular, greater familiarity with session content reduced the time needed for preparation. For this reason, **A.L.** stated that delivering a Tier II EBI “gets easier every year.” Clinicians also described greater flexibility and ability to adapt Tier II EBIs to suit student needs as they grew more familiar with these interventions. Several clinicians shared that they used subsequent deliveries of a Tier II EBI as an opportunity to make modifications that could improve its feasibility or fit. Several clinicians also reported

that they have sustained individual components of Tier II EBIs across the years, if not the full protocol, in their work with individual students.

Greater resource availability continued to be a facilitator for clinicians in the Sustainment Phase. **B.H.** noted that reduced expectations for documentation and consent forms after the initial implementation year meant she had more time for intervention delivery which made sustainment feel more feasible. Clinicians indicated that having materials available also facilitated sustainment and made “life easier” according to **B.M.**

*Administrators.* Most of the facilitators to sustainment described by district administrators highlighted the importance of taking initiative and planning for sustainability at the start of the implementation process. They shared that sustainment was a consideration when making decisions about which clinicians and schools to approve for initial implementation.

When we determined who would get what intervention, that was definitely one of the things that we looked at. Did we offer them an intervention last year? Did they do it last year? Then we’re more likely to give them a new intervention or “oh well, you actually did this and you implemented, we’ll stick with that intervention,” as opposed to adding. (**R.P.**)

Similarly, readiness and school culture were identified as school level facilitators to sustainment that were ideally assessed and included in the decision-making for initial implementation. The SEL committees were facilitators of sustainment because they offered stability when there was staff turnover. SELD has also expanded consultation support past the initial year to support clinicians during the Sustainment Phase. **A.K.** explained that the goal of this support is to encourage continuity in the work from year to year and avoid clinicians thinking “oh well that was last year’s project” and move on to the next intervention.



### *Sustainment Phase Facilitators Related to Race, Culture, and SES*

Once again, clinicians and administrators did not describe facilitators related to student race, culture, or SES in the Sustainment Phase.

### **Discussion**

Youth from racial/ethnic minority (REM) and low-income backgrounds have faced persistent disparities in their access to high-quality mental health services. Despite efforts to address these disparities through the provision of evidence-based interventions (EBIs) in schools, challenges with implementation have contributed to the underutilization and weaker outcomes of EBIs in this setting. The present case study used interviews with administrators and school-based clinicians to examine the implementation of group-based (Tier II) EBIs in one of the largest school districts in the country. A hybrid deductive-inductive content analysis drew from the Exploration, Preparation, Implementation, and Sustainment (EPIS) framework to explore barriers and facilitators across different phases of the implementation process. In addition, this study examined how the implementation process was influenced by student racial, cultural, and socioeconomic background—an area that has been understudied in the school-based implementation literature. Overall, the findings of this study reveal important barriers and facilitators to EBI implementation specific to both the setting and the student population.

This study contributes to the school-based implementation literature by documenting barriers and facilitators that impact EBI implementation across different stages of implementation. The majority of research in this area has focused on the Implementation Phase, and both the Exploration and Sustainment Phases have been identified as priority areas for future implementation research in schools (Aarons et al., 2011; Moullin et al., 2019; Owens et al., 2014). Given that the majority of implementation studies in schools have focused on the

Implementation Phase, prior findings in the literature may be biased toward emphasizing barriers and facilitators that are most relevant to schools that can successfully move through the Exploration and Preparation Phases. The inclusion of all EPIS phases in the present study allowed participants to share about factors salient to the earlier stages of the process that may impede reaching the Implementation Phase. Similarly, relatively little attention has been paid to what happens after the Implementation Phase is completed and a district, school, and/or clinician are tasked with sustaining an EBI. Understanding the factors that impact the Sustainment Phase can guide districts and schools toward implementation strategies that ensure continued benefits from EBIs after successful initial implementation. As discussed below, the findings from the present study suggest that most barriers and facilitators were endorsed across multiple EPIS phases while taking different forms depending on the phase, consistent with prior research (Massey et al., 2021) in schools.

Among the factors that were relevant across EPIS phases, the barrier of *limited resources* was unique in that it emerged in every phase. Specifically, a lack of time was a consistent barrier across phases, with clinicians endorsing this barrier in every phase and administrators in all but the Exploration Phase. On the other hand, greater availability of time was endorsed as a facilitator by clinicians in all phases except the Implementation Phase. These findings are in line with numerous other studies that identify lack of time as a barrier to implementation and sustainability in schools (Corteselli et al., 2020; Langley et al., 2010; Nadeem & Ringle, 2016). The ubiquity of time constraints as a barrier in school implementation research has prompted some researchers to examine it as a uniquely influential implementation factor for treatment outcomes in schools (Zhang et al., 2021).

*Buy-in* for Tier II EBIs was another factor that was relevant across EPIS phases and was endorsed as a barrier when absent (i.e., lack of buy-in) and as a facilitator when present. Clinicians experienced challenges with carrying out activities in the Preparation, Implementation, and Sustainment Phases due to a lack of buy-in from administrators, teachers, students, parents, and even themselves, depending on the phase. This finding reveals that clinicians often carried the significant burden of convincing others that Tier II EBIs are important and helpful for students. Without the initial buy-in for participation or support from some stakeholders, clinicians worked harder and spent more time on implementation activities such as gaining student assent to participate in the groups. Importantly, district administrators in this study did not experience low buy-in for the Exploration Phase, which is likely a critical facilitator to the Tier II EBI program overall. With some exceptions (Langley et al., 2010; Langley et al., 2013), buy-in *per se* has not emerged as a major factor in other school-based implementation studies. However, several studies have noted barriers related to engagement of students and parents (Corteselli et al., 2020; Nadeem & Ringle, 2016), which included challenges with buy-in. It is unclear if the importance of buy-in in this study is a result of a different approach to content coding or reflects a unique challenge to implementation in this district. Nonetheless, it was notable that participants in the present study spoke often about their own and others' skepticism or enthusiasm for Tier II EBIs.

*Teamwork* was a factor closely related to buy-in that emerged as a facilitator for the Exploration, Preparation, and Implementation Phases, according to clinicians and administrators. Participants highlighted how cooperation and support among different school stakeholders (typically clinicians, administrators, and teachers) facilitated the work that clinicians had to do to move implementation forward. This is consistent with prior research where school clinicians

have emphasized collaboration with other school staff as critical to overcoming potential barriers to implementation (Langley et al., 2013). In the present study, clinicians and administrators alike noted that a crucial way that administrators supported clinicians was by increasing teacher cooperation with clinicians' implementation efforts, especially with scheduling group sessions. Teamwork with teachers was especially important in light of *competing priorities*, which was endorsed as a barrier in situations where attending to students' mental health needs conflicted with attending to their academic needs. This finding aligns with prior work examining features of a school's organizational climate that support EBI implementation. Locke et al. (2019) used focus groups with stakeholders at different organizational levels of the school system to determine the applicability of organizational constructs developed through implementation research in other settings. They found that "prioritization of EBP [evidence-based practice]" was a new organizational dimension unique to schools that captured the alignment between the EBP and the school and district priorities (Locke et al., 2019). As such, administrators can greatly facilitate implementation in schools by establishing EBIs as a priority.

When comparing barriers and facilitators in the Exploration and Implementation phases, an interesting difference emerges with regard to the factor *taking initiative*. Specifically, clinicians' initiative presented a barrier to implementation during the Exploration Phase but acted as a facilitator during the Implementation Phase. Although these findings appear to be contradictory, they reflect the different ways that EBIs can fulfill a clinician's desire to address their students' needs. Clinicians reported that they were generally open to Tier II EBIs but perceived some to be less relevant to student needs or a poor fit for other reasons. As they considered their options, some clinicians took the initiative to seek out interventions offered by outside agencies or by creating their own. In this way, taking initiative impeded adoption of Tier

II EBIs as clinicians pursued other options. During the Implementation Phase, the same commitment to serving students contributed to clinicians creatively and successfully addressing barriers they experienced while delivering interventions (e.g., paying out of pocket for incentives). This set of findings illustrates the importance of conducting implementation research focused on the Exploration Phase in schools, as it may yield barriers and facilitators unique to the decision-making process around initial EBI adoption.

Another major contribution of this study was increased insight into how clinician and administrator perspectives compare throughout the implementation process. It also filled important gaps in the literature regarding administrator perspectives on EBI implementation in schools. Prior studies have found high levels of agreement between clinicians and local leadership (Beidas et al., 2016; Massey et al., 2021). Consistent with this work, clinicians and administrators in this study endorsed many of the same barriers and facilitators. In addition to the barriers and facilitators described above, clinicians and administrators also agreed on the challenges caused by *changes and instability* during the Implementation and Sustainment Phases. *Changes and instability* referred to disruptions within a school day, throughout the school year, and across school years that primarily made it difficult for clinicians to plan and be consistent in their implementation activities. Several other qualitative implementation studies have captured this barrier in schools under the categories of unpredictable schedules, attending to crises, job instability, and staff turnover (Corteselli et al., 2020; Lyon et al., 2014; Nadeem & Ringle, 2016; Yu et al., 2012). In light of the competing priorities and responsibilities for staff at all levels of the school system, it is unsurprising that both clinicians and administrators would highlight how unpredictable and constantly shifting circumstances impact the work of implementation.

An unexpected facilitator endorsed by both clinicians and administrators was *emotional support* provided to clinicians during the Implementation Phase. Administrators reported that their cheerleading for clinicians helped clinicians feel confident to pursue implementation, while clinicians acknowledged that getting encouragement helped ease their apprehension about delivering unfamiliar Tier II EBIs. This is a new contribution to the literature as prior implementation studies in schools have not identified this as a facilitator. Nonetheless, this finding is not surprising given that prior studies have documented clinician anxiety about delivering EBIs (Willging et al., 2015), feelings of isolation among implementing clinicians (Lyon et al., 2014), and the importance of connecting with other colleagues who are also implementing an EBI (Langley et al., 2010). Although administrators often lacked specific knowledge of the Tier II EBI implementation process, the results of this study suggest that administrators were at least somewhat attuned to the needs of clinicians.

Administrators also often correctly identified barriers that clinicians reported experiencing. For example, district administrators understood the ways in which clinicians' *competing responsibilities* presented challenges to their involvement in training for Tier II EBIs. Similarly, clinicians sometimes commented on the pressures carried by administrators and teachers that were contributing to implementation barriers. These findings suggest that clinicians and administrators have a shared understanding of the implementation context and potential challenges experienced at different organizational levels. It is possible that this has been facilitated by the work being done by SELD in the district to coordinate the implementation process and put systems and supports in place to assist with this work.

Despite these areas of similarity and shared understanding, there were some important differences in the implementation factors endorsed by clinicians and administrators. Many of

these differences stemmed from the different levels of involvement that administrators had throughout the implementation process, especially during the Implementation and Sustainment Phases. In this school district, clinicians primarily carried out Implementation Phase activities independently and were solely responsible for the decision to sustain Tier II EBIs. Perhaps for this reason, clinicians, but not administrators, endorsed barriers and facilitators related to buy-in for the Sustainment Phase. Another important difference that emerged between clinician and administrator perspectives was the importance of *knowledge and data* for administrators in the first three EPIS phases. Administrators acknowledged that they often lacked data about Tier II EBI outcomes or the implementation process, which contributed to their lower buy-in and less support provided to clinicians. On the other hand, greater data and knowledge regarding student mental health needs contributed to more overall support for Tier II EBIs, especially at the district level. Although this has not often emerged among barriers and facilitators in school-based implementation research, Massey et al. (2021) noted that “data and evaluation” was a surprising facilitator endorsed by their respondents who spanned multiple levels of the school system. This greater reliance on data and knowledge for administrators is understandable given their role in decision-making and that they are not typically involved in intervention delivery. Based on these results, it is clear that progress monitoring of EBI implementation and outcomes in schools is important for administrator buy-in and support, and should be explicitly incorporated into implementation planning.

The third major contribution of this study was that it addressed a major gap in the literature regarding the impact of student race, culture, and SES on the implementation process in schools. As implementation science begins to focus more explicitly on addressing health inequities (Brownson et al., 2021), it is critical to consider how implementation can be impacted

by factors related to the sociodemographic characteristics of the target population. Limited research in this area has indicated that some clinicians experience unique barriers when implementing EBIs with underserved student populations (Farahmand, 2013; Gamble & Lambros, 2014; Lyon et al., 2014; Santiago et al., 2013), while others find relatively low impact of cultural considerations on the implementation process (Hicks et al., 2014). The present study found that participant perspectives varied greatly with regard to the impact of these student sociodemographic factors across EPIS phases. Some participants reported not considering student background in their work or not noticing a particular impact of these factors in the implementation process. Other participants talked at length about the impact of student race, culture, and SES across phases. These differing levels of awareness or perceived impact did not appear to consistently differ across Sectors A and B, though participants in Sector B were somewhat less likely to comment on concerns about race. This may have been due to there being fewer Black and Latino participants in this sector. Importantly, very few studies have examined administrator perspectives with regard to implementation of EBIs with youth from diverse backgrounds. The administrator subsample in this study offered new insights into how school and district leaders consider race, culture, and SES during implementation. Both clinicians and administrators described more impact of these factors during the Exploration and Implementation Phases and generally endorsed fewer ways in which they impacted the Preparation and Sustainment Phases.

Several barriers emerged related to student race, culture, and SES, and those were *inequities, bias, lack of cultural relevance*, and *stigma*. The latter two barriers represent contributors to poor buy-in to Tier II EBIs among clinicians and administrators (*lack of cultural relevance*) and students and their families (*stigma*). This underscores how a major general barrier



(*buy-in*) can be exacerbated when districts aim to implement these interventions with REM and low-SES students. Prior studies have similarly found that clinicians are concerned about the relevance of EBIs for their REM and low-income clients (Farahmand, 2013; Lyon et al., 2014), perhaps in part due to the paucity of EBIs that are considered well-established for these populations (Pina et al., 2019). Several participants shared their impression that EBIs are typically developed with and for White, middle class populations, which is a perception corroborated by the literature (e.g., Polo et al., 2019). Thus, it is unsurprising that clinicians in this study took initiative in modifying the language and content of Tier II EBIs to be more culturally relevant for their students. Research in community settings has found that clinicians often make adaptations to EBIs, typically by augmenting delivery and content, in order to improve the fit of interventions for diverse clients (Barnett et al., 2019). Given the availability of EBIs that have already been adapted for REM and low-income youth (Park et al., 2021; Pina et al., 2019), offering culturally adapted EBIs in the district may not only improve treatment outcomes for these youth, but also increase buy-in among clinicians and administrators and decrease implementation burden among clinicians.

The barriers of *inequities* and *bias*, along with the facilitators of *knowledge* and *focus on equity* reveal the level of awareness among participants about the broader societal context and its impact on REM and low-SES students. Several participants highlighted how this growing awareness especially impacted the Exploration and Preparation Phases through both an increasing focus on the unique needs of this student population and systemic efforts to reach them with Tier II EBIs. It is worth noting that the administrator subsample in this study was majority-Black and thus may have demonstrated a level of awareness that is not representative of administrators more generally. Some clinicians also appeared to conflate sociodemographic

factors with biased expectations about academic abilities. Although not all clinicians reported considering student race, culture, and SES, greater awareness and sensitivity were overall important facilitators to implementation for EBIs in this school district.

This is believed to be the first study to document perspectives on how student race, culture, and SES impact the different stages of the implementation process for EBIs in schools. The study's findings highlight the complexity of studying the impact of sociodemographic factors on implementation. For instance, participants often combined race, culture, and SES in their responses even though they were asked to comment separately for race/culture and SES. This may be partly due to how commonly these sociodemographic factors intersect in this school district. Relatedly, it was difficult to disentangle student- and school-level factors related to race/ethnicity and SES in this study. One reason for this is that student-level implementation factors influence school-level factors and vice versa, especially when student populations are relatively homogenous with respect to race and SES. For example, because the resources available to public schools are often determined by the demographics (especially SES) of the student population, comments made by participants about factors like *limited resources* may reflect the impact of student background, even if not explicitly stated as such by participants. Thus, when participants commented on the implementation process more generally it is likely inaccurate to say that these barriers and facilitators were independent of student racial, cultural, or socioeconomic background.

Overall, the findings described above reveal mixed feelings regarding Tier II EBIs in schools. Prior research has documented some of these mixed feelings for clinicians (Corteselli et al., 2020), but less has been known about administrator perspectives for EBIs. In this study, district administrators, whose roles were to support Tier II EBI implementation, generally

reported buying in to the Tier II EBIs, while school administrators reported more skepticism. Among both clinicians and administrators, the perceived strengths and weaknesses of Tier II EBIs included general factors, as well as factors related specifically to student race, culture, and SES. For school administrators, this pattern of general and more identity-specific factors is reminiscent of work done by Green et al. (2018) focused on sexual and gender minority students. Likewise, clinicians expressed concerns about the fit of EBIs for students' general needs and about their cultural relevance and suitability for REM and low-SES students, specifically. Clinicians in this study also shared that Tier II EBIs were appealing because they were likely to be helpful to students, required less time for preparation, and were often well-received by students. However, they also acknowledged important challenges with fitting Tier II EBIs into the setting given the flexibility required of them on a daily basis. Prior research has documented that EBI flexibility is an important factor impacting the perceived appropriateness of an intervention (Lyon et al., 2014), and several studies have begun to examine the outcomes of modular EBIs as a flexible approach to EBIs in schools (Kininger et al., 2018). Clinicians also noted that they wished to deliver more Tier II EBIs but could not feasibly do so. This mirrors recent findings from a study with therapists in community mental health settings that found that delivering more EBIs was associated with greater burnout (Kim et al., 2018). In summary, clinicians described considerations about the fit of EBIs with both their students and with their setting. In some cases, poor fit contributed to the use of homegrown interventions or other interventions not sanctioned by the district, indicating that the particular EBIs offered by the district may have been inadequate to a degree that impeded adoption.

Although it was not a primary objective of this study, it is important to consider how the barriers and facilitators described by study participants map onto the conceptual model described

in the EPIS framework (Aarons et al., 2011). In general, it was difficult to fit the implementation factors in this study with those outlined in the EPIS framework, perhaps owing to the interview approach of asking broad, open-ended questions about the barriers and facilitators most salient to participants. The majority of barriers and facilitators in this study were reported to occur in the inner context, which is considered to be the school building itself when implementation occurs in the school system (Lyon & Bruns, 2019). Several factors spanned both the inner and outer contexts. For example, *limited resources* referred to those resources within the school building (staff, time, materials) as well as those in the district (training spots). Similarly, most of the factors that emerged related to race, culture, and SES appeared to reflect the sociopolitical realities of the outer context as well as organizational and individual characteristics of the inner context. In this way, it is possible to conceptualize these sociodemographic factors as bridging factors that connect the inner and outer contexts for implementation in schools. Lastly, *cultural relevance* was the only barrier or facilitator in this study that would fit under the category of innovation (i.e., intervention) factors. It may be that the realities of this particular school district and Tier II EBI initiative were less compatible with the EPIS conceptual model compared to other settings.

The contributions of this study should be considered in light of its limitations. One important limitation to highlight is that results were combined for participants from the higher and lower income sectors, and that administrator results were combined for school- and district-level administrators. Due to the small number of participants, it was not possible to more systematically examine how differences in perceived barriers and facilitators were related to these or other important variables, such as participants' own demographic characteristics. However, some participants in schools serving lower-income students shared their perspective of

having to work harder during the implementation process. Likewise, participants in the higher-income sector described having more options and greater flexibility during implementation. Although attempts were made to increase the variability of the sample, it is possible that some perspectives were under- or over-represented and thus may have skewed the final results regarding overarching themes. In particular, since all clinicians who participated had previously participated in implementing at least one Tier II EBI (the previously mentioned depression intervention), it is possible that their impressions of Tier II EBIs were more favorable than the average clinician. The low response rate among school administrators is also noteworthy and may reflect their decreased engagement and investment in the Tier II EBI implementation process. It is also important to note that key stakeholders in the school system (e.g., students and teachers) were not included in this study, and so important insights about the implementation process are missing from the findings. The focus on EBIs in the district's elementary and middle schools is another limitation of this study, as it is unclear whether the findings of this study are applicable to EBIs adopted in high schools. Given that high school students have unique academic and mental health needs, this is an important area for further research. Finally, the results of this study must be interpreted within the expectations of a qualitative case study, which seeks to understand a phenomenon in a particular context. Thus, while the results can inform our general understanding of EBI implementation in the school setting, the results may not be generalizable to other school districts, which may have different processes and contextual factors that impact implementation.

Despite the limitations, there are several insights offered by this study that can inform future EBI implementation efforts in schools as well as research in this area. First, this case study demonstrates that stakeholders at different levels of the school system offer unique and valuable

contributions to implementation success. Districts that are planning to implement EBIs should aim to engage these stakeholders throughout the implementation process. This may be especially important for school administrators, who wield significant power in the school building, but in this study reported feeling detached and uninformed about the implementation process. More clearly communicating the progress and outcomes of EBIs to school administrators has potential to increase their buy-in to EBIs and their practical and emotional support for clinicians.

Likewise, clinicians in this study were largely responsible for securing buy-in from school administrators, parents, teachers, and students. This is a significant burden for clinicians already struggling with limited resources and competing responsibilities. Districts can help by educating school administrators and teachers directly about the utility and benefits of EBIs for students.

Second, there are complex ways in which student race, culture, and SES impact the implementation process in schools. Understanding and addressing these will be critical for implementation success with REM and low-SES students. Participants in this study especially reported skepticism about the cultural relevance of the EBIs being offered and several clinicians described making adaptations during their delivery to increase their relevance with students. School districts should consider offering culturally relevant EBIs to match the target student populations and provide more support for cultural adaptations when EBIs are not culturally relevant. Importantly, some participants did not perceive an impact of race, culture, or SES on their work or stated that they did not often consider this possibility. This suggests that increased training in cultural sensitivity and/or recruitment of clinicians and administrators from REM and low-SES backgrounds would strengthen district implementation efforts. For researchers, more work is needed to help disentangle the complicated relationship between student sociodemographic background and the school setting. School-based implementation research

should also more explicitly attempt to bridge implementation research with mental health equity research in order to better address the relative impact of client racial, cultural, and socioeconomic factors on implementation of EBIs.

Lastly, school districts should proactively work to mitigate barriers and bolster facilitators in order to create the conditions that are most likely to result in implementation success. Since limited resources were endorsed as a barrier in every phase of the process, districts (and policy makers) should allocate more funding, staffing, and time toward EBI implementation in schools. To address the barrier of limited time, districts should consider designating blocks of time for SEL, which can include EBI implementation. This would also help to resolve tension around balancing mental health and academic priorities. It is especially important for districts to address barriers and facilitators that can impact the implementation process during its early stages. In particular, there is a risk of clinicians evaluating their options and deciding to pursue other community-based or homegrown interventions rather than EBIs offered by the district. This appears to be at least partly motivated by mixed feelings about EBIs and their relevance to student needs. School districts should provide additional support and outreach during the Exploration and Preparation phases in order to ensure that clinicians and schools first choose to adopt an EBI and then are sufficiently prepared for its delivery. EBIs that have fewer sessions and minimize the amount of work needed outside of sessions may be better received (e.g., no parent collateral work, no individual work, no materials creation). In summary, to increase the likelihood of a successful implementation program, district administrators should attend to the barriers and facilitators related to the setting, the population, and the interventions.

The school setting presents unique challenges and opportunities for mental health service delivery. In addition to more easily being able to reach youth underserved by the mental health

system, an important strength of the school setting is the multilevel team of stakeholders who share a common mission of serving and supporting students. This qualitative case study deepens our understanding of the implementation barriers that interfere with achieving this mission through EBIs. It is clear that overcoming these barriers will require the engagement of multiple stakeholders and a critical examination of the impact of race, culture, and SES on the implementation process. Doing so has the potential to significantly improve the uptake and outcomes of EBIs in schools serving REM and low-SES students and to thereby reduce mental health disparities that have persisted for decades.



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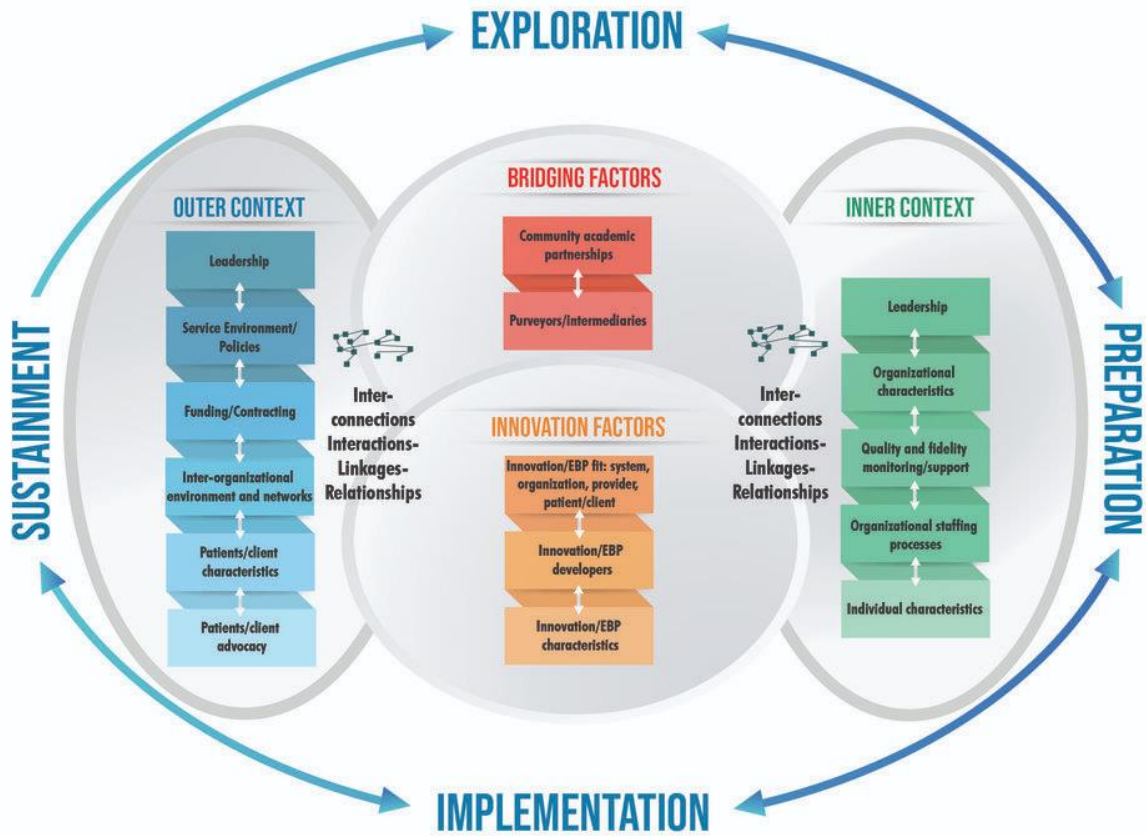
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**Figure 1**

*Diagram of The Exploration, Preparation, Implementation, Sustainment (EPIS) framework.*



Source: [episframework.com](http://episframework.com).

**Table 1***Sociodemographic data for the clinician subsample.*

| <b>ID</b>   | <b>Sector</b> | <b>Number of times delivered<br/>depression intervention in<br/>pilot trial</b> | <b>Racial/Ethnic<br/>Background</b> |
|-------------|---------------|---|-------------------------------------|
| <b>T.S.</b> | A             | 2   | White                               |
| <b>B.E.</b> | A             | 1   | Latina                              |
| <b>K.M.</b> | A             | 2   | Black                               |
| <b>B.M.</b> | A             | 2   | Black                               |
| <b>A.L.</b> | A and B       | 2   | White                               |
| <b>B.H.</b> | B             | 1   | White                               |
| <b>K.P.</b> | B             | 2   | White                               |

**Table 2**

*Major themes of implementation barriers and facilitators derived from participant interviews, organized by EPIS phase and participant subgroup.*

|                             |                     | <b>Clinicians</b>  | <b>Administrators</b>  | <b>Race, Culture, SES<br/>(All Participants)</b>   |
|-----------------------------|---------------------|--|--|--|
| <b>Exploration Phase</b>    | <b>Barriers</b>     | <ol style="list-style-type: none"> <li>Limited resources (time, staffing)</li> <li>Taking initiative</li> <li>Changes and instability</li> </ol>   | <ol style="list-style-type: none"> <li>Lack of knowledge/data</li> <li>Lack of buy-in</li> <li>Limited resources (budget, staffing)</li> </ol>   | <ol style="list-style-type: none"> <li>Inequities</li> <li>Bias</li> <li>Lack of cultural relevance</li> <li>Stigma</li> </ol> |
|                             | <b>Facilitators</b> | <ol style="list-style-type: none"> <li>Teamwork</li> <li>Buy-in</li> <li>Knowledge/data</li> <li>Greater resource availability (time, materials, staffing)</li> </ol>  | <ol style="list-style-type: none"> <li>Taking initiative</li> <li>Knowledge/data</li> <li>Buy-in</li> <li>Teamwork</li> </ol>  | <ol style="list-style-type: none"> <li>Knowledge (about mental health)</li> <li>Cultural relevance</li> </ol>                  |
| <b>Preparation Phase</b>    | <b>Barriers</b>     | <ol style="list-style-type: none"> <li>Lack of buy-in</li> <li>Lack of teamwork</li> <li>Limited resources (time, training spots)</li> <li>Competing priorities</li> <li>Competing responsibilities</li> </ol> | <ol style="list-style-type: none"> <li>Limited resources (time, staffing, budget)</li> <li>Competing priorities</li> <li>Competing responsibilities</li> <li>Lack of buy-in</li> </ol> | <ol style="list-style-type: none"> <li>Bias</li> <li>Lack of cultural relevance</li> </ol>                                     |
|                             | <b>Facilitators</b> | <ol style="list-style-type: none"> <li>Buy-in</li> <li>Teamwork</li> <li>Greater resource availability (time, materials)</li> </ol>  | <ol style="list-style-type: none"> <li>Data</li> <li>Buy-in</li> <li>Teamwork</li> <li>Taking initiative</li> </ol>  | <ol style="list-style-type: none"> <li>Focus on equity</li> </ol>  |
| <b>Implementation Phase</b> | <b>Barriers</b>     | <ol style="list-style-type: none"> <li>Lack of buy-in</li> <li>Limited resources (time)</li> <li>Competing responsibilities</li> <li>Competing priorities</li> <li>Changes and instability</li> </ol>          | <ol style="list-style-type: none"> <li>Lack of knowledge/data</li> <li>Limited resources (time)</li> <li>Competing responsibilities</li> <li>Changes and instability</li> </ol>        | <ol style="list-style-type: none"> <li>Stigma</li> <li>Lack of cultural relevance</li> </ol>                                   |
|                             | <b>Facilitators</b> | <ol style="list-style-type: none"> <li>Buy-in</li> <li>Teamwork</li> <li>Emotional support</li> <li>Greater resource availability (materials)</li> <li>Taking initiative</li> </ol>                            | <ol style="list-style-type: none"> <li>Buy-in</li> <li>Teamwork</li> <li>Systems of support</li> <li>Emotional support</li> </ol>  | <ol style="list-style-type: none"> <li>Taking initiative</li> </ol>  |
| <b>Sustainment Phase</b>    | <b>Barriers</b>     | <ol style="list-style-type: none"> <li>Changes and instability</li> <li>Lack of buy-in</li> <li>Limited resources (time, materials)</li> </ol>   | <ol style="list-style-type: none"> <li>Changes and instability</li> <li>Limited resources (materials, budget)</li> </ol>   | None   |

|  |                     |  |  |      |
|--|---------------------|--|--|------|
|  | <b>Facilitators</b> | <ol style="list-style-type: none"><li>1. Buy-in</li><li>2. Knowledge/experience</li><li>3. Greater resource availability (time, materials)</li></ol> | <ol style="list-style-type: none"><li>1. Taking initiative</li></ol> | None |
|--|---------------------|--|--|------|

**Table 3***Aggregated barrier and facilitator themes combined across all participants for each EPIS phase.*

|                            | <b>Exploration</b> | <b>Preparation</b> | <b>Implementation</b> | <b>Sustainment</b> |
|----------------------------|--------------------|--------------------|-----------------------|--------------------|
| Resources                  | X                  | X                  | X                     | X                  |
| Taking Initiative          | X                  | X                  | X                     | X                  |
| Knowledge/Data             | X                  | X                  | X                     | X                  |
| Buy-In                     | X                  | X                  | X                     | X                  |
| Teamwork                   | X                  | X                  | X                     |                    |
| Cultural Relevance         | X                  | X                  | X                     |                    |
| Changes and Instability    | X                  |                    | X                     | X                  |
| Bias                       | X                  | X                  |                       |                    |
| Stigma                     | X                  |                    | X                     |                    |
| Competing Priorities       |                    | X                  | X                     |                    |
| Competing Responsibilities |                    | X                  | X                     |                    |
| Inequities                 | X                  |                    |                       |                    |
| Focus on Equity            |                    | X                  |                       |                    |
| Emotional Support          |                    |                    | X                     |                    |
| Systems of Support         |                    |                    | X                     |                    |

## Appendix A: Interview Topic Guides

### Clinician Topic Guide

#### **Background Information**

*To start the interview, I'd like to learn more about you, your role in the school, and your general perspective on mental health services in schools.*

- How many years have you worked in schools/[the district]?
  - What roles have you held while working in schools/[the district]?
  
- How many years have you worked at your current school? In what capacity?
  - Do you work in any other schools?
  
- What are your responsibilities at your school?
  - How much time do you spend on each activity (e.g., teaching, one-on-one counseling, IEP meetings, etc.)?
  - Are you also a case manager?
  
- What are the mental health needs of your school?
  - What issues do students face that could be addressed by mental health services?
  - In what way do student race/ethnicity and income/SES background affect their mental health needs in school?
  - How do other school staff impact your understanding of student mental health needs?
  
- How much experience have you had with Tier 2 interventions in [the district]?
  - Which interventions do you know about?
  - Which interventions have you been involved with or delivered?
  
- Did you have experience with these kinds of interventions prior to receiving training through [the district]/SELD?

#### **Roles within [district]**

*I'm interested in knowing who is involved in bringing interventions into schools and what roles they generally play. We'll talk more in depth about the actual*

*process in a few minutes, but it would be great to get your perspective on who the key players are.*

- Who is responsible for successful implementation of interventions in your school?
- What is the contribution of the behavioral health team (aka MTSS team, Tier 2 team) in your school?
  - How much confidence do you have in the rest of the clinical team at your school?
- When it comes to interventions, what is the role of...
  - Principal/AP
  - Sector liaison
  - SELD staff
  - Clinician
- What kinds of interaction or communication do you have with them related to interventions?
- Are there other key decision-makers within your school/[the district] not listed above?

### **Exploration Phase**

*Now, I'd like to shift our discussion to the process of actually bringing an intervention to a school from beginning to end. First, I'd like to hear about your thoughts and experiences with the process of considering interventions and making the decision to implement them in your school.*

- Are you familiar with the SELD/[district] push for MTSS and Tier 2 interventions?
- What do you know about the SELD/[district] push for MTSS and Tier 2 interventions?
  - What is the rationale behind it?
  - What are the goals for this push?



- Whose concerns is it meant to address? (e.g., families, teachers, principals, etc)
- What kind of funding is available for these interventions?
- How does it fit in with [district] goals overall?
  
- Please walk me through the process of bringing an intervention to your school.
  - Who initiates?
  - How are the options presented?
    - Do you know why particular interventions are offered?
  - Who is involved in discussions?
  - How long does this process take?
  - How often does this process happen?
  - Who ultimately makes the decision to bring in an intervention?
  
- Have interventions ever been considered specifically to address needs of students from particular racial/ethnic and socioeconomic backgrounds?
  - If yes, what particular factors were considered?
  - What happened?
  - Have any interventions ever been ruled out based on these student background factors?

**Preparation Phase**

*Now I'd like to hear more about the process of preparing for an intervention to be implemented once it's been chosen. This includes a consideration of potential barriers and facilitators to successful implementation.*

- What factors make it easier to bring an intervention to your school?
  - What factors make it harder?
  
- How do you or others determine the appropriateness of an intervention for your school?
  - Do you consider student race/ethnicity or culture?
  - Do you consider socioeconomic status?
  
- How do you or others determine the feasibility of an intervention for your school?
  - Do you consider school resources?
  - Do you consider the balance of responsibilities for staff?
  - Do you consider any other constraints/practical considerations?

- Which ones?
- Are there any potential barriers to intervention success that you anticipate specifically related to student racial/ethnic or socioeconomic background?
  - How about any facilitators?

### **Implementation Phase**

*I'd like to shift now to discussing actual experiences that you have had with interventions. For this part of the interview, I'm interested in knowing more about what it actually looks like when an intervention is delivered in your school(s).*

- How much communication do you generally have with principals, sector liaisons, and SELD when you are delivering interventions?
- What are your thoughts on the amount of support that you've gotten from...
  - Principal/AP
  - Sector liaison
  - SELD
  - Others?
- What factors do you consider when labeling an intervention a success?
- Tell me about instances where the interventions were successful or unsuccessful.
  - Which interventions?
  - What do you think contributed to their success or failure?
- When delivering interventions, have you experienced any challenges/difficulties/hurdles related to...
  - Staffing
  - Space
  - Time
  - How were these challenges addressed?
- Have there been instances where your initial assessment of the feasibility or appropriateness of the intervention changed?
  - In what way?

- In what ways do the racial/ethnic or cultural backgrounds of students impact the delivery of interventions?
  - How about socioeconomic background?

### **Sustainment Phase**

*Finally, I'd like to discuss the last stage of the implementation process for interventions, which is sustainability. Usually a lot of training and resources go into getting an intervention delivered once with the hope that it can be delivered again in the future. I'd like to understand whether and how the interventions you've delivered have achieved sustainability in your school(s).*

- How many of the interventions that you've delivered once did you deliver again in a school?
  - Did you deliver it in the same school?
  - For these interventions delivered again, was this done with less support than the first time delivered?
  
- To your knowledge, how many of the interventions that you've delivered once were delivered at least one more time in your school(s)?
  
- What factors make sustainability more or less likely?
  
- Who is involved in the decision to deliver an intervention again?
  - What do discussions look like?
  - What factors considered in delivering intervention again?
  
- In what ways do the racial/ethnic or cultural backgrounds of students impact the sustainability of interventions?
  - How about socioeconomic background?
  
- Are there interventions where you had to adapt the intervention to make it more sustainable?
  
- Have you ever chosen to not deliver the full intervention again, but instead used some of the components in your clinical work?

- Do you consider sustainability when choosing which interventions to deliver?

## **Administrator Topic Guide**

Note: Questions preceded by [S] are for school-level administrators and questions preceded by [D] are for district-level administrators.

### **Background Information**

*To start the interview, I'd like to learn more about you, your role in the school/sector/[district], and your general perspective on mental health services in schools.*

- [ALL] How many years have you worked in schools/[district]?
  - What roles have you held while working in schools/[district]?
- [S] How many years have you worked at your current school? In what capacity?
- [ALL] What does a typical day look like for you in your role?
- [ALL] Have you had any training or education in mental health?
- [ALL] What are the mental health needs of your school(s)/[district] schools?
  - What issues do students face that could be addressed by mental health services?
  - In what way do student race/ethnicity and income/SES background affect their mental health needs in school?
  - How do school staff impact your understanding of student mental health needs?
- [S] What kind of services are provided in your school? Who provides these services?
- [ALL] How do mental health services fit in with other priorities in your school(s)/[district] schools?

- [ALL] How familiar/involved are you with Tier 2 interventions in [the district]?
  - Which interventions do you know about?
  - Which interventions have you been involved with?

**Roles within [district]**

*I'm interested in knowing who is involved in bringing interventions into schools and what roles they generally play. We'll talk more in depth about the actual process in a few minutes, but it would be great to get your perspective on who the key players are.*

- [ALL] Who is responsible for successful implementation of interventions in your school/[district] schools?
- [ALL] What is the contribution of the behavioral health team (aka MTSS team, Tier 2 team) in your school(s)/[district] schools?
  - How much confidence do you have in the clinical team at your school(s)/[district] schools?
- [ALL] When it comes to interventions, what is the role of...
  - Principal/AP
  - Sector liaison
  - SELD staff
  - Clinician
    - What other responsibilities does the clinician have in the school (e.g., case manager, teaching)?
- [ALL] What kinds of interaction or communication do you have with them related to interventions?
- [ALL] Are there other key decision-makers within your school(s)/[district] not listed above?

**Exploration Phase**

*Now, I'd like to shift our discussion to the process of actually bringing an intervention to a school from beginning to end. First, I'd like to hear about your thoughts and experiences with the process of considering interventions and making the decision to implement them in a school.*

- [S] Are you familiar with the SELD/[district] push for MTSS and Tier 2 interventions?
  
- [ALL] What do you know about the SELD/[district] push for MTSS and Tier 2 interventions?
  - What is the rationale behind it?
  - What are the goals for this push?
  - Whose concerns is it meant to address? (e.g., families, teachers, principals, etc)
  - What kind of funding is available for these interventions?
  - How does it fit in with [district] goals overall?
  
- [ALL] Please walk me through the process of bringing an intervention to your school(s)/[district] schools.
  - Who initiates?
  - How are the options presented?
  - Why do they offer particular interventions?
  - Who is involved in discussions?
  - How long does this process take?
  - How often does this process happen?
  - Who ultimately makes the decision to bring in an intervention?
  
- [ALL] Have interventions ever been considered specifically to address needs of students from particular racial/ethnic and socioeconomic backgrounds?
  - If yes, what particular factors were considered?
  - What happened?
  - Have any interventions ever been ruled out based on these student background factors?
  
- [D] How are schools chosen for implementation of specific interventions?
  
- [D] Is it possible to predict which schools will successfully implement an intervention?
  - If yes, what factors help you make these predictions?

## **Preparation Phase**

*Now I'd like to hear more about the process of preparing for an intervention to be implemented once it's been chosen. This includes a consideration of potential barriers and facilitators to successful implementation.*

- [ALL] What factors make it easier to bring an intervention to your school(s)/[district] schools? Can be factors at school or intervention level!
  - What factors make it harder?
  
- [ALL] What possible challenges/difficulties/hurdles do you think clinicians could experience with delivering interventions?
  - Staffing
  - Space
  - Time
  - Do you expect more of these challenges for particular kinds of interventions?
  
- [ALL] How do you or others determine the appropriateness of an intervention for your school(s)/[district] schools?
  - Do you consider student race/ethnicity or culture?
  - Do you consider socioeconomic status?
  
- [ALL] How do you or others determine the feasibility of an intervention for your school(s)/[district] schools?
  - Do you consider school resources?
  - Do you consider the balance of responsibilities for staff?
  - Do you consider any other constraints/practical considerations?
    - Which ones?
  
- [ALL] What kind of support do you offer to a clinician/school delivering an intervention?
  
- [ALL] Are there any potential barriers to intervention success that you anticipate specifically related to student racial/ethnic or socioeconomic background?
  - How about any facilitators?

## **Implementation Phase**

*I'd like to shift now to discussing actual experiences that you and others have had with interventions. For this part of the interview, I'm interested in knowing more about what it actually looks like when an intervention is delivered in your school(s)/[district] schools. I understand that you may have had either no or very minimal involvement with the actual delivery of the intervention, but it would still be helpful to get a sense of what you do know about this phase of the process.*

- [ALL] How much communication do you have with clinicians when they are delivering interventions?
  
- [ALL] What factors do you consider when labeling an intervention a success?
  
- [ALL] Are you aware of instances of successful or unsuccessful intervention delivery in your school(s)/[district] schools?
  - Which interventions?
  - What do you think contributed to their success or failure?
  
- [ALL] Are you aware of any challenges/difficulties/hurdles experienced related to...
  - Staffing
  - Space
  - Time
  - How were these challenges addressed?
  
- [ALL] What modifications, if any, do you know of clinicians or schools making to the interventions?
  
- [ALL] From your perspective, what additional support could clinicians/schools have received to make intervention delivery easier?  
From...
  - Principal/AP
  - Sector liaison
  - SELD
  - Others?
  
- [ALL] Have there been instances where the initial assessment of the feasibility or appropriateness of the intervention changed?



- In what way?
- [ALL] In what ways do the racial/ethnic or cultural backgrounds of students impact the delivery of interventions?
  - How about socioeconomic background?

### **Sustainment Phase**

*Finally, I'd like to discuss the last stage of the implementation process for interventions, which is sustainability. Usually a lot of training and resources go into getting an intervention delivered once with the hope that it can be delivered again in the future. I'd like to understand whether and how interventions have achieved sustainability in your school(s)/[district] schools from your perspective.*

- [ALL] To the best of your knowledge, how many interventions in your school(s)/[district] schools have been delivered at least twice? This can be a rough estimate of percentage.
  - For these interventions delivered again, was this done with less support than the first time delivered?
- [ALL] Who is involved in the decision to deliver an intervention again?
  - What do discussions look like?
  - What factors considered in delivering intervention again?
- What factors make sustainability more or less likely?
- [ALL] Are you aware of instances where a clinician/school had to adapt the intervention to make it more sustainable?
- [ALL] In what ways do the racial/ethnic or cultural backgrounds of students impact the sustainability of interventions?
  - How about socioeconomic background?
- [D] What differentiates a site that sustains interventions from one that doesn't?
- [D] How do you predict which sites will sustain the intervention with less support?

- [D] Is an intervention considered “sustained” if it isn’t fully implemented but components are?
  - Have there been cases where just components have been delivered again?
  
- [D] Is sustainability considered when choosing which interventions to offer?