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Designing Context-Specific Interventions: Maximizing Treatment Fit and Engagement in Low- and Middle-Income Countries

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Designing Context-Specific Interventions: Maximizing Treatment Fit and Engagement in Low- and Middle-Income Countries

A dissertation submitted in partial satisfaction of the

requirements for the degree Doctor of Philosophy

in Psychology

by

Resham Carole Gellatly

2021

ABSTRACT OF THE DISSERTATION

Designing Context-Specific Interventions:
Maximizing Treatment Fit and Engagement in
Low- and Middle-Income Countries

by

Resham Carole Gellatly
Doctor of Philosophy in Psychology
University of California, Los Angeles, 2021
Professor Bruce Frederick Chorpita, Chair

The gap between the need for mental health treatment and access to services is vast, especially in low- and middle-income countries (LMICs; Wang et al., 2007), and particularly among children and adolescents in these under-resourced settings (Patel et al., 2008). Closing the gap has become a public health priority in recent years (Lancet Global Mental Health Group, 2007). Task sharing and scaling up evidence-based treatments (EBTs) have been identified as two possible strategies to addressing the gap, with promising results (Singla et al., 2014). However, questions remain concerning the transportability of treatments developed in the West

to populations for whom they were not initially intended, and in contexts that bear little resemblance to the highly controlled research settings in which they were conceived.

The goal of this dissertation was to describe the process of building a context-sensitive, context-centered intervention using an evidence-informed design system and to evaluate user acceptability, satisfaction, and engagement. The first study used qualitative methods to document the iterative process of developing a treatment protocol in collaboration with local stakeholders and experts. Results demonstrate the central role that cultural/contextual considerations, protocol material and content, and complexity played in the design process, providing a blueprint for bringing together established treatment design principles with local knowledge to develop an intervention that is acceptable to providers and satisfying for youth participants in low-resource settings. The second study evaluated youth engagement in the intervention, as well the overall acceptability, feasibility, and fit of treatment from the youth and provider perspectives. Findings revealed that youth and providers largely perceived the treatment to be engaging, acceptable, and appropriate for the context. These results, along with participant recommendations for improvements, have the potential to inform the development of resources that promote youth engagement in the intervention. Taken together, these studies provide an inside look at the collaborative design-in-context approach of building an intervention in a low-resource setting along with users' experience with the intervention in an initial pilot. Findings have the potential to narrow the treatment gap through promoting the development and scale up of acceptable, effective, and sustainable mental health treatments for one of the most vulnerable populations: children and adolescents in LMICs.

The dissertation of Resham Carole Gellatly is approved.

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2021

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CHAPTER 1:

A Qualitative Analysis of Collaborative Efforts to Build a Multi-Problem, School-Based Intervention for Common Adolescent Mental Health Difficulties in India

Abstract

In low- and middle-income countries (LMICs), the gap between need for treatment and access to services is especially stark, particularly among children and adolescents. This study evaluated the approach of designing a school-based, stepped care, multi-problem mental health treatment in its intended context, using a combination of local wisdom and knowledge derived from the evidence base, in an effort to narrow the treatment gap. Specifically, the current study aimed to qualitatively describe the process of developing a stakeholder-informed intervention for adolescents in urban Indian schools. Qualitative sources included meeting notes, in-text feedback, field notes, and supervision notes, which were coded and analyzed using the qualitative analytic approach of coding consensus, co-occurrence, and comparison. Descriptive statistics were conducted to characterize the frequency of codes across qualitative sources. Results revealed that codes involving cultural/contextual considerations, protocol material and content, and complexity arose consistently throughout treatment development and across document types, illustrating their central role in the design process. These findings have implications for the future of mental health treatment development and implementation in LMICs and high income countries (HICs) alike.

Introduction

Around the world, millions of people suffer from mental illness. The 2010 Global Burden of Disease Study found that mental disorders were the leading cause of years lived with disability (YLD), accounting for 32.4% of all YLDs worldwide (Vigo, Thornicroft, & Atun, 2016). Despite the high need, up to 90% of those affected by mental illness in low- and middle-income countries (LMICs) do not receive care (Kohn, Saxena, Levav, & Saraceno, 2004; Wang et al., 2007). This unmet need is often referred to as the "treatment gap." Individuals with mental illness in LMICs face numerous barriers to treatment, including low mental health literacy, stigma around mental disorders, and lack of trained mental health workers (Barker, 2007). India, home to 1.3 billion people, is no exception. Trained mental health professionals are scarce, with an estimated 4000 psychiatrists for the entire population, compared with approximately 50,000 psychiatrists for 300 million people in the United States (Patel, 2012). Were India's psychiatrists to do nothing other than see clients full-time for a year, they would be able to serve less than 10% of individuals in need, illustrating the dire need for a trained workforce (Patel, 2009).

The gap between the need for services and access to treatment is even more pronounced for children and adolescents (Patel, Flisher, Nikapota & Malhotra, 2008). Young people, defined by the World Health Organization (WHO) as between 10 and 24 years old, may be particularly impacted by lack of access to services. Youth face additional barriers to treatment, such as lack of knowledge about navigating healthcare systems and concerns about confidentiality (Patton et al., 2016). Health risks that increase during adolescence, including alcohol and tobacco use, injuries, obesity, infectious diseases, and sexually transmitted infections and pregnancy, are associated with negative mental health outcomes (Patton et al. 2016). In LMICs, early exposure to poverty and associated stressors including substance use, violence, inadequate education, and

limited employment are risk factors for and consequences of mental disorders (Patel, Flisher, Hetrick, & McGorry, 2007). Adolescents in India, who comprise nearly a quarter of the country's population and represent 20% of adolescents worldwide, may be at heightened risk for developing psychosocial problems due to these stressors coupled with rapidly changing cultural norms and values in the context of globalization (Pillai et al., 2008). Given the high proportion of children and adolescents in many LMICs, the potential burden of untreated mental health disorders in this age group is significant (Patel et al., 2008).

The global mental health field has prioritized closing the treatment gap (Lancet Global Mental Health Group, 2007). Several potential strategies to addressing this gap have been proposed and tested; two of the most promising are (1) task sharing, and (2) scaling up evidence-based treatments (EBTs). Task sharing is an approach in which non-specialist providers (NSPs) are trained to deliver psychological treatments with support from mental health specialists (Singla et al., 2014). Task sharing addresses the issue of the limited specialized workforce in LMICs, although experts in mental health are still critical to ensuring quality delivery of services through training, supervision, and monitoring and evaluation (Patel, 2009). A recent meta-analysis found that interventions delivered by NSPs had medium to strong effects on improving outcomes in adults with common mental health problems, which include depressive, anxiety, and posttraumatic stress disorders (Singla, Kohrt, Murray, Anand, Chorpita, & Patel, 2017).

Another proposed solution for narrowing the treatment gap has been adopting EBTs developed and tested in high-income countries and implementing them wholesale in LMICs. Given the demonstrated effectiveness of EBTs in the United States and other Western settings, some researchers have advocated for the implementation of those same EBTs in LMICs, where they have the potential for significant impact (Pearson & Jordan, 2010), without making

modifications that could potentially compromise effectiveness. For example, the WHO has supported the use of EBTs in their Mental Health Gap Action Programme (mhGAP). In recent years, a number of EBTs have been implemented in LMICs, with evidence supporting their effectiveness and feasibility (Bolton et al., 2007; Bolton et al., 2003; Bolton, Bass, & Murray, 2011; Patel, Chowdhary, Rahman & Verdeli, 2011; Rahman, Malik, Sikander, Roberts, & Creed, 2008). Although the majority of these studies have been conducted with adult populations, several child-focused EBTs have been tested in LMICs as well, with positive outcomes (Bolton et al., 2007; O'Callaghan, McMullen, Shannon, Rafferty, & Black, 2013).

Findings that EBTs developed in high-resource settings can be effective in treating LMIC consumers offer hope that the treatment gap can be addressed through dissemination and implementation of established treatments. However, implementing an evidence-based treatment in a context for which it was not designed has its challenges. The majority of EBTs for youth in the West have been developed in research settings and tested primarily with middle class, Non-Hispanic White children and families (Southam-Gerow, Rodriguez, Chorpita, & Daleiden, 2012). Youth in LMICs differ from these participants in terms of ethnicity, socioeconomic status, and culture. Given the high level of comorbidity between different mental disorders among the general population (Kessler et al., 2011), children and adolescents in need of treatment in LMICs are also likely more clinically complex than subjects of research trials, which typically exclude individuals with comorbid disorders. In addition, the context of care in LMICs bears little resemblance to that of clinical trials in the West, where study providers typically have a mental health background, extensive training in the practice they deliver, implementation supports such as ongoing supervision and consultation, and access to resources (e.g., supplementary materials, printers, therapy rooms).

Given these differences, there is a potential lack of fit between treatments developed in the West and the target population in LMICs. Making adaptations to EBTs is seen by some as an essential way to enhance acceptability, feasibility, and effectiveness of treatments for new contexts. Typical adaptations include translating materials into local languages, incorporating cultural idioms (although, see Kliewer et al., 2011 for exceptions), analogies, and practices, increasing accessibility of materials by reducing the amount of text for low literacy populations, and adjusting session length and treatment duration. One might be concerned that these adaptations could compromise the effectiveness of transported EBTs, and that is a potential risk. However, the efficacy of EBTs adapted for LMICs has been demonstrated in several trials, suggesting that core components of treatment can remain intact even after significant adaptations have been made (Kaysen et al., 2013; Patel et al., 2017; Patel et al., 2011; Verdeli et al., 2003; Verdeli et al., 2008). Nevertheless, given the extent of adaptations made to EBTs to render them feasible in LMICs and the complexity of the adaptation process (Kaysen et al., 2013; Murray et al., 2013), it is worth considering whether there might be another approach to designing treatments for LMICs depending on the constraints of a specific setting and the needs of the target population.

Building a treatment *for* a context *in* that context has been proposed previously as a way to increase a treatment's fit with the intended population (Chorpita, 2002). Despite a proliferation of EBTs with demonstrated efficacy in research settings, youth receiving these treatments in community clinics often do not improve at the level expected (Weisz et al., 2013). Multiple factors likely contribute to the relatively poor outcomes, from outer context factors, such as service system policy and funding environments, to inner context factors, including organizational, provider, and consumer characteristics (Aarons, Hurlburt, & Horowitz, 2011).

Overall, the highly controlled environments in which treatments are developed do not resemble the settings for which they are intended. Because of this, there have been calls to develop and test interventions outside of research university settings, in the contexts where they will ultimately be implemented, with input from treatment providers and recipients (Chorpita, 2002; Weisz, 2015).

The mission to build a treatment that fits with real-world contexts has led to innovations in mental health treatment design, culminating in the creation of systems that help providers address the complexities of working with youth in community settings. In deciding on a design approach for the current study, the development team determined (see Chorpita et al., 2020) after trialing candidate EBTs that building in context was more suitable to the project aims than the previously described approaches. The team initially considered adapting promising candidates that were transdiagnostic and had high flexibility that might lend themselves to a new context, but ultimately decided they were still too far off from the desired intervention goals. In executing the strategy of building in context, the design team used resources from the Managing and Adapting Practice (MAP, Chorpita & Daleiden, 2014) direct service builder system. MAP provides a toolkit enabling providers to design their own treatments individualized for clients using evidence-based elements and systems of coordination. Given the evidence that MAP's design principles (see Chorpita & Daleiden, 2018) can be used to build effective, well-liked treatments for specific settings, it is worth investigating whether its evidence-based content, design principles, and collaborative method could be used to build a context-sensitive treatment in an LMIC.

The current study describes the process of using this evidence-informed design system to develop a modular, multi-problem treatment for adolescents in India in collaboration with local

experts and stakeholders. A flexible, transdiagnostic treatment for adults with mood and anxiety disorders was previously developed using Chorpita, Daleiden, and Weisz's (2005) common elements approach (Murray et al., 2014) and tested in LMICs, with positive results (Murray, Dorsey, & Weisz, 2012). However, it was designed for three countries, not one specific context, and did not include the active involvement of users in the treatment design process. The current study packages evidence-based practices for youth with common mental health disorders in a modular format using a user-centered design (UCD) approach. Candidate practices were identified through a review of the mental health literature using the Distillation and Matching Model (DMM, Chorpita, Daleiden, & Weisz, 2005) and chosen through consultation with local experts (see Boustani et al., 2020, for a detailed account of this process).

UCD calls for user involvement throughout the design process, primarily through a process of rapid prototyping in which users provide feedback on low-fidelity versions of a product that is then refined by the design team. This iterative process has been demonstrated to increase a product's ease of use and fit with users (Gordon & Bieman, 1995). In recent years, taking a UCD approach to mental health treatment development and implementation has been proposed as a way to increase the effectiveness and acceptability of interventions (Lyon & Koerner, 2016). Involving users in treatment development increases the chances that the end product will be acceptable and useful to the target users, which in turn raises the likelihood that the treatment sees sustained use (Taylor & Todd, 1995). This study aimed to qualitatively describe the process of developing and implementing a stakeholder-informed mental health intervention using UCD principles to maximize fit, acceptability, and scalability.

Method

The current study gives a rich qualitative picture of the iterative design and the negotiated concerns and priorities of the front line designers and the implementation and clinical teams involved in developing a multi-problem, modular, school-based intervention for anxiety, depression, and conduct problems for adolescents in India. Qualitative methods were used to describe the process of intervention development beginning in the "design and build" phase of a three-phase development process (Chorpita et al., 2020) and running through the end of a clinical case series (CCS) during which the protocol was piloted in Goa and Delhi, India. Data were collected between November 2016 and May 2019. All study procedures were approved by the Institutional Review Boards at the University of California, Los Angeles, Harvard Medical School, Sangath, and the Indian Council of Medical Research.

Background of the PRIDE study

PRIDE is a research program whose goals are to (1) develop a transdiagnostic, stepped-care intervention targeting common mental disorders in school-going adolescents in India, and (2) evaluate its effectiveness in reducing symptom severity and improving recovery rates among adolescent participants. PRIDE takes a stepped care approach and is comprised of two sequential treatments of incremental intensity (Steps 1 & 2). Stepped care reserves more intensive treatments for individuals who do not benefit from initial, lower-intensity treatments, or for those who are determined to need more intensive services at the outset, thus increasing accessibility and efficiency of evidence-based mental health care (Bower & Gilbody, 2005), which is particularly important in low-resource settings. Step 1 is a brief (4-5 session), low-intensity problem solving intervention guided by lay providers and supplemented by a printed workbook (see Michelson et al., 2020, for a full description of the development of Step 1). Step 2 is a high-

intensity, face-to-face psychological treatment delivered by qualified psychologists to adolescents who are non-responders to Step 1 as determined by locally-validated cutoff scores on the Strengths and Difficulties Questionnaire (SDQ; Bhola, Sathyanarayanan, Rekha, Daniel, & Thomas, 2016).

The intervention underwent a multi-process evaluation in two broad phases of research, drawing on PREMIUM methodology for developing and scaling up psychological treatments in low-income settings (Patel et al., 2014). Phase 1 consisted of intervention development and formative evaluation, including a CCS and pilot RCT. Phase 2 evaluated the intervention through a full-scale RCT. The current study examined treatment engagement in the Step 2 intervention in the Phase 1 CCS.

Collaborative Design Process

A comprehensive overview of the collaborative design of Step 2 from conception through early piloting is outlined elsewhere (Chorpita et al., 2020) and is recommended to readers of the present paper, as it provides a detailed description of the theory behind and activities involved in the development process. For the purpose of the current study, the broader process of developing the Step 2 intervention, which was composed of three phases of formative activities (see Figure 1, from Chorpita et al., 2020), will be described in brief.

The first phase was an intensive *context review* by members of the Intervention Working Group (IWG), comprised of an intervention development team at UCLA who worked closely with research coordinators and clinical experts based in the UK and at Sangath, India, and the Scientific Advisory Group (SAG), a group of international researchers and clinicians with expertise in global mental health and treatment design. This phase included in-person visits to schools in Goa and Delhi, India, and review of the literature, local policies, and research

conducted by various Sangath teams in order to assess student and provider needs and preferences. The review of the context resulted in a *Statement of Values and Preferences* that informed the team's design decisions in the next phase of development. The second phase of formative activities, *adopt-adapt-assemble*, centered around deciding on a treatment design strategy that would result in a protocol that satisfied the values and preferences identified in the context review phase. The team considered whether it would be appropriate to *adopt* an existing evidence-based treatment (EBT) and transport it to the PRIDE context as-is; *adapt* a candidate program by modifying certain features to increase fit with the target context; or *assemble* the treatment specifically for the Indian school context using evidence-based practices and strategies. The IWG and SAG spent a significant amount of time discussing these potential pathways forward before deciding that assembling the protocol for the context was the best option given the distinct features of the setting and the values and preferences identified in the prior phase of activity, such as the need to balance flexibility and structure within a relatively complex, multi-problem protocol delivered by a non-specialist workforce. This second phase of formative activities resulted in the *Parameter Specification* output, which mapped onto the dimensions outlined in the *Statement of Values and Preferences* and specified the tiers of control guiding decisions related to resources, activities, coordination, and outcome integrity. The *Parameter Specification* values were used to organize development of the protocol blueprint in the third and final phase of formative activities: *design and build*.

The design and build phase, much of which is the focus of the current study, began with identification and selection of practices to include in the Step 2 protocol (Boustani et al., 2020). Priority problems and needs of the target population were identified using the Youth Top Problems Assessment, a brief idiographic instrument on which youth identify and rank by

severity their top three problems (Weisz et al., 2011), at the two sites for this research project. The UCLA team used a simplified approach to relevance mapping (Chorpita, Bernstein, & Daleiden, 2011) to identify a selection of evidence-based practices that would cover the maximum number of reported youth problems. According to the literature, practices relevant to the problem types and age group included rapport building, psychoeducation, goal setting, relaxation, behavioral activation, assertiveness and communication skills, exposure, problem solving, cognitive coping, and maintenance. The IWG discussed the suitability of these practices for the context, including how acceptable they were for the youth population and the feasibility of practice delivery for a non-specialist workforce, and decided to move forward with their inclusion. The current study documents the process of building the Step 2 treatment from post-practice selection through the conclusion of two clinical case series in Goa and Delhi during which successive iterations of the protocol were piloted.

Design Objectives

Based on the literature and feedback from youth and providers regarding their experiences with Step 1 protocol materials (Michelson et al., 2020), we identified a number of design objectives for the Step 2 protocol development during the latter half of the design and build phase. Design objectives fell into two categories: content (back-end) and format (front-end). Content design objectives were defined as characteristics of the protocol that met the needs of the target population and clinicians delivering the intervention, whereas format design objectives were defined as aspirations for the look and feel of the protocol.

Content Design Objectives

Content design objectives of the protocol concerned the data and logic components of the intervention. For example, assessment, planning, intervention practices and coordination,

monitoring, and supervision were considered "back end" matters that were within the purview of the intervention developers and researchers in the IWG, as they were primarily responsible for determining what practices were indicated for the target population, how those practices go together, who should receive what practices based on initial assessment and ongoing monitoring scores, and how to support providers in treatment delivery. Major content design objectives for the protocol included the following: (a) multi-problem focus; (b) efficient to learn and deliver; (c) feasible within a limited (~35 minute) clinical encounter; (d) appropriate for a workforce with varied educational backgrounds; (e) able to be delivered by providers after a relatively condensed training; (f) able to be delivered within a set number of sessions for a problem; (g) fit within a stepped care model whose initial step involves a brief (4-5 session), provider-led, low-intensity problem solving intervention delivered using a printed workbook.

Format Design Objectives

Format design objectives were articulated for the purpose of designing a protocol interface that met its end users' wants and needs. Provider considerations included the appropriate level of complexity; a protocol interface that was acceptable and enjoyable; and high perceived utility. Goals for the youth experience were similar: appropriately complex; student-facing materials that were likeable; and strong fit with the culture and context. Therefore, format design objectives were specified as: (a) culturally appropriate for India (appropriate graphics, examples, analogies, activities); (b) intuitive and suitable for the workforce; (c) engaging for youth; (d) accessible for youth with varying levels of literacy; (e) reduce barriers to implementation (e.g., reducing the number of assessments, providing worksheets rather than workbooks for each individual student).

Participants

Intervention Working Group (IWG). The intervention working group (IWG) was comprised of an intervention development team at UCLA who worked closely with research coordinators and clinical experts based in the UK and at Sangath, India. The IWG communicated frequently by email and in meetings that were held at least every month and sometimes as often as weekly during certain stages of development. The IWG members who most regularly participated in meetings included the PI on the project (VP), the treatment development team from UCLA (BC, MB, RG, KK), and members of the India-based treatment development team (DM, KM). The first author (RG) was a participant-observer in the study and was also a treatment provider in Goa, though she is not included in the provider sample described below.

Provider sample. This study included mental health providers (N = 5) employed by Sangath, a non-governmental, non-profit organization conducting research and providing psychosocial services across India. All providers participated in weekly supervision meetings. One provider (KM) was part of the IWG and joined IWG meetings regularly throughout the pre-implementation and implementation phases. Other providers joined IWG meetings less frequently. Participants consisted of one (20%) expert provider (i.e., no degree in psychology but significant experience working as a provider on mental health interventions and studies within Sangath), two (40%) Master's psychologists, and two (40%) post-doctorate clinical psychologists. All providers were Indian nationals and self-identified as female. The average age of providers was 30.8 years (SD = 4.55, Range = 26-38) and the mean number of years of clinical experience was 7.8 (SD = 2.39, Range = 5-11). Four providers (80%) had previously delivered services in secondary schools; three (60%) had been therapists on research studies or in community mental health settings; and all (100%) had experience working in clinic and hospital

settings. Providers (100%) reported delivering services in English and Hindi; one provider (20%) also reported providing treatment in Konkani and Marathi.

Measures

In order to describe the process of developing a stakeholder-informed mental health intervention for adolescents in a low-resource setting, we coded qualitative data sources, including meeting notes, in-text feedback on protocol components, field notes, and supervision notes.

Meeting notes. Meetings primarily included members of the IWG, although providers joined meetings periodically. Detailed notes were taken by the first author (RG) at meetings conducted over Skype beginning in November 2016, after the intervention practices had been selected and finalized. Notes were circulated via email to the broader research team, including the PI (VP) of the study, who then reviewed the suggested protocol modifications and made recommendations.

In-text feedback. Throughout the iterative revision process, members of the IWG, as well as providers, made in-text edits to and comments on the protocol. Documents with comments and edits relevant to protocol development were coded.

Field notes. Field notes are a critical component of qualitative research, providing rich contextual information to inform data analysis (Creswell, 2013; Lofland, Snow, Anderson, & Lofland, 2005; Mulhall, 2003; Patton, 2002). The first author (RG) took field notes primarily as a means to document informal conversations related to treatment development and implementation that occurred amongst the IWG and providers.

Supervision notes. In each weekly supervision meeting throughout the clinical case series, different providers took turns taking notes on meeting content. Supervision meetings were

also audio-recorded, and the first author (RG) cross-checked a random sample of notes against their corresponding recordings to ensure accuracy.

Data Analysis

Data sources (meeting notes, in-text feedback, field notes, and supervision notes) were coded and analyzed using the qualitative analytic approach of coding consensus, co-occurrence, and comparison described by Glaser and Strauss (1967) and Willms (1990). The first author (RG), who served as master coder, generated an initial set of *a priori* codes and definitions based on the Statement of Values and Preferences and Parameter Specifications generated in the first two phases of formative activities (Chorpita et al. 2020). Codes that were relevant only to earlier phases of development (e.g., funding) were excluded from the coding manual. Based on the team's interest in assessing whether the protocol fit the context as planned, Cultural/Contextual Considerations, which was not included as a dimension in the earlier outputs, was added as a code. Emergent codes were allowed to arise through the process of coding, consensus, and comparison. For example, secondary (child) codes were added during the coding process after recognizing the need to provide additional specificity to broad codes such as Time, which was broken down further into Session Duration, Spacing of Sessions, Treatment Duration, and Impact of School Calendar. See Appendix A for more information about this coding system.

All documents were coded using Dedoose, a qualitative data analytic software program. Eight undergraduate research assistants were trained in coding theory and procedures via two one-hour training sessions that included review of the coding scheme, review of each individual code (using examples), group coding of a sample document using Dedoose, and group discussion of potential new codes. Following the training, each coder was assigned two documents to code independently for practice and to gain familiarity with Dedoose. Issues that arose during practice

coding were discussed and resolved as a group. The coding framework was then applied to two "gold standard" documents by the master coder. Research assistants were assigned the gold standard documents, and their coding was compared to the master coder's coding. Discrepancies were discussed in a group meeting, and codes and definitions were refined after reaching consensus. The remaining documents were divided among the coders for independent coding. Coders were encouraged to identify potential emergent codes, which were discussed amongst the coding team in weekly meetings and incorporated into the codebook if consensus was reached on the value of their inclusion. All coding was reviewed by the master coder, who left memos in Dedoose for the coder to address; research assistants were asked to meet with the master coder to discuss questions about the memos, and final codes were not applied until consensus was reached.

Results

Qualitative Themes

Coded documents were comprised of four categories: meeting notes, in-text feedback on protocol documents, field notes, and supervision notes. All documents were coded using the same coding framework. Documents were categorized into two phases for analysis: the pre-implementation phase, which began in November 2016 and ran through July 2018, and the implementation phase of the clinical case series, which ran from August 2018 through May 2019. Pre-implementation documents were analyzed separately from implementation phase documents, which were further divided into two categories: 1) supervision notes with providers only, and 2) meeting notes with the IWG, which providers sometimes joined, and field notes. These categories were analyzed separately in order to examine differences in the type and

frequency of codes applied in supervision with providers only compared to meetings with the larger team.

The following tables present codes that were applied in at least 60% of documents in each phase of implementation, along with definitions and exemplar quotes. Coded topics that arose in less than 40% of total documents per each of the three analyses were dropped. Of code categories that included both primary (parent) codes and secondary (child) codes, only secondary codes were included in the analysis to provide specificity of code application.

The most frequently applied codes in the pre-implementation phase were cultural/contextual considerations (84%), student-facing materials (80 %), practice content (71%), provider-facing materials (69%), episodes (69%), complexity – student (62%), and engagement (60%) (see Table 1).

In the implementation phase, the most commonly reported codes in meeting and field notes were provider-facing materials (90%), clinical decision making (86%), practice content (82%), cultural/contextual considerations (77%), assessment (73%), treatment architecture (73%), complexity – student (68%), monitoring (64%), and complexity – provider (64%) (see Table 2).

Peer supervision notes from the implementation phase were also coded. The most prevalent codes were provider-facing materials (96%), engagement (96%), complexity – student (96%), practice content (83%), clinical decision making (78%), student-provider relationship (78%), complexity – provider (74%), cultural/contextual considerations (70%), and episodes (61%) (see Table 3).

Discussion

This study describes the process of designing a protocol to address the mental health needs of adolescents in India using qualitative methods to identify key challenges, considerations, and conversations that arose during the collaborative treatment development process. While aspects of this process have been described in detail elsewhere (Boustani et al., 2002; Knudsen et al., under review), and while the overarching theory informing the development process is critical to understanding the rationale for and steps involved in building the treatment (Chorpita et al., 2020), the current study offers a unique, behind-the-scenes look at the ways in which large, cross-national teams negotiate the terms of intervention design and reach consensus on complex decisions using a combination of local knowledge and the broader evidence base. Results illustrate how priorities shifted throughout the implementation process and highlight the types of issues most relevant to different groups of team members. The prevalence of topics and descriptive exemplars of their content shed light on ways in which the treatment development team successfully anticipated and addressed challenges, as well as the areas in which they fell short. These findings have implications for the next phase of the PRIDE research project and for the future of treatment design and development more broadly in LMICs and HICs alike, as they illuminate issues likely to require substantial time and consideration in the design process.

As described earlier, the treatment design team decided on pursuing the *assemble* strategy for Step 2 treatment development after considering *adopt* and *adapt* approaches and deciding that existing candidate interventions did not meet the needs and preferences of the context (Chorpita et al., 2020). Results from the current study suggest that while not perfect, the collaborative Step 2 design process may have facilitated exchange of ideas between the local

(Indian) implementation team, the intervention design laboratory at UCLA, and international experts, and that most major design considerations identified at the outset of the design phase remained relevant throughout, though the content of their discussion varied depending on stage of implementation and discussants.

Fours codes arose consistently throughout the development and implementation process and across document types: cultural/contextual considerations, practice content, provider-facing materials, and student complexity. Although the frequency of applications of these codes differed between the three document categories, the consistency in their prevalence underscores their importance and suggests that while these issues can be considered and partially mitigated in advance of implementation, on-the-ground challenges are likely to arise due to the complexities of culture that reveal themselves within contexts, students' understanding and use of practice content once they actually interact with it, and the ways in which providers interface with materials when using them in real-life sessions. For example, in the pre-implementation meeting notes, culture was taken into consideration when designing materials, as in the suggestion to include "use of local terms for anxiety/depression ('tension')," whereas in supervision notes during implementation, providers raised the contextual challenge of space: "Need to do something about the noise levels in the clinic; lots of background noise from other counselors and construction." Similarly, the topic of discussion of complexity of student materials and content shifted over time. Pre-implementation, the IWG noted the importance of incorporating visuals to facilitate student comprehension and reduce the burden of writing, e.g., "Instead of handout, could have flashcards, flipchart, vicious cycle with blanks to fill in. Have something visual/graphic that is interactive; eliminate writing as much as possible." Although the design team followed through with this recommendation and created materials that were visually

pleasing and that students found acceptable (Gellatly et al., in preparation), other issues related to the complexity of student content cropped up during implementation. In supervision, a provider described a student's difficulty grasping content in the assertiveness and communication module: "Currently in assertiveness and communication. Taking some time to understand the concepts. Could only relate to conflict. Provider had to explain more and go more slowly with him." These concerns were then brought to the IWG, and potential solutions were discussed and documented in meeting notes: "Use of vignettes – feedback from counselors has been that youth like the scripts, it helps make concepts more understandable and concrete." Rather than seeing the persistent presence of these four codes as a failure on the part of the design team to anticipate and address challenges prior to implementation, it may be helpful to recognize that it is expected and perhaps even positive that these topics continued to be discussed during the implementation phase, and that issues brought up in supervision were brought into the larger team meetings as well.

At the same time, the downward trend in the frequency of application of the cultural/contextual code from pre-implementation to implementation suggests that robust discussion of this topic prior to implementation may have been effective in reducing challenges in this sphere and that the design team's efforts to build a protocol that would fit the culture and context was as successful as it could have been at that stage of development. Similarly, student-facing materials were discussed at length in the pre-implementation phase and were not raised as prominent concerns during the implementation. The UCLA design team spent a considerable amount of time prototyping student materials and eliciting feedback from the India design team in the pre-implementation phase. These efforts may have led to student-facing materials that, per

providers' perceptions during implementation and student exit interviews (Gellatly et al., in preparation), were largely acceptable to student participants.

Two codes came up in pre-implementation meeting notes and supervision notes but did not reach the threshold of inclusion in the implementation meeting and field notes analysis: episodes, which concerned the transition from Step 1 to Step 2, and engagement, which related to student engagement in the intervention. It is possible that while the design team spent time planning for challenges associated with stepping up and engagement in the pre-implementation phase of development, providers faced significant, unanticipated obstacles with these components during implementation. For example, pre-implementation conversations about engagement revolved heavily around the engagement literature, such as the suggestion to "Use engagement strategies available from the literature and include in workbook. For example: instilling optimism that the program works; setting expectations about what to expect from counseling; use of motivational enhancement techniques . . ." These engagement strategies were incorporated into the intervention and may have facilitated student engagement. During the CCS, however, providers faced barriers to engagement related to school stressors and logistics, such as the provider who said in supervision, "Right now, students aren't even showing up to sessions because of the exam period; academic stressors take precedence." Yet engagement did not emerge as a frequent topic of discussion in the implementation meeting notes, suggesting there was either a breakdown in communication between providers and the larger IWG, or, conversely, providers may have felt like they had enough support from one another to address these challenges as a team in supervision meetings. Future phases of Step 2 piloting might include a formal feedback mechanism through which providers can directly communicate concerns to the larger design team, including topics like student-provider relationship, which emerged as another

significant theme in supervision but not implementation meetings notes, and that have broader implications for design despite seeming to be constrained to a more proximal clinical context.

Clinical decision making and provider complexity were coded at similar rates in meeting, field, and supervision notes during the implementation phase, while they were not frequently discussed during the pre-implementation phase. Providers reviewed the manual and other provider-facing materials during the pre-implementation phase and provided feedback, which the design team incorporated into the many iterations of the protocol that were shared with providers prior to implementation. However, not until the manual was used in practice did a number of issues come to light. In supervision, it was noted that "There are a lot of loopholes in the manual, like when to use the treatment planner. Could put instructions for how to use it in the manual, like bringing it out at the start of each module to orient the student to where they are in the treatment." This question of how much support to build into the protocol without sacrificing flexibility was discussed in IWG meetings, where the group agreed with providers' suggestion to add more structure: "Struggling with material: We can try and make manual more structured, which can give the beginner therapist more structure but as they become experienced, they can have more flexibility." Providers also described a need for more support with clinical decision making, which was another component of the protocol with a high level of complexity. In supervision, providers expressed frustration with the lack of clarity about how to select a treatment focus for a student: "What is the information we need to gather in order to make a decision about flow after relaxation? Are we looking at scores? Progress monitoring tools? Goals? What variables do we need to look at to better understand which flow to take?" A potential solution to this was offered in an IWG meeting: "Need to have more structure/prompts/script in the manual for the therapist to gather more information about the

student's problem. Difficult for the therapist to decide what flow the student should go into if there isn't a lot of information about the problem." In addition to revising the manual to include more guidance for providers to gather this information, the team responded to providers' desire for more support by creating a one-page decision-making resource that was found to be effective and acceptable, and which providers began using regularly when making decisions about treatment flow (Knudsen et al., under review). Conversations about clinical decision making and provider complexity likely contributed to the IWG's focus on monitoring, assessment, treatment architecture, and quality assurance and improvement, all of which were prominent codes in implementation meeting and field notes but not in supervision notes. It is not surprising that these topics were discussed at length in meetings with the IWG, as they concerned "back end" development issues that were within the IWG's domain.

One of the aims of the adopt-adapt-assemble (second) phase of formative activities (Chorpita et al., 2020) was to generate a set of parameters that fit with the values and preferences identified in the context review (first) phase of development. The parameters identified in the second phase were divided into design-time and run-time categories in order to differentiate between clinical procedures whose inclusion were determined in advance by the design team (design-time) and those whose selective inclusion would be reserved for the therapeutic context (run-time), in hopes that Step 2 providers would have enough support from the manual, training, and supervision (all products of design-time) to make run-time decisions in session. Building in this distinction allows for flexibility within an evidence-informed system and has been a key feature in effective and widely implemented treatments (e.g., MAP; Chorpita & Daleiden, 2014). At this stage of treatment development, however, maintaining the boundaries between design-time and run-time was difficult. Given that this study was the initial case series of the Step 2

treatment, challenges emerged that typically would not come up in a more advanced stage of treatment development, when the messiness and uncertainty associated with trialing a new intervention in a brand-new context has passed. These challenges impacted providers' level of comfort making run-time decisions, such as how many sessions to extend a module, because they felt they lacked the clarity and autonomy to do so. The design team specified parameters regarding the types of modifications that could be made without consensus from the larger team. Modifications that could be made without approval from the IWG were minor and largely related to the interface (look and feel) of the protocol. Changes that were structural in nature and concerned back-end issues were brought to the IWG for discussion, and decisions were not made until critical threshold was reached in terms of the number of students and providers who had engaged with the content or materials in question. Therefore, providers had to tolerate uncertainty as the IWG waited on more participant data to help them come to decisions about design modifications, which limited providers' run-time decision-making abilities. The tension of that process emerged in the current qualitative findings, as well as the provider exit interviews (Gellatly et al., in preparation).

As uncomfortable as that phase of the process may have been for providers, it was necessary in that it allowed the team to make data-driven decisions about protocol revisions. When revisions were deemed necessary, they were typically made to solidify key structural (back-end) design considerations, often with the aim of giving providers tools to support them in making run-time decisions. For example, we piloted a decision-making resource with a sample of Indian counselors in response to Step 2 providers' expressed challenges with deciding between treatment flows; the resource was found to significantly increase providers' ability to make decisions in line with experts and improve their confidence in doing so, and demonstrated

high utility and acceptability (Knudsen et al. under review). In future treatment development initiatives, there should be clear communication with study providers regarding the "messiness" of early implementation in order to set realistic expectations and buffer against loss of confidence when the challenges are a more likely a product of the phase of implementation than skillset.

Building an effective, sustainable protocol for the Indian school context was the overarching goal of the Step 2 development process. The current study brings to light the steps taken in service of that goal: conversations across continents and cultures in pursuit of crafting an intervention to help close the treatment gap and improve adolescents' lives in India. These steps, while incremental on their own, have implications for the future of mental health treatment development and implementation when taken together and considered within the context of our increasingly globalized world. As described above, during early phases of treatment development and piloting, communication between the design team and on-the-ground team members gaining experience with the protocol is essential. Having the whole team in one location with access to both the evidence base and local knowledge could make this process more seamless. However, we might also see that, looking ahead into the future of treatment design in global mental health, there will be different teams who focus the majority of their work on "front end" vs. "back end" matters, as in the current study, especially as advances in technology make long-distance collaboration easier. Each approach has its merits, and both options increase the potential to scale up treatment innovation and reach, especially if combined. Being open to reimagining the landscape of mental health in this way allows for new ideas and exchange of information and knowledge flowing both ways – not just West to the rest of the globe. Adopting a "glocal" perspective, which breaks down artificial barriers between global and

local research, facilitates a richer, more cohesive understanding of problem areas that have largely been found to be consistent across settings, such as depression, while considering how cultural and structural issues impact treatment and implementation. The current study moves us in that direction by adding to the local evidence base on treatments for adolescents in India, highlighting critical considerations in the process of designing a treatment in collaboration with individuals from a range of cultural and experiential backgrounds, and centering feedback from stakeholders whose real-life experiences with the treatment are essential to its success.

Limitations and Future Directions

The present study has a number of strengths, including its in-depth qualitative investigation of the multi-phasic process of building and testing an intervention using a novel *adopt-adapt-assemble* model with the aim of maximizing fit and scalability of an evidence-informed treatment in a low-resource setting. However, we must acknowledge several limitations. The sample size is limited, and therefore it is difficult to quantitatively examine whether differences in the types of topics raised in various document types could be attributed to background characteristics, such as training and experience, of participants. Additionally, while the coded documents were selected for inclusion because they provided the most complete picture of treatment development in written form, the complete range of discussions related to design and implementation was not captured in the current study, as informal conversations about the process were ongoing throughout the development process in multiple locations and were not formally documented in full. Relatedly, it is possible that providers may not have felt comfortable raising certain issues in supervision knowing that the meetings were documented. In future studies on intervention design, providers might be encouraged to keep field notes on their individual experiences to submit anonymously to the design team to facilitate open feedback

without fear of judgment. Another limitation concerns lack of direct student input during this phase of design. Although providers reported on their experience in session and described the ways in which youth engaged with content and materials, youth were not approached about their experiences until the end of treatment, when they completed exit interviews, giving us their perspectives on the intervention at a single time point (Gellatly et al., in preparation). Future studies may want to introduce a mechanism through which students can anonymously provide feedback to the design team to report on their experiences throughout their treatment without worrying about their comments impacting the nature of the therapeutic relationship.

Conclusion

These limitations notwithstanding, this study offers a valuable and unique contribution to the literature on youth mental health treatment development and implementation in LMICs. Along with its companion papers (Chorpita et al., 2020; Boustani et al., 2020; Knudsen et al., under review; Becker et al., in preparation), the current paper addresses a gap in the literature on the process of selecting, designing, and implementing a multi-problem, modular treatment in a low-resource setting. It provides a methodology for developing a treatment that is high in both complexity and utility and flags potential challenges to anticipate when designing for a workforce with varied training and experience in delivering structured, evidence-based treatments. Lessons learned from this process can be applied not only in other LMICs, but also in HICs, where culture, context, and complexity are equally important to consider in designing mental health treatments. This is particularly relevant as populations in the U.S. and elsewhere become increasingly diverse and where the treatment gap, while markedly less vast than in LMICs, is still a barrier to meeting the needs of adolescents experiencing mental health

difficulties – a problem that, unfortunately, remains a common challenge for the global community.

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Table 1. *Pre-implementation phase meeting notes (N = 55)*

Code	Presence across documents (%)	Definition	Exemplar quotes
Cultural/Contextual Considerations	83.6	Discussions involving how to take culture and context into account when developing Step 2	"Use visual aids that are culturally appropriate/relevant to Indian youth: plate of rice instead of fork and knife; inclusion of emotion scale instead of mood thermometer; use of X out of 100 rather than percentages; use of local terms for anxiety/depression ("tension"); modification of skin color to be both acceptable and representative of youth."
Student-Facing Materials	80.0	Discussions on developing youth-facing materials: consent forms, youth measures, handouts, Youth Top Problems dashboard, and flipbook; illustration rich, culturally representative, and character-based analogue material in Hindi, and English	"Use of visuals. Each session built around a visual? Experience has been positive with visuals, helps to stimulate conversation and is a good memory aid. Interactive, not so boring. It feels nice for the kids. Key messages to have in some form of pictorial representation – easy to follow and remember."
Practice Content	70.9	Discussion related to development of practice content (Psychoeducation & Engagement, Relaxation, Behavioral Activation, Exposure, Assertiveness & Communication, Cognitive, Problem-Solving, Maintenance & Termination), including conversations about prioritizing concrete behavioral over abstract techniques	"Embed some cognitive work in the beginning of the behavioral modules to help students understand the rationale behind learning these skills (the TFA cycle related to depression, anxiety, conduct problems; not all thoughts are facts, thoughts are changeable), but save cognitive restructuring for a separate module."
Provider-Facing Materials	69.1	Discussions on developing provider-facing materials: manual,	"Adaptations for counselors:

		flipbook, clinical record form, appendices	Being more directive and thorough in the manual Quick tips: better to define these sections explicitly – once you have done this section, direct counselors to ask specific questions, e.g., 'Ask the student if they have understood.'"
Episodes	69.1	Discussions on episodes of care (i.e., Step 1, Step 2, referring out) and how to determine whether a youth participant goes into Step 1, Step 2, or is referred out; discussions about how to transition between steps (i.e., episodes of care)	"Problem-solving SHOULD be kept in Step 2 and should be the feature that provides continuum between the 2 steps Need to make Step 1 and Step 2 as similar as possible – a continuum rather than 2 separate treatments Step 2 can be designed as a continuation of step 1 options library: Addressing psychological rather than practical problems and offering more sophisticated options into the POD problem-solving framework"
Complexity – Student	61.8	Discussions about making Step 2 content and material appropriately complex for student participants	"Instead of handout, could have flashcards, flipchart, vicious cycle with blanks to fill in. Have something visual/graphic that is interactive; eliminate writing as much as possible."
Engagement	60.0	Discussions about client engagement, i.e., how to keep student participants engaged in treatment and prevent dropout. May be brought up in relationship to the REACH domains (i.e., Relationship, Expectancy, Attendance, Clarity, Homework) or client satisfaction	"Use engagement strategies available from the literature and include in workbook. For example: Instilling optimism that the program works Setting expectations about what to expect from counseling Use of motivational enhancement techniques: "How would your life be different if you didn't have that problem?" Use of barrier checklist: what might get in the way of completing this workbook?"

Table 2. *Implementation phase meeting notes and field notes (N = 22)*

Code	Presence across documents (%)	Definition	Exemplar quotes
Provider-Facing Materials	90.0	Discussions on developing provider-facing materials: manual, flipbook, clinical record form, appendices	"The manual may need to have guideline for providers covering three scenarios that are possible in terms of time available for delivery: (i) when the required optimal time is available (say 8 weeks), how the intervention delivery can be structured (ii) when the minimal time required to deliver intervention is available (say 4 weeks only), how the intervention delivery can be structured (twice a week session, every week) (iii) and how intervention can be calibrated if it's been initiated only few days before vacations/ break in school."
Clinical Decision Making	86.4	Discussions involving clinical decision making: how to guide providers with limited clinical experience to make decisions about which problem to target and which module to choose for that problem, as well as decisions about transitioning between modules, repeating content, and ending treatment	"Need to have more structure/prompts/script in the manual for the therapist to gather more information about the student's problem. Difficult for the therapist to decide what flow the student should go into if there isn't a lot of information about the problem."
Practice Content	81.8	Discussion related to development of practice content (Psychoeducation & Engagement, Relaxation, Behavioral Activation, Exposure, Assertiveness	"In the manual, we use a specific phobia as an example, though that hasn't come up in our sample; we should revise the manual to fit the problems that have come up (social anxiety)"

		& Communication, Cognitive, Problem-Solving, Maintenance & Termination), including conversations about prioritizing concrete behavioral over abstract techniques	
Cultural/Contextual Considerations	77.3	Discussions involving how to take culture and context into account when developing Step 2	"How did we choose the four images for activities in BA? Did we consult with students? We should consult with young people. Having someone sitting in front of a computer is not necessarily a good example of an activity to break a cycle of low mood – could be counterproductive, not realistic for Delhi schools. Think about what is realistic, acceptable, and frequently cited by young people as something they do to make themselves feel better. Then get those illustrations done."
Quality Assurance and Improvement	77.3	Discussions about training, supervision, and expert consultation. Content regarding supervision will likely come up in the context of how to structure peer supervision.	"Continue developing a supervision model for peer supervision that serves important formative and normative functions, as well as restorative functions related to preventing burnout, boosting team morale, normalizing difficult cases, etc."
Assessment	72.7	Discussions revolving around what measures to include in the initial and outcome assessment battery (e.g., RCADS, YTP, SDQ) in order to assess a) eligibility, and b) clinical outcomes at the end of treatment	"Right now, students are completing the YTP, SDQ (Impact and SxS), and emoji mood rating regularly, along with homework that often involves them taking mood ratings. The RCADS is completed with the researcher at baseline. The amount of time and paperwork required to complete these forms is a burden to the student and the therapist."
Treatment Architecture	72.7	Discussion about treatment architecture (e.g., order of modules,	"Currently, the flow seems rigid; if it has a more specific focus on integrating cognitive

		number of sessions per module, which modules should be optional, optimal dosing)	and behavioral, will be easier to go between these concepts."
Complexity – Student	68.2	Discussions about making Step 2 content and material appropriately complex for student participants	"Use of vignettes Feedback from counselors has been that youth like the scripts, it helps make concepts more understandable and concrete."
Monitoring	63.6	Discussions revolving around what measures to administer as ongoing symptom monitoring during Step 2 treatment (e.g., YTP, SxS, mood rating with smiley face). In other words, youth and provider report of emotional, behavioral, and risk status across sessions	"Consensus from providers is that the YTP is most useful, takes less than 5 mins. SxS is difficult for the student to read, they don't reflectively think about responses."
Complexity – Provider	63.6	Discussions about how to balance complexity of the intervention with making it simple enough to be used by non-specialist providers, thus making it scalable (i.e., able to be delivered by a large non-specialist workforce), while not compromising features that can be used by providers with increasing experienced. May discuss the importance of providing explicit guidance for clinical decision-making; using single framework with common design elements; limiting the number of modules and decisions to make about extending or repeating content, as well as transitioning between modules	"Struggling with material: We can try and make manual more structured, which can give the beginner therapist more structure but as they become experienced, they can have more flexibility."

Table 3. *Implementation phase supervision notes (N = 23)*

Code	Presence across documents (%)	Definition	Exemplar quotes
Provider-Facing Materials	95.7	Discussions on developing provider-facing materials: manual, flipbook, clinical record form, appendices	"There are a lot of loopholes in the manual, like when to use the treatment planner. Could put instructions for how to use it in the manual, like bringing it out at the start of each module to orient the student to where they are in the treatment."
Engagement	95.7	Discussions about client engagement, i.e., how to keep student participants engaged in treatment and prevent dropout. May be brought up in relationship to the REACH domains (i.e., Relationship, Expectancy, Attendance, Clarity, Homework) or client satisfaction	"Right now, students aren't even showing up to sessions because of the exam period; academic stressors take precedence"
Complexity – Student	95.7	Discussions about making Step 2 content and material appropriately complex for student participants	"Other student is very distracted but is able to concentrate on the activities in session. Currently in assertiveness and communication. Taking some time to understand the concepts. Could only relate to conflict. Provider had to explain more and go more slowly with him. In the next session, she will do role plays."
Practice Content	82.6	Discussion related to development of practice content (Psychoeducation & Engagement, Relaxation, Behavioral Activation, Exposure, Assertiveness & Communication, Cognitive, Problem-Solving, Maintenance & Termination), including conversations about	"Provider 1: How did you introduce the idea of learning yet another skill? Find it hard to know what to say when certain things haven't worked. Provider 2: I do it in a collaborative way – give students the option of practicing skills that appear to have worked for them based on

		prioritizing concrete behavioral over abstract techniques	the reduction in their scores or learning something else new that might help. Whatever it is, you want to be integrating the skills they learned previously. If you're teaching assertiveness and communication, they can use relaxation techniques like deep breathing before talking to a friend assertively."
Clinical Decision Making	78.3	Discussions involving clinical decision making: how to guide providers with limited clinical experience to make decisions about which problem to target and which module to choose for that problem, as well as decisions about transitioning between modules, repeating content, and ending treatment	"What is the information we need to gather in order to make a decision about flow after relaxation? Are we looking at scores? Progress monitoring tools? Goals? What variables do we need to look at to better understand which flow to take?"
Student-Provider Relationship	78.3	Discussions on the nature of the student-provider relationship and how to balance a more collaborative style with some representation of provider as an "expert" due to cultural role expectations	"Students are both happy and sad to end; you are spending more time with them, and you are more familiar. One student wanted my number to be able to call for help in the future."
Complexity – Provider	73.9	Discussions about how to balance complexity of the intervention with making it simple enough to be used by non-specialist providers, thus making it scalable (i.e., able to be delivered by a large non-specialist workforce), while not compromising features that can be used by providers with increasing experienced. May discuss the importance of providing explicit guidance for clinical decision-making;	"At first, I tried to stick to the manual as much as possible. I later realized you can consolidate certain section and adapt to the child."

		using single framework with common design elements; limiting the number of modules and decisions to make about extending or repeating content, as well as transitioning between modules	
Cultural/Contextual Considerations	69.6	Discussions involving how to take culture and context into account when developing Step 2	"Need to do something about the noise levels in the clinic; lots of background noise from other counselors and construction. Difficult to ask kids to relax in this environment when I cannot even relax. The relaxation module will only work if it's in an ideal situation."
Episodes	60.9	Discussions on episodes of care (i.e., Step 1, Step 2, referring out) and how to determine whether a youth participant goes into Step 1, Step 2, or is referred out; discussions about how to transition between steps (i.e., episodes of care)	"Since many students in Delhi won't have gone through Step 1, we may want to spend more time thinking about how to engage them and discuss psychoeducation more."

Figure 1. *PRIDE Step 2 Design Activities*

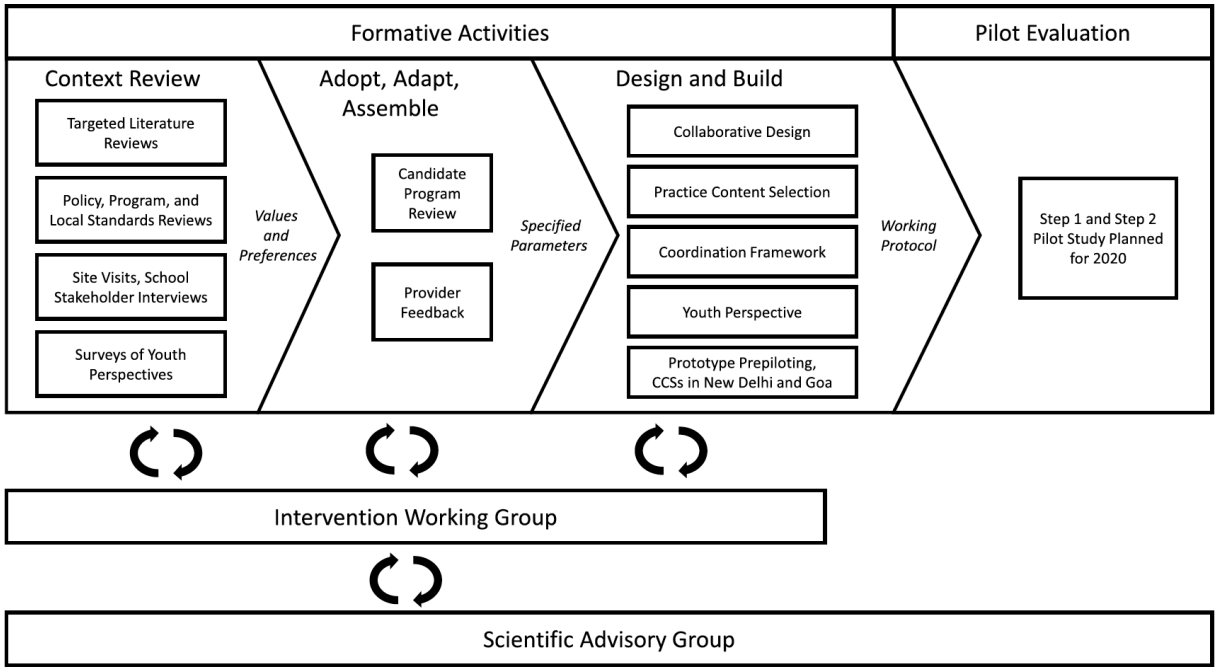
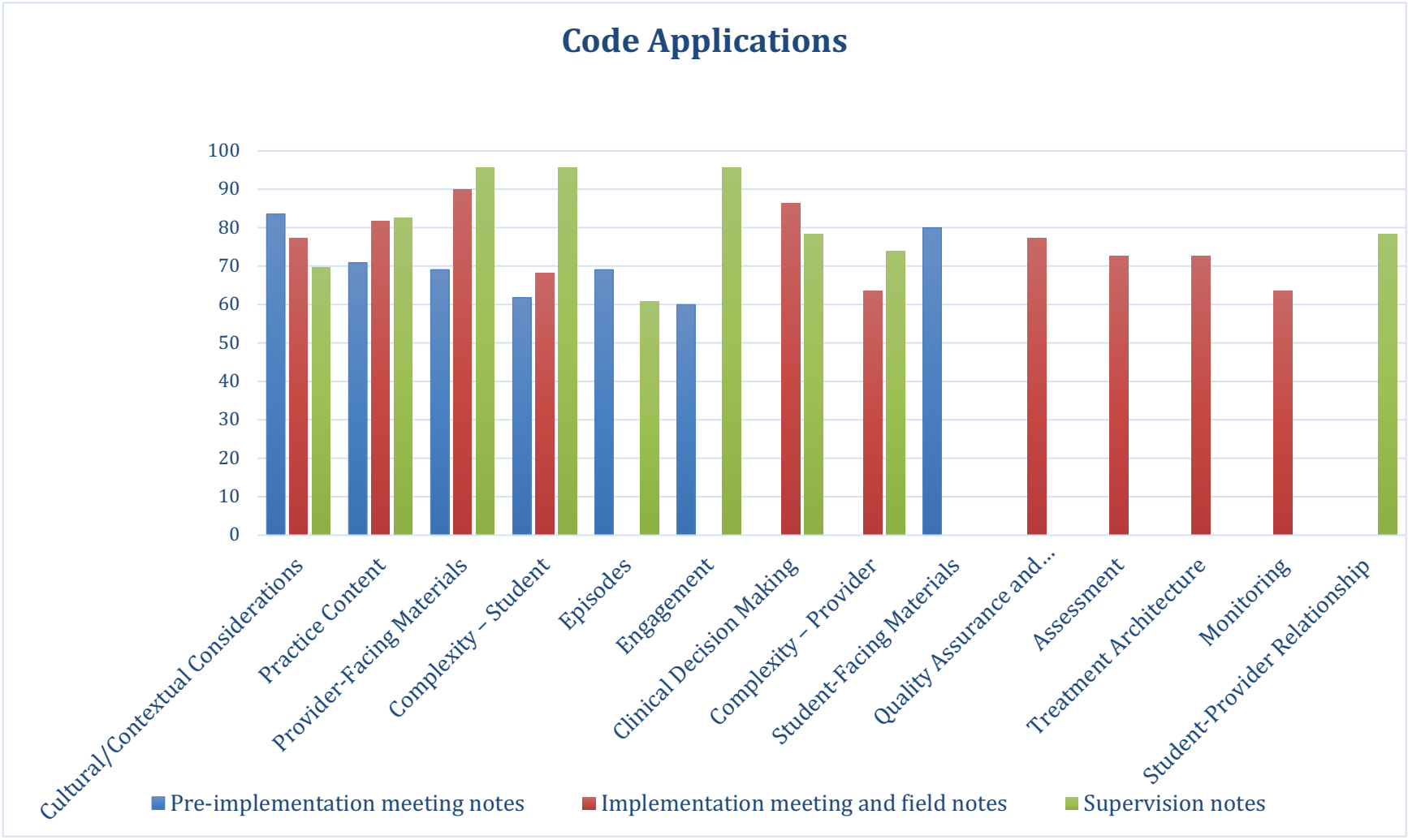


Figure 2. *Code Applications*



CHAPTER 2:

Adolescent Engagement in a Transdiagnostic Mental Health Treatment Delivered in Indian Schools

Abstract

Poor engagement in children's mental health services has long been a public health concern. Given the relationship between poor engagement and worse treatment outcomes, improving engagement has been the focus of attention in recent years, with emerging evidence for the use of specific interventions to enhance engagement. Less is known about treatment engagement in low- and middle-income countries (LMICs). The present study, which is part of a larger project (PRemIum for aDolEscents [PRIDE]), describes engagement challenges that arose in the pilot trial of a school-based, modular, transdiagnostic, stepped-care intervention delivered in urban Indian communities. Specifically, the study aimed to (1) characterize barriers and facilitators of engagement from provider and youth perspectives; and (2) evaluate the overall acceptability, feasibility, and fit of treatment from the perspectives of youth who engaged in the intervention and providers who delivered it. Providers and youth completed semi-structured interviews, which were transcribed and coded using the qualitative analytic approach of coding consensus, co-occurrence, and comparison. Participants described numerous facilitators to engagement and reported high overall satisfaction with the intervention, while also identifying barriers to engagement and offering suggestions to increase fit and acceptability. Findings highlight ways in which youth engagement can be enhanced and implementation supports improved in order to maximize treatment effectiveness in LMICs.

Introduction

Poor engagement in children's mental health services has long been a public health concern. Up to 50% of youth in need of services do not enter treatment (Merikangas et al., 2010). Among those who do begin treatment, the majority terminates prematurely (Nock & Ferriter, 2005; Pellerin, Costa, Weems, & Dalton, 2010). Given the association between poor engagement and worse treatment outcomes (Danko, Garbacz, & Budd, 2016; Haine-Schlagel & Walsh, 2015; Karver, Handelsman, Fields, & Bickman, 2006; Kazdin & Wassell, 1999), improving youth engagement in treatment has become a public health priority. Accordingly, the past four decades have been marked by significant advances in the development and testing of interventions designed to facilitate child, adolescent, and family engagement in mental health services (Becker, Boustani, Gellatly, & Chorpita, 2018).

Less is known about treatment engagement in low- and middle-income countries (LMICs). Compared with high-income countries, which have proportionately more researchers and resources available to develop and test mental health interventions, relatively few RCTs of psychological treatments have been conducted in LMICs (Patel & Sumathipala, 2001; Saxena, Paraje, Sharan, Karam, & Sadana, 2006). Further, the majority of investigations in LMICs have been in adult populations, with only a handful of studies examining child and adolescent interventions (Murray et al., 2013; Patel, Flisher, Nikapota, & Malhotra, 2008). This is of chief concern given that there are 1.9 billion adolescents in the world (United Nations Children's Fund, 2011), 90% of whom live in LMICs and who experience mental health challenges at a population rate of at least 10%. The scope of the problem of adolescent mental health concerns and the substantial burden it places on individuals and countries with already limited resources is troubling. While there have been advances in testing and scaling up child and adolescent mental

health treatments in LMICs, services need to be utilized in order to be beneficial at the individual youth and population levels, demonstrating the need to identify and address barriers to youth treatment engagement in LMICs. Yet among child-focused studies conducted in low-resource settings, engagement has rarely been a focus of inquiry.

When engagement in youth interventions in LMICs has been described, its definition and measurement have largely been restricted to attendance and program completion (Murray et al., 2014; Meza et al., 2020). Attendance is an important indicator of treatment engagement and one that has also been shown to be associated with treatment outcomes (Kim, 2017; Nock & Ferriter, 2005; Reardon, Cukrowicz, Reeves, & Joiner, 2002). However, overreliance on attendance as the sole or primary engagement outcome is problematic for a number of reasons. First, attendance alone is not sufficient to ensure positive treatment outcomes (Nock & Ferriter, 2005), because while youth may be present in a session, active participation can be variable and is impacted by numerous potential challenges to engaging with the session content (Gellatly et al., 2018). Second, it is likely that social and cognitive factors support or interfere with attendance, yet there exist very limited data regarding these associations. Finally, relying on attendance alone as an indicator of engagement may be a missed opportunity to intervene earlier to address engagement challenges and prevent premature termination. Thus, there is a need to understand what treatment engagement looks like in LMICs in domains of engagement beyond attendance.

A number of conceptual models of engagement have been proposed to elucidate potential contributors to poor engagement in children's community mental health in the United States. Models of engagement consistently include multiple engagement dimensions, such as behavioral, social and cognitive (e.g., Haine-Schlagel & Walsh, 2015; King, Currie, & Petersen, 2014; Lindsey, Chambers, Pohle, Beall, & Lucksted, 2013). For example, behavioral dimensions

include attendance, homework completion, and other markers of participation in treatment; social dimensions include therapeutic alliance and other aspects of relationship quality; and cognitive dimensions include attitudes, motivation, and perceptions of therapy and providers.

Based on these conceptual models and the literature, Becker and colleagues (2018) posited that engagement is multidimensional, transactional, and dynamic, such that the various dimensions exert a reciprocal influence upon one another and that these influences could change over time. They further offered a measurement model, referred to as the REACH framework, which specifies five domains of engagement (*Relationship, Expectancy, Attendance, Clarity,* and *Homework/participation*) to characterize the literature on engagement interventions in children's mental health. A review of 50 randomized controlled trials (RCTs) targeting youth engagement revealed that certain practices were associated with improved engagement in each REACH domain (Becket et al., 2018). These findings suggest that engagement can be enhanced through the use of specific interventions, at least within children and adolescent community mental health settings in the United States in which the majority of these studies were conducted.

Results from a recent pilot study demonstrated that engagement challenges in REACH domains could be detected using a coordinated knowledge system, which includes resources to (1) identify engagement problems, (2) support selection of procedures to address the problems, and (3) measure progress of these engagement problems. School-based mental health providers who used this system reported that it was feasible and acceptable, and that it facilitated conversation about engagement challenges in supervision (Becker, Park, Boustani, & Chorpita, 2018). These findings, along with an overall increase in interest in treatment engagement, represent steps toward a better understanding of engagement in children's mental health services in the United States.

Although some interventions tested in LMICs incorporated strategies aimed at facilitating engagement, such as including family members in treatment, providing psychoeducation about services, and sending appointment reminders (Murray et al., 2013), it remains unclear whether the selected strategies address actual engagement challenges encountered in delivering the intervention and if they were effective. The scarcity of knowledge about youth engagement in treatment in LMICs, coupled with the need to promote child and adolescent mental health, underscores the urgency to understand what types of engagement challenges arise in low-resource settings in order to identify procedures to address challenges, enhance engagement, and improve clinical outcomes.

A number of engagement challenges were identified during the initial formative research phase of PRemIum for aDolEscents (PRIDE), a research project aimed at developing a school-based, stepped-care mental health intervention for Indian youth in Delhi and Goa. PRIDE aims to (1) develop a multi-problem treatment targeting common mental disorders (depression, anxiety, and conduct problems) in school-going adolescents, and (2) evaluate its effectiveness in reducing symptom severity and improving recovery rates among adolescent participants.

Initial formative research evaluated the acceptability and feasibility of Step 1, which was a low-intensity, provider-led, guided self-help problem solving intervention delivered through a workbook format. Providers reported that 20% of youth participating in the Step 1 case series dropped out prematurely. Youth who stayed in treatment often did not show up to session and needed to be brought by providers from their classrooms to the therapy room. Once in the room, providers reported poor in-session engagement. Primary contributors to limited engagement in the case series included low literacy, which impeded youths' ability to engage with written therapy materials, and limited time to complete out of session homework, reasons described by

both youth and providers in semi-structured interviews and focus groups at the end of the Step 1 case series. Youth cited additional barriers to engagement such as low motivation, family obligations, and difficulty understanding how to use skills taught to address their problems. These preliminary indicators suggest that engagement is a concern to be addressed in the context of the PRIDE project. Nevertheless, knowledge about the specific types of engagement challenges encountered in this setting remains limited. Gaining a more thorough understanding of engagement challenges allows for the development of a context-sensitive treatment that centers engagement strategies in its design and can also address engagement challenges as they come up.

The current study describes engagement challenges that arose in the Step 2 clinical case series (CCS), which was a pilot trial evaluating the acceptability and feasibility of the higher-intensity psychological treatment within the stepped care model of PRIDE. Specifically, the study aimed to (1) characterize barriers and facilitators of engagement from provider and youth perspectives; and (2) evaluate the overall acceptability, feasibility, and fit of treatment from the perspective of youth who engaged in the intervention and providers who delivered it.

Method

The current study focused on understanding youth engagement in a multi-problem intervention for anxiety, depression, and conduct disorders developed for adolescents in schools in India. Qualitative methods were used to characterize engagement challenges from provider and youth perspectives in order to inform revisions to the treatment protocol prior to evaluation of the intervention through a full-scale RCT. Data were collected between 2018 and 2019. All study procedures were approved by the Institutional Review Boards at the University of

California, Los Angeles, Harvard Medical School, Sangath, and the Indian Council of Medical Research.

Background of the PRIDE study

PRIDE is a research program whose goals are to (1) develop a transdiagnostic, stepped-care intervention targeting common mental disorders in school-going adolescents in India, and (2) evaluate its effectiveness in reducing symptom severity and improving recovery rates among adolescent participants. PRIDE takes a stepped care approach and is comprised of two sequential treatments of incremental intensity (Steps 1 & 2). Stepped care reserves more intensive treatments for individuals who do not benefit from initial, lower-intensity treatments, or for those who are determined to need more intensive services at the outset, thus increasing accessibility and efficiency of evidence-based mental health care (Bower & Gilbody, 2005), which is particularly important in low-resource settings. Step 1 is a brief (4-5 session), low-intensity problem solving intervention guided by lay providers and supplemented by a printed workbook (see Michelson et al., 2020, for a full description of the development of Step 1). Step 2 is a high-intensity, face-to-face psychological treatment delivered by qualified psychologists to adolescents who are non-responders to Step 1 as determined by locally-validated cutoff scores on the Strengths and Difficulties Questionnaire (SDQ; Bhola, Sathyanarayanan, Rekha, Daniel, & Thomas, 2016).

The intervention underwent a multi-process evaluation in two broad phases of research, drawing on PREMIUM methodology for developing and scaling up psychological treatments in low-income settings (Patel et al., 2014). Phase 1 consisted of intervention development and formative evaluation, including a CCS and pilot RCT. Phase 2 evaluated the intervention through

a full-scale RCT. The current study examined treatment engagement in the Step 2 intervention in the Phase 1 CCS.

Intervention

The Step 2 intervention, as noted above, was developed to be the most intensive treatment component of a school-based, stepped-care treatment for adolescents with common mental health problems (anxiety, depression, and conduct/anger). The process of Step 2 treatment development is detailed elsewhere (Chorpita et al., 2020; Gellatly et al., in preparation). The version of the working protocol for the current study was a modular design that started with two compulsory modules (Psychoeducation and Engagement, Relaxation) for all youth, regardless of problem type; three behavioral modules (Behavioral Activation, Exposure, Assertiveness and Communication), a minimum of one which was selected by providers based on a combination of the youth's reported top problems, scores on progress monitoring tools, and youth preference; two optional modules (Cognitive Coping, Problem Solving) that could be added if youth response to the behavioral module(s) was suboptimal; and Maintenance and Termination, which was delivered to all youth (see Figure 3). Modules were designed to encompass two to three sessions, although providers had the flexibility to spend more or less time in a module depending on a student's demonstrated understanding of and proficiency with the concepts and skills. Protocol materials were developed collaboratively with the intervention design teams based at Sangath, India; the University of California, Los Angeles, India; and institutions in the U.K. Materials included a provider-facing manual, a flipbook with provider-facing and student-facing components, illustrated handouts for students to complete in session and at home, and appendices with supplementary guides for providers.

Setting

The study was conducted in Delhi, India's capital and the second largest urban area in the world, and Goa, a small state on India's southwestern coast with the country's highest proportion of urban population. In Goa, the CCS was conducted in six co-educational secondary schools supported by the Archdiocese Board of Education (ABE). Delhi schools included four senior secondary government-run schools: two co-educational, and one that ran in two shifts of all-boys and all-girls.

Participants

Provider sample. This study included mental health providers (N = 5) employed by Sangath, a non-governmental, non-profit organization conducting research and providing psychosocial services across India. Participants consisted of one (20%) expert provider (i.e., no degree in psychology but significant experience working as a provider on mental health interventions and studies within Sangath), two (40%) Master's psychologists, and two (40%) post-doctorate clinical psychologists. All providers were Indian nationals and self-identified as female. The average age of providers was 30.8 years (SD = 4.55, Range = 26-38) and the mean number of years of clinical experience was 7.8 (SD = 2.39, Range = 5-11). Four providers (80%) had previously delivered services in secondary schools; three (60%) had been therapists on research studies or in community mental health settings; and all (100%) had experience working in clinic and hospital settings. Providers (100%) reported delivering services in English and Hindi; one provider (20%) also reported providing treatment in Konkani and Marathi. The first author (RG) also delivered the intervention in Goa. However, due to the extent of her involvement in the treatment development process, she was not interviewed and therefore is not included in the provider study sample. One provider delivered Step 2 in both Goa and Delhi. As

this provider saw more cases in Goa, her characteristics included in the Goa sample of the provider characteristics table (Table 1).

Youth sample. Youth participants in the present study included 14 students from Goa and five students from Delhi who completed exit interviews. Sixteen students from Goa and 16 students from Delhi entered the Step 2 intervention. The parents of one of the Goa students did not consent for research participation, so although the student received the intervention and completed an interview, her data were not included in the final analysis. Another student in Goa was not included because although he was eligible for Step 2, he withdrew from the study prior to initiating treatment. Eleven students in Delhi declined to participate in interviews or were lost to follow-up. In the current study sample of interview completers, youth participants in Goa were on average 14.5 years (*SD* = 0.73, Range = 13-15), while the average age of Delhi students was 15.6 years (*SD* = 0.39, Range = 15-16). Eligibility for participation in the Step 2 intervention was determined by non-response to Step 1 as defined by scoring at or above locally determined cutoffs of the SDQ Total Difficulties Score (>/=19 for boys and >/=20 for girls) and/or a score of 2 or greater on the SDQ Impact Score. In Goa, eligible students were in grades 8-10, while in Delhi, students from 9th-12th grade were invited to participate. Study research staff obtained written informed youth assent and caregiver informed consent for youth under the age of 18 years. Youth over 18 years old provided written informed consent. Youth and caregivers had the option to decline research assent/consent while still participating in the treatment; as described above, one participant from Goa declined research consent. Table 1 presents the youth sample characteristics.

Provider Training

Providers participated in a three-day training for Step 2 in early August 2018 led by two members of the study team (RG and KM) who developed the training in collaboration with a UCLA-based postdoctoral fellow on the project (MB). Two weeks prior to the training, a survey was sent to participating providers with questions about demographics, including age, gender, ethnicity, highest degree earned, and languages spoken; clinical experience, including experience delivering treatment in various settings (e.g., primary school, hospital), number of cases seen (child and adult), and supervision received; and familiarity with the practices taught in the Step 2 treatment (e.g., relaxation, behavioral activation, exposure, assertiveness training, problem solving, and cognitive coping. Providers were asked to define each of these practices in their own words, report on the number of cases to whom they had delivered each practice, and indicate their level of confidence in delivering each practice and engaging youth and families using a six-point Likert scale (strongly agree, agree, somewhat agree, somewhat disagree, disagree, strongly disagree). The survey also assessed providers' experience administering and interpreting study measures (SDQ, Youth Top Problems assessment, and the Revised Children's Anxiety and Depression Scale). Providers reported their confidence in selecting a student's target problem area using progress monitoring tools and case history. Providers were encouraged to be honest in their responses in order to help trainers tailor the training to their needs. Their responses informed the training format and content, which included didactics about the practices, case examples, modeling, and role plays centered around each of the modules, as well as training on how to use clinical decision making to select a treatment flow. Providers were encouraged to ask questions and share feedback on intervention content and materials throughout the training.

Goa providers began seeing Step 2 cases in early October 2018, two months after the training. Delhi providers were expected to begin delivering Step 2 in January 2019. Although

providers from both Goa and Delhi had been participating in group supervision for the duration of the Goa CCS, Delhi providers requested a refresher training prior to the CCS onset in Delhi, given the five-month gap between the initial training and their anticipated start date of Step 2 delivery. Based on this request, a one-day refresher training was held for all providers in the end of January 2019. Providers were asked to fill out a Google document with topics they would like reviewed in the training. Clinical decision making, linking Step 1 to Step 2 content, gathering and documenting information on students' problems, integrating materials into the session, and goal setting were flagged as high-priority items. Discussions in the training, as well as Goa providers' reports from the field, informed revisions of the provider-facing manual and some student-facing materials, and clarified the purpose of and procedures for the different progress monitoring tools. However, the rollout of Step 2 in Delhi was further delayed to mid-March 2019, which meant that Delhi providers experienced another extended gap between training and intervention delivery.

Measures

Semi-structured interviews with youth and providers.

Youth interview guide. In order to evaluate student and provider perceptions of student engagement in and acceptability of Step 2, semi-structured interviews were conducted at the end of the case series. The youth interview guide was adapted from an existing Step 1 case series interview guide (see Michelson et al., 2020). Questions and format were refined and updated through use in the field. The semi-structured interview included broad, open-ended questions organized into five sections: (1) Initial engagement (e.g., "What were your initial thoughts when you first heard about the counseling service?"); (2) Relationship with providers (e.g., "Please tell me about your experience with your counselor"); (3) Experience with Step 2 content and

materials (e.g., “How did the activities you learned relate to your problem?”); (4) Impacts of the intervention (e.g., “In what ways, if any, has counseling helped to bring about changes to your problems?”); and (5) Areas for improvement/experience ending counseling (e.g., “What other suggestions do you have about how to improve the counseling service for young people like you?”). Interviewers used non-leading probes such as “Tell me more about that,” and “Can you share an example?” to elicit additional information about youth experiences. Two study staff translated the student interview guide for use with students whose preferred language was Hindi.

Provider interview guide. The provider interview guide was adapted from previous research and demonstrated to be effective in eliciting responses from providers delivering a psychosocial intervention in a LMIC (Munodawafa, Lund, & Schneider, 2017). The semi-structured interview included broad, open-ended questions organized into nine sections: (1) Capacity building (e.g., “What do you think about the week of training that you got before you started counseling on Step 2?”); (2) Environment issues (“How did you manage to do counseling sessions in the schools?”); (3) Self-assessment (e.g., “Before you started delivering Step 2, what concerns did you have about your ability to deliver the treatment?”); (4) Challenges (e.g., “What are the challenges that you faced in delivering Step 2?”); (5) Engagement (e.g., “Please describe your relationship with your students.”); (6) Fidelity (e.g., “Were you able to deliver the treatment as intended?”); (7) Design (e.g., “What did you think about the materials used in counseling?”); (8) Effectiveness (e.g., “What do you think was the most effective part of the counseling (the part that helped the students most)?”); and (9) Therapist experience (e.g., “Do you have any suggestions for improving Step 2?”). Interviewers used non-leading probes such as “Tell me more about that,” and “Can you share an example?” to elicit additional information about providers’ experiences. As with the youth interviews, field research team members

provided feedback on the interview guide during the training and throughout the interview process in order to increase cultural fit.

Interview Procedure

Two Goa-based research staff were trained by the first author (RG) to conduct the semi-structured interviews with students and providers in Goa. The training consisted of didactics on interviewing techniques (e.g., how to use probes to gather additional information), modeling, and a role-play of the entire interview, with the first author playing the role of interviewee. Three research staff conducted student and provider interviews in Delhi. All interviews were done in person, and written consent was obtained from providers and caregivers; youth assent was also obtained. Participants were offered the option of completing the interviews in their preferred language. All provider participants ($N = 5$) opted to complete the interview in English. Student interviews were conducted in English ($n = 8$); Hindi ($n = 8$); and Konkani ($n = 3$). Five students from Delhi and 14 students from Goa participated in interviews. All interviews were audio-recorded. Hindi interviews were transcribed and translated into English by a professional Delhi-based agency who had previously been contracted to do interview translation for Sangath; English interviews were transcribed by the same agency. As the agency did not provide translation services for Konkani, the three Konkani interviews were translated into English and transcribed by a Sangath researcher with prior experience with interview translation and transcription. Three members of the study team (RG, PN, and RM) cross-checked the transcriptions against the original audio recordings to verify accuracy.

Data Analysis

Provider and student interview transcripts were coded and analyzed using the qualitative analytic approach of coding consensus, co-occurrence, and comparison described by Glaser and

Strauss (1967) and Willms (1990). The first author (RG), who served as master coder, generated an initial set of *a priori* codes and definitions based on the interview guides. For the student interviews, this taxonomy was applied to two "gold standard" student transcripts, which were coded by the master coder. All interviews were coded using Dedoose, a qualitative data analytic software program. Two undergraduate research assistants were trained in coding theory and procedures via two one-hour training sessions that included introduction to the coding scheme, review of each individual code (using examples), group coding of a sample transcript using Dedoose, and group discussion of potential new codes. Following the training, each coder was assigned two gold standard transcripts to code independently. Coded transcripts were compared with the master coder's gold standard coding. Discrepancies were discussed in a meeting, and codes and definitions were refined after reaching consensus. The remaining student transcripts were divided among the two coders to be coded independently. All coded transcripts were reviewed by the master coder, and discrepancies were resolved through discussion. Coders were encouraged to identify potential emergent codes, which were discussed amongst the coding team in weekly meetings and incorporated into the codebook if consensus was reached on the value of their inclusion (see Appendix B for the full coding framework).

A similar procedure was followed for the five provider interviews, all of which were double coded by the first author (RG) and one undergraduate research assistant who was chosen to code based on her excellent performance on the student interview coding. The provider codebook was developed based on the interview guide with a priori codes, and emergent themes were allowed to arise through the process of coding, consensus, and comparison. The coding team met weekly to discuss and resolve discrepancies (see Appendix C for the full coding framework).

Once all student and provider transcripts were coded, two members of the study team (RG and MB) synthesized codes into categories, themes, and sub-themes using qualitative thematic analysis (Braun & Clarke, 2006). They independently reviewed excerpts and identified key themes, then met to compare, discuss, and decide on final themes for inclusion.

Results

Student Interviews

Qualitative Themes

Table 2 presents qualitative results from student interviews, including categories, themes and sub-themes with exemplar quotes. Student responses fell into four broad categories of (a) Facilitators to treatment engagement; (b) Barriers to treatment engagement; (c) Impacts of the intervention; and (d) Recommendations for improvement. Descriptions of these categories, key themes and sub-themes are discussed below.

Category 1: Facilitators to treatment engagement

Students described a number of facilitators to treatment engagement. Facilitators included activities built into the intervention with the aim of increasing engagement, such as whole-school sensitization activities intended to provide psychoeducation about counseling and promote referrals, as well as more organic methods, including youth sharing positive perceptions about counseling with each other.

Theme 1.1. Sensitization activities increased awareness and positive perceptions of counseling

Whole-school sensitization activities were carried out at the beginning of the CCS in order to provide psychoeducation about services to school staff and students and generate appropriate referrals (Michelson et al., 2020). School principals and teachers were briefed on the purpose of counseling, including the types of students for whom counseling might be helpful. Teachers were

asked to speak with students they felt could benefit from counseling before referring them to the study team. This was recommended in order to provide basic psychoeducation about mental health services and thus foster trust in the referral process. Classroom-based sensitization activities for students included counselor-delivered psychoeducation about services via an animated video, followed by a guided group discussion during which students were encouraged to ask questions and raise concerns.

Subtheme 1.1.1. Sensitization video resonated with students

Students described the short video shown in the classroom sensitization session as relevant to their problems. One student said, "I liked the video a lot. I also understood [counseling] and I thought that I will like that. And when we go to study, then we don't feel like studying, so I thought this problem will be solved; when we don't feel like studying, then we go to counseling it might work." Students also reported that the video portrayed counseling in a positive light and facilitated engagement in services. As one student explained, "I had seen the video and I knew that counseling is not something bad."

Subtheme 1.1.2. Expectation that counseling will solve problems

Sensitization activities centered around the idea that counseling helps students learn how to solve their problems - consistent with the content of the brief problem-solving intervention that made up the first step of the stepped care intervention. This message stuck with interviewed students, who shared a belief that counseling would solve their problems. Some students explained that initially, they believed counselors would solve their problems for them, such as the student who reflected on their expectation that "They can solve our problem." Another student recalled thinking, "I think that I will try, I will

share my problems with the counselor teacher, and I thought that it will work like Miss said." It is possible that these positive expectations about counseling paved the way for students to self-refer and engage in treatment.

Theme 1.2. Youth engagement was impacted by others' support

Initial treatment engagement was reportedly facilitated by friends and family who recognized the benefit of counseling, often through their own treatment experiences or positive expectations. Students heard about or saw firsthand that counseling was helpful to or approved by loved ones, which may have increased motivation to engage in services.

Subtheme 1.2.1. Peers' successful experiences with counseling encouraged youth to seek support

Positive peer experiences in counseling were an especially powerful motivator of youth engaging in treatment. Students explained that their friends enjoyed counseling, which made them eager to experience it for themselves. As one student said, "All my friends love counseling, so I went for counseling." Students also reported that seeing counseling work for their friends was a factor in seeking treatment, like the student who stated, "All my friends were going there because all they were having problem. Because their problems were solved, that is why also I went to the counseling." Finally, students' friends who were already in counseling explicitly encouraged the respondents to try it out. One student recalled, "My friends were going first, and they told me to go and they will sort my problems. I was like, 'Will they really do it?' I was thinking if they would understand my problems because they were adults. So, then I said I will also try. Then I went for it."

Subtheme 1.2.2. Parental awareness and approval of counseling made youth feel comfortable engaging

Parental support for counseling emerged as an engagement facilitator. Students who were open with their parents about seeking treatment described receiving support in return, such as one student who shared, "I told my family members that I have gone there for counseling. My father told me that you should have told the counselors that you get angry easily." Another student explained that it was important for his father to know that he was engaging in treatment because if he had not told him, "Then there will be tension that I am doing it without informing."

Theme 1.3. Positive relationship with counselor facilitated treatment engagement

The therapeutic relationship emerged as one of the most prominent facilitators of treatment engagement. Students expressed positive feelings toward their counselors and shared that they could trust their counselors and felt understood. One student in Goa, a state in which Christians comprise the second largest religious grouping after Hindus, said, "When I saw present counselor, it seems that she is like a God to me, more than my father and mother. I thought I can speak to her about anything just like I can with God." Some students noted that they were sad about not seeing their counselors once treatment ended and expressed a desire to stay in contact.

Subtheme 1.3.1. Youth perceived counselors as friendly, which helped them feel comfortable

Counselors were frequently described as friendly, nice, and happy, and students shared that these characteristics helped them feel comfortable. The way counselors spoke and explained concepts emerged as one distinct facilitator. One student said, "Actually, how she is explaining is nice, and I can share everything to her, and because of that she is

telling what to do, how to do, if there is any problem there you can talk with others . . . Because how she is talking, I am feeling very nice." Another said about their Step 1 and Step 2 counselors, "She was talking very friendly. Both of them." Counselors' warmth and friendliness was also noted to have a positive impact on engagement, as a student who shared that she liked her counselor because of, "Her smile, and like she is very happy person so it was like very comfortable and I was thinking I can talk with her comfortably, I can share my problem."

Subtheme 1.3.2. Youth appreciated counselors taking time to learn about their interests

The process of rapport building emerged as a facilitator of treatment engagement. Students reported enjoying discussing their interests with their counselors, such as the student who stated, "She spoke lovingly. She wanted to know more about me. I tried to tell as much as possible." These conversations were also noted to be an avenue for counselors to obtain information about students' problems in a non-threatening manner. One student explained, "She was very friendly. We didn't directly start discussing with the problem, like she told me where she was from, and I was asking about her, then she was asking about my likes, dislikes, and then suddenly she was asking me like, 'You like this subject?' or 'What you want to do?' That way she came to know about my problem, and I told her, which she didn't directly discuss. So, I found that she was very friendly and kind."

Theme 1.4. Skills taught were relevant and enjoyable

Students largely reported that the skills they learned were relevant to their problems and fun to learn and practice. Some students found the skills so helpful that they introduced session content

to friends and family, suggesting that the practices were transferable to the home setting and that students did not perceive them as stigmatizing.

Subtheme 1.4.1. Youth perceived specific skills as relevant to their problems

After completing the psychoeducation and relaxation modules, students received one of three behavioral modules depending on their problem type, followed by optional cognitive coping or problem solving modules if indicated. Students described the skills taught as relevant to their presenting problems. One student who self-referred for difficulties with anger reflected on learning assertiveness and communication skills through roleplays with her counselor: "I used to fight a lot with my sister. I would talk with her in aggressive manner, when I talk in aggressive manner, then she, too, would talk in aggressive manner. Like Miss used to give example like my sister. She would talk and I would pretend to be shouting at her. She would be me and I would be my sister. Then she would talk and show and tell me that if I spoke to my sister like this then my problems would be reduced." One student noted that Step 2 was tailored to her problems, in contrast to her experience of the Step 1 brief problem solving intervention being more general. She stated, "In a half session only, I understood whatever [Step 2 counselor] tried to explain to me, but after a long session with [Step 1 counselor], it was like everything was something not of use. Actually, she didn't give me something what I wanted; some things she explained were not my kind of my problem. So, I wanted something which was based on my problem, which [Step 2 counselor] said."

Subtheme 1.4.2. Youth expressed varied preferences for relaxation activities depending on which skills they enjoyed and found most useful

Three relaxation activities were taught in the mandatory relaxation module: deep breathing, “Happy Place” guided imagery, and progressive muscle relaxation. After learning all three, students selected one activity to practice more in depth. Students varied in their preference of the three activities, with students reporting liking one or more relaxation practices depending on perceived relevance, ease of use, and fun. A student explained why she preferred Happy Place to deep breathing: “It was like my biggest problem is concentration. I can’t concentrate and remember things. It was like because negative thoughts are just going all around my brain. So, Happy Place was something after a good imagination, after opening my eyes I would go and do my work, whatever I have to do. So, it was like a minute of work, so I would just finish it easily but in breathing in and breathing out, it was a same old procedure for me.” Conversely, another student felt that deep breathing was more accessible than Happy Place, explaining, “Deep breathing was most helpful because at certain times you are sad and all you can’t just think about Happy Place. It takes quite a lot of time to keep yourself at corner and be with yourself doing Happy Place. Deep breathing you can do anywhere, so it was like very adjustable and comfortable for everything.”

The combination of deep breathing and deep muscle relaxation was beneficial to a student managing her anger, who shared, “When I get angry, I start doing that deep muscles relaxation and deep breathing. She told me that you do this when you feel angry. If I get angry suddenly, Miss comes in my mind, she tells me every time and her face is going to come, then I started doing deep breathing. So, this I am doing when I am angry. I am not getting angry as first I am getting. Now it is okay.”

Subtheme 1.4.3. Youth shared session content with friends and family

Many students reported that they discussed with family and friends their experience in counseling. One student noted that sharing takeaways helped them synthesize information, explaining, “Talking to them made me realize what was I doing in the counseling. So psychologically it will make me remember things because as they asked me things so I would tell them, and they remember that I did this in this counseling. So, it affects.” Some students taught skills to their family and friends, as the student who stated, “I taught this muscle relaxation and deep breathing to my friends also. They loved it. They are doing now also sometimes.”

Theme 1.5. Enjoyed tracking improvement via progress monitoring tools

Students’ progress was tracked using three tools: a bar graph version of the Youth Top Problems measure, a mood rating using “smiley” emojis, and the Session by Session (SxS) version of the Strengths and Difficulties Questionnaire. Students reported that it was motivating to see their problems decrease throughout treatment, as the student who said, “Every session she would give me this. She would always ask me, ‘How much better do you think you will be in one month’s time?’ and I would say, ‘I always hope for a great day’ and that actually happened. These papers are not just papers, actually, because they made me understand myself, which is a very great thing because we should be self-confident, which I was not at first, but these helped me to know myself.” Students also shared that they liked the bar graph format of the YTP. One student said, “First when I saw this, I was like, ‘What to do?’ I just hate to write. I thought she is going to tell to write. If I have to write, then it is going to be more boring. She told me that you can just draw the biograph. I started to draw that. That helped me. First day my anger was in 10, but at the last day of counseling, when we were closing our counseling, my anger was in 2. Then she showed

me about that. Then she told me which day and for what reason for this change. I can see this, and I can remember about that."

Category 2: Barriers to treatment engagement

While students described numerous facilitators to treatment engagement, they also reported a number of barriers, including low mental health literacy, concerns about confidentiality, worries about stigma, and challenges with scheduling.

Theme 2.1. Youth initially had a limited understanding of counseling that contributed to hesitations about engaging in treatment

For many students, counseling was a relatively unknown concept prior to the initial study rollout. Students reflected on their initial expectations of counseling, including worries about their privacy being violated.

Subtheme 2.1.1. Lack of knowledge about what counseling is and how it might help

Students reported that their limited understanding of counseling and its potential benefits contributed to hesitations about seeking services. One student shared, "I was not sure of counseling but to tell our problems." Another was not sure how counseling might provide additional support and skills to cope with their "tension," a catchall phrase for anxiety and stress, recalling, "When they had come the first time, I was in seventh or eighth standard [grade]. They were telling if you want counseling and all. At that time, I thought I will not take. I had tension but I was not thinking about that. I was thinking that I can manage my own things. Afterwards when I came to ninth standard, I had more stress about the co-curricular activities and so I had to do [counseling.]"

Subtheme 2.1.2. Concerns about confidentiality presented a barrier to initiating treatment

Many students described worries about their problems being shared as a barrier to engaging in treatment. Concerns about parents, teachers, and friends finding out about their challenges came up frequently. One student said, “I was scared that they will inform at our home.” Another endorsed feeling fearful, stating, “I was feeling scared. I thought Miss will say something to someone else.” When students learned about confidentiality, they expressed relief: “I came to know from other kids that your issues will not be shared with anyone and it will be a secret.” As students built relationships with their counselors, their worries about confidentiality were allayed, as the student who said, “I felt confident about her. I thought that she is trustworthy and will not disclose my things to anyone.”

Theme 2.2. Worries about stigma from friends/family made students hesitant to be open about seeking counseling

Although less commonly reported than expected based on the literature on stigma as a prevalent barrier to treatment in LMICs (Patel et al., 2011), several students stated that they were wary of coming to counseling and being open about seeking treatment because of concerns about stigma. Per one student’s report, “Friends and all will tell each other ‘He is going to a counselor,’ and would make fun of me if I shared with them.” Another described general negative perceptions of counseling, explaining, “I don’t know but everyone thinks that going to counseling is a foolish thing. I don’t know why.”

Theme 2.3. Sessions interfered with classes, which was especially problematic for older students

Some students felt that coming to sessions was a challenge because they had to miss class. For students in older grades who faced increasing academic demands and pressure, continuing to miss classes for treatment was not a viable option. As one student explained, “Now I will take off my name from counselor sessions because I am in class 10, and I want to concentrate on my

studies. Yes, I am in 10th standard and studies are tough. I don't want to take risk as students often get failure in this class." Another shared that they did not get enough time in counseling because of competing academic demands: "It was not that much, 30 minutes per session . . . It was less, because we have all this lecture, then I informed Miss that in any free period I will let you know. Also, because I had final exams, that's why."

Category 3: Impacts of the intervention

Overall, students described positive treatment effects, including both symptom reduction and improvement in functioning across settings. They reported noticing changes in themselves and receiving feedback from others that suggested a positive benefit from counseling.

Theme 3.1. Treatment resulted in functional improvement in youths' lives

A number of students shared that their lives had changed as a result of participating in counseling. Across problem types, students reported that the skills they learned were relevant, transferable, and effective – even when they didn't expect the skills to work, as the student who said, "It was like a very big difference in me, and I was thinking like it was small, small activities. I was thinking it won't help me. First, I thought – I am telling you honestly – like I thought the counselors are good, but I thought these activities are like, stupid. I thought, 'Let me try, let's see what happens.' I was trying, trying and it was like part of my life and it started improving me and I noticed it." Another student said simply, "I was getting angry earlier but now the anger is less. I am doing everything nicely in right time, right way."

Students reported that their friends, family, and teachers also noticed positive changes. One recalled, "Teachers also noticing that I am in the class quiet. Between when school was opened and I came to school and now, they can see a difference. First, I was different, kept talking, not completing book also, and now I am like a good student." Similarly, a student commented on her

parents' observation of her improved ability to control her anger: "My parents noticed, like when I got angry when I was watching TV and my father shut it down. Miss told me that I should start taking deep breaths, and my mother said 'She didn't get angry, something is there . . .' I was talking nicely with my father. So, I said 'This is because of counseling.' So, she said, 'Good, go for counseling if that happened because of the counseling.'"

Importantly, students felt prepared to use skills on their own. One student summed it up: "I have learned new skills to decide on my own, like now I can decide what is right and what is wrong."

Category 4: Recommendations

Students offered recommendations to improve the counseling experience, ranging from materials to treatment duration to different delivery formats.

Theme 4.1. Overall satisfaction with materials but suggestions for improvement included more color

Most students did not provide extensive feedback on the materials, which included the student-facing flipbook and handouts. They generally described the materials as "helpful" and "easy." However, several students offered suggestions, including incorporating more colors to make the materials "attractive" and using colors to facilitate understanding, such as the student who offered, "Like red color means bad and yellow color means good. If a person is angry, it should be flagged as red and if a person is not angry it should be flagged as good and yellow. It would be easy for others to understand." Another student recommended having more blanks to fill out on the handouts to allow for practice: "These blank spaces, like there are only 8. It could be 15 instead so that children could do more after the session and all."

Theme 4.2. Desire for more treatment in order to spend more time with counselors

Given students' reports of strong therapeutic alliance, it is not surprising that several respondents suggested increasing the session duration, frequency, or overall length of treatment to spend more time with their counselors. One student explained, "I want more time with my counselor, I want to sit alone with her and talk nicely. She also talks nicely." Another stated, "It is like twice in a week is actually not ok. So at least make it thrice a week."

Theme 4.3. Activities can be improved in various ways, including having more options and different formats

Students suggested that the treatment include more "fun" and "accessible" activities, in addition to more options for relaxation practices. Changing the format of counseling was also a recommendation given by one student, who said, "One of the ideas is group counseling. It should be done with the friends and the people who have the same problems. It will make you think lesser. The same person will explain the whole lot of things to the same group. They will understand and it will be utilized. It will also save time."

Theme 4.4. Increase students' privacy by changing the system for calling students and making materials more discreet

Confidentiality was repeatedly brought up as an essential element of treatment. Students were typically called to session by counselors receiving them from the classroom, which was noted as problematic by some. One student said that she did not like, "How counselor called students in the class loudly. There are other students, also, so that thing should be changed. That should be changed by giving note. You can call for the first counseling but in the next counseling, you can give note that these students should come. We can show that note to teacher and they can come for counseling." Making the handouts more discreet was offered as another recommendation to increase privacy: "If I take something in my hand and they are standing there and they read and

say, 'Hey, [student's name] got the certificate as she is going for counseling.'"

Provider Interviews

Table 3 presents themes and sub-themes with exemplar quotes. Provider responses fell into four key themes: (a) Facilitators to treatment engagement; (b) Barriers to treatment engagement; (c) Training and supervision; and (d) Complexity. Descriptions of these key themes and sub-themes are discussed below.

Category 1: Facilitators to treatment engagement

Providers described engaging in behaviors to facilitate students' participation in and commitment to treatment. They also identified characteristics of the intervention, setting, and parental support as facilitators to engagement.

Theme 1.1. Tailoring treatment enhanced engagement

Providers described making adaptations to treatment content in order to engage students. They reported that taking a collaborative, rather than directive, stance also improved engagement.

Subtheme 1.1.1. Providers adapted their style of delivery according to students' cultural backgrounds

Providers reported noticing differences in students from various cultural backgrounds and adapting the treatment accordingly. One provider described her perception of how students in Delhi compared to students in Goa: "I feel like just the exposure is different. Like I can't compare the Goa site to the Delhi site smoothly. It's just that like there is sort of an exposure that the students in Delhi have. For example, let's say exposure to, more access to, information. It's just different information that the students in Delhi might be interested in." Another provider shared that she adapted her style of delivery to engage a student from Haryana, a state bordering Delhi, explaining, "You know what are

Haryanvis like, right, so you have to adapt your style because if you do this style, I think it may be too new for them. She is anyway not engaging me, what she expects is not this style of work. So, I think it's just like, adapt the style to see if that keeps the client engaged in any way."

Theme 1.1.2. Going beyond the manual to build rapport facilitated engagement

Providers felt strongly that engaging students required extra effort and the use of engagement strategies beyond what was written in the manual. They described taking time to learn about the students' interests and really listening to them as positively impacting engagement, even if doing so temporarily interfered with teaching skills. As one provider put it, "I would say the therapist's comfort with the treatment, their ability to make the student feel comfortable, their rapport building, their ability to sometimes just listen to what the student has to say, being more attentive to the students' needs at that particular point of time, because sometimes they come and they might have all these concerns that are not necessarily part of the agenda, and then if you want to pursue the agenda you might lose the student because they don't want to talk about your agenda, so just having those kinds of skills to be able to attend to the student and engage with the student, essentially, that was beyond the treatment manual and I think that makes a huge difference to having the student be engaged."

Theme 1.1.3. Taking a collaborative approach improved engagement

Inviting students to be active participants in treatment was reported as one way to get students more engaged. Providers felt that being collaborative, rather than directive, provided students with a relationship markedly different from their relationships with other adults in their lives. They also noted that they tried to prioritize the students'

logistical needs to make it easier for them to attend session. One provider described her approach to engaging students: “Maybe just like, this is all usual, but just saying, ‘Please interrupt me whenever, if you have any questions,’ or I think a lot of it had to do with scheduling at a time that was convenient to them which made it comfortable for them to attend. Other than that, I think, just acknowledging that ‘This may be awkward, and you might feel like you don't know what you're doing here, you know, there's a lot of uncertainty but don't worry, we'll figure it out.’”

Theme 1.2. Relaxation was relevant, easy to deliver, and improved engagement

Relaxation was perceived by providers as means to build rapport in addition to being a useful skill that was culturally aligned. One provider explained, “I would say that the relaxation is the most helpful because you have already done the psychoeducation, and the child is more familiar with you. Relaxation is something that children enjoy also, so I that think that really helps cement the alliance and that also is something which children actually took back home with them. Something they could practice also so it is helpful.”

Theme 1.3. Stronger engagement was seen in schools compared to the clinic setting

Although the intervention was originally developed to be school-based, changes at the Delhi site led to Step 2 being delivered in a clinic near the schools instead of in the school buildings. Providers felt that requiring students to leave the school premises to attend sessions interfered with their ability to engage in treatment. One provider spoke to the more robust engagement seen in school compared with the clinic: “I think the ease of access could have been another reason. When you are in school, whenever you are free, you can just go and meet the counselor, but I think the whole burden of okay, I have to take time, either leave early or have to come after school [to the clinic].”

Theme 1.4. Parents can serve as facilitators or inhibitors of treatment

Providers mentioned parents' impact on student engagement. Depending on the parent's attitude toward therapy, parental involvement was seen as a inhibitor or facilitator to treatment engagement. One provider noted, "All the children who were coming for counseling are the ones whose family members seems to be quite supportive. The children also seem to be supported. They did not seem to have concerns related to stigma or anything related to literacy or social class." Conversely, another provider described how family expectations can interfere with engagement: "If the parents say, 'Don't go for counseling, don't go for treatment,' or if the parents have some feedback to say about, you know, 'I am not comfortable with you going,' then maybe that could be an issue, because there was one student in another school where she was motivated to come but she didn't come because of her parents and all."

Category 2: Barriers to treatment engagement

Providers reported a number of barriers that presented challenges to engaging students. Components of the content and presentation of the intervention were cited as barriers, as were practical concerns related to the school context. The transition from Step 1 to Step 2 also emerged as a barrier.

Theme 2.1. Some intervention content and materials interfered with engagement

Providers described challenges with teaching several concepts to students, especially those that were not translated into the local language in the manual. They also noted that the materials could be overwhelming to students in session and offered recommendations for improvement.

Subtheme 2.1.1. Certain concepts were challenging to translate and seemed difficult for students to grasp

Providers felt that some of the skills in Step 2 were difficult for students to understand and that the manual did not provide appropriate language to facilitate learning. In particular, the concept of assertive communication was challenging for students to grasp. Translation also presented a challenge. Providers noted that the technical terms for body parts used in the deep muscle relaxation script were not culturally aligned, with one stating, "It was quite awkward especially in Hindi. No one ever uses the names of the actual muscles. It is very difficult to point to specific body parts in Hindi. Even in clinical settings when I was speaking to other psychologists, it is done in more informal yet professional manner. No one ever says the exact word, tighten XYZ muscle and release it and feel that, so that level of sophistication of language the kids just didn't understand."

Subtheme 2.1.2. The volume of materials interfered with student engagement

The number of student-facing materials was thought by some providers to interfere with student engagement. In each session, providers had students complete three different questionnaires about their mood and problem; they presented handouts relevant to the session content; and they used an illustrated flipbook to help students understand concepts. For some students, the amount of material was reportedly a distraction: "Flipbooks, two of my students, they were engaged. But other students, the two students, one who dropped out and one from 8th standard, they continuously kept on changing the pages just to look on what is there, and when the counselor is talking, they keep on staring at that particular page which is displayed. So those I felt like, those stuff is quite disengaging even you don't feel like the way you communicate, so that time you feel like it's a barrier sort of thing."

Subtheme 2.1.3. Materials could be improved to better fit the context

Despite the fact that the treatment and training materials were collaboratively designed with members of the India treatment, some providers felt that they did not fit the context. One provider stated that she would have appreciated it "If the person who was responsible for developing the manual was more responsive to our needs, which I felt was obviously not responsive to our needs." Although not all providers shared that perspective, another provider said, "Handouts also, I think they are very westernized. It did require kids to do a lot of writing, which in these settings where we are working, the kids are not great at doing it. I am not saying kids do not do it, but the setting we are working in, the kids might not be able to do it."

Theme 2.2. School structure and setting negatively impacted engagement

Although providers reported that delivering treatment in schools led to better engagement compared with the clinic, they also described challenges associated with the school system and setting that negatively impacted engagement.

Subtheme 2.2.1. Lack of space and privacy interfered with ability to deliver treatment

One contextual challenge that providers reported related to the physical space available for sessions. In both the clinic and school settings, providers described limited privacy. Of the Delhi clinic, one provider stated, "In clinic, there were lots of difficulties. The room was large, and we had fixed several screens. But noise was definitely an interference especially if you have concurrent session going on right to you." Space was also a concern in some of the Goa schools. One provider expressed frustration that she did not have a set room for therapy, explaining, "The counselor itself was moving from one place to another, and I had to shift between the rooms and ask, otherwise I'd have to

wait in the library or the passage till the room gets vacant and then take the sessions there. So, there it was bit challenging."

Subtheme 2.2.2. Going to therapy during class time was a barrier for students

Providers reported that students cited not wanting to miss class as a reason for inconsistent attendance or dropping out of Step 2 completely. Upper-level students in particular were concerned about missing class, as pressure around exams and grades increases as students prepare to apply for or enroll in senior secondary education, equivalent to 11th and 12th grade in the U.S. One respondent noted that those least likely to attend sessions were "10th standard students because they don't want to come, and some student didn't want to come as they miss out on the portion and whatever the things the teacher gives them, the homework, and they would miss the notes, and the other students would not give their books to complete."

Subtheme 2.2.3. Vacations and exam periods interfered with engagement

The school calendar interfered with engagement as well. Students were often unable to attend sessions regularly due to extended vacations, often for religious holidays, and exam periods of up to three weeks, during which regular classes were canceled and students came to school only to take their exams. One provider described how summer vacation led to a student dropping out: "The other one just moved to village and say she is not coming. She is going to village for two and a half months for summer vacation so that's too much long time for gap in services."

Theme 2.3. Transition from Step 1 to Step 2 negatively impacted engagement

Students participating in the intervention stepped up from Step 1 to Step 2 if their scores on the SDQ Total Difficulties or Impact scales were above clinical thresholds. Stepping up necessitated

a switch in providers, with students moving from a lay counselor in Step 1 to a more experienced psychologist in Step 2. Step 2 provider respondents reported that the transition from Step 1 to Step 2 presented a barrier to student engagement. Providers suggested that students did not understand the rationale for changing providers. They also thought that students were not well-informed about the reason for continuing treatment. One provider explained, "So, already they have completed 5 sessions and then they come to Step 2. So, there are queries at the start, 'Why have I been stepped up?' or 'Why I have to come in for Step 2?' you know . . . So that was the challenge, just to make student understand that your one problem may be solved or may not be solved, and we are just trying to teach you some new skills apart from skills what you have learned."

Theme 2.4. Engagement was poor when students did not find the module relevant to their problem

Providers commented on the lack of fit between a student's problem and the treatment modules as a likely reason for poor engagement. In addition to students feeling like the module was not relevant to their problem, requiring them to move through mandatory modules extended the overall length of treatment, compounding engagement challenges. As one provider explained, "I think there was some initial curiosity as to what was on offer but after it took a while, and I feel like I lost some of them because it took longer than required to get to their core concern . . . I don't think they were engaged in the content enough to appreciate it and come back. They should have at least been told clearly that it will take this long. I think lot of them just came in just to see what it was, and when it was sort of getting boring or when they felt like this wasn't what they expected, they just dropped out."

Category 3: Training and supervision

Providers described their experience with the Step 2 training and supervision model. Responses largely conveyed challenges that providers experienced during training and supervision. Providers offered recommendations to improve both processes.

Theme 3.1. Desire for more and different training

The Step 2 training was described as falling short in preparing providers to deliver Step 2. They identified areas for improvement in terms of training content and format.

Subtheme 3.1.1. Training did not adequately prepare providers to deliver treatment

Nearly all providers reported feeling that a three-day training did not sufficiently prepare them to deliver Step 2. Multiple providers expressed a need for additional training on the cognitive and exposure modules. For example, one provider stated, “They have mentioned a lot about how the cognitive module was really difficult to teach and for the students to be receiving and understanding. If that is the case, I feel the focus of the training should be much larger for that area.”

They also expressed a desire for training in general CBT skills, noting, “As I already mentioned, general CBT skills are something which can be included . . . because it will be a fallacy on our part to assume everybody knows those basic skills. Everybody has to be trained.” Similarly, suggestions were made to spend time on common factors: “It would be really helpful for us to go over the idea of how to get a student comfortable. Even though, let’s say, we are trained psychologists and we do know lots of these things, there is no harm in reminding us, just some basic skills.”

Providers described the gap between the training and initiation of treatment, which for some providers was several months, as a challenge. They commented that a refresher

training would have been helpful: “Even if it was a day-long training, that would have been helpful just to have us recap everything once and then go into delivery.”

Subtheme 3.1.2. Dislike role plays in training

Role plays were an integral part of the training, offering trainees the chance to practice teaching skills, as well as receive feedback from peers and trainers. However, providers’ feelings about the role plays were largely negative. Providers expressed a desire for more modeling with real-life examples. One provider explained, “What would have been nice is to see a video of a therapist-student interaction or a more authentic-looking example because even in the training, like, the facilitators were sort of making along as they go. So, it would have been nicer to see something closer to real life even for the training.”

Theme 3.2. Supervision format and focus can be improved

Providers shared challenges experienced during supervision. They noted that having more supportive, structured supervision would have been helpful, especially given the challenges of communication across sites.

Subtheme 3.2.1. Supervision felt punitive rather than supportive

Providers shared that supervision often lacked the support they desired, particularly because they perceived Step 2 as more complex than Step 1. Although they recognized a need to hear feedback about their areas of growth, they also expressed a desire to be recognized for what they were doing right: “During the process of supervision, it is important – for both Step 1 and Step 2 supervision – that we give a constructive feedback. When we say constructive, it also means if you think something was not done well, give options how it could have been done better. Of course, reflect on what has been done well.” One provider suggested that adopting a more reflective and

collaborative style could improve supervision because "that would help me or have me take home more points for me to improve my treatment versus me sitting there and just feeling like I am going to be assessed every time, and then I am not feeling like sharing any of my details because I feel like I am already being judged or persecuted for the session that I have put out."

Subtheme 3.2.2. Supervision should be more structured in order to yield useful feedback

The structure of supervision was in flux for the majority of the CCS as the treatment development team tested different supervision formats. This resulted in providers feeling like supervision was unstructured and offered limited opportunities for meaningful feedback. One provider said, "Most of the time I feel like the supervision was poorly organized; it was not very well structured. It felt like there was lot going on in there, but I didn't really feel that I understood what kind of feedback points I was getting." Several providers suggested listening to session audio prior to supervision rather than during supervision to save time and create space for discussions about how to deal with challenging cases. Some providers voiced a need for support outside of weekly supervision, citing the two-hour supervision meeting as untenable given the number and complexity of Step 2 cases.

Subtheme 3.2.3. Multi-site setup presented barriers to communication between team members

The team of providers was split across the Goa and Delhi sites, and respondents noted that the distance interfered with communication. One provider explained, "So, somehow I think this cross-site phenomena makes it difficult especially if you are not connected. So, a lot of us have not worked with [Provider 1] as much as [Provider 2] or [Provider 3] so

> obviously your degree of comfort, your similar contexts – we share a context, we know each other a lot, it's easier to understand what everyone says just because you are there. It makes a difference. It's more easy to convey to a person sitting next to you, we can say, 'Okay, fine, I understand' while lots of these small nuances are difficult to pick up in these inter-site meetings."

Category 4: Complexity

One of the central considerations of Step 2 development was balancing complexity with utility. The team aimed to minimize complexity of the treatment to make it suitable for a non-specialist workforce while allowing for flexibility and high utility in order to increase the impact of the intervention. Provider responses suggested that this goal was partially met. Many expressed a desire for additional support with more complex components of the treatment while also reporting an increased ability to handle complexity with experience delivering the treatment.

Theme 4.1. Lack of enthusiasm for manualized protocol because it interferes with "good" care

The manualized nature of the treatment, while allowing for flexibility, left providers feeling restricted in their ability to deliver quality care. As one provider explained, "Using sometimes a manual intervention is not satisfying at my level, because there you feel if I have to do exposure as per what I know, I could have done more spontaneous and more adaptive to the need of the client and respond to that client rather than going by the steps. But that's the problem with any manual-based intervention – once you have experience, it's very difficult to follow a manual, you feel spontaneity would work much better for you interacting with your client or participant. But that is a limitation of any manual." Providers suggested that needing to follow a manual interfered with their ability to engage students: "With some of them I think, I don't think I have made as much of effort to engage with them as much I would have maybe liked because I think I

was little wrapped up in what the treatment was like in the manual, and therefore I might have lost a little bit of that idea of just engaging with them, paying more attention to them and just listening to them little bit more and being more attentive."

Theme 4.2. Provider-facing materials were overwhelming

Providers discussed the challenges they faced navigating the various treatment materials. As one provider said, "Earlier it was like there were too many documents to refer them. Like manual was there. The therapist guide was there. The flipbook was there. Handouts. Plus, the clinical record form, the mood rating, so it was too many just to give the records of. I didn't know where it was, like in session you had to refer a lot, many things at one go." She noted that while the decision to consolidate some materials midway through the case series, was helpful, more streamlining would be better: "So, then it was modified, like the scripts, the relaxation scripts, it was added to the manual. So, it could be like, the therapist guide could be added to the manual. It could be one single document just to refer, and apart from that, manual plus flipbook so these two things are helpful, and then clinical record form."

Theme 4.3. Past experience helped providers with treatment delivery, along with increasing familiarity with the intervention

Providers' previous clinical training and experiences were cited as helpful to learning a new, relatively complex intervention, although educational background and familiarity with certain concepts varied across providers. Repeated delivery of Step 2 also led to increased comfort with the treatment.

Subtheme 4.3.1. Prior education and training gave providers a foundation on which to build when learning Step 2

Providers reported that their past experience facilitated learning and delivering the Step 2 intervention, even when certain components were unfamiliar. However, providers came in with different backgrounds, so although they all reported feeling confident in their abilities as counselors, some skills were less familiar to certain providers. One provider explained, "I have been in counseling for many years, so quite some time, and I was quite confident of delivering counseling to the student, but this was something new to me because there were some parts which I had not delivered earlier . . . So that was little bit, you know, it was not difficult, but you know, I think so, a bit challenging."

Subtheme 4.3.2. Providers' sense of confidence and competence increased with experience delivering Step 2

Providers shared that with time and practice, they were more confident in their ability to deliver Step 2. Respondents discussed feeling more facile with the materials and less reliant on supports like the manual scripts, such as the provider who said, "Earlier I used to refer to the manual, like looking out for the things which I have covered, which I have not covered, which I have missed. But over the period of time, it was easier."

Theme 4.4. Clinical decision making was a challenge

Clinical decision making emerged as one of the most significant challenges experienced by providers during this phase of implementation. They expressed a desire for increased support around the decision making process.

Subtheme 4.4.1. Uncertainty about the process of identifying the "best" module for the treatment focus

Selecting a behavioral module was commonly reported as a challenge. Providers expressed feeling frustrated when they perceived a mismatch between a student's

reported problem and the three behavioral treatment flow options. They also reported difficulty choosing a module when more than one module could be appropriate for the student's problem. For example, one provider shared, "So, I think it's in the overlap of the three modules that you kind of get confused. Because any one of the three you could have chosen. Each one has its own benefits. It's not like sure shot for symptoms versus module, right? You can't be that cut right about it. Like BA could work, exposure could work, which one do you pick? You know, so, and it's time sensitive. I think it's convenient that we say, 'Okay, but it couldn't hurt' but then, you've sort of made the child come for two more weeks. And at the end of the day, what matters is whether they feel any change or not. Not that we say, 'Oh, but it didn't hurt,' you know. Not hurting is not the same as helping. You know what I mean?"

Subtheme 4.4.2. Need for support with clinical decision making

Providers expressed a need for support when making clinical decisions, such as choosing a treatment focus, repeating content, or deciding when to terminate treatment. Supervision was the primary means through which providers sought support, but they described a desire for additional guidance for making clinical decisions. A provider stated, "There are times where I found it difficult to understand when to initiate maintenance and termination module . . . that kind of part where you think that the student has learned enough to be able to initiate termination can get a little tricky, and to what extent you want to review and revise things within that maintenance and termination would be helpful to have some guidelines."

Discussion

This qualitative study examined barriers and facilitators to treatment engagement from youth and provider perspectives in a pilot study of a modular, multi-problem, school-based intervention for adolescents in Goa and Delhi, India. Youth and provider participants also described their overall satisfaction with the treatment in terms of acceptability and fit. Although youth reported preliminary hesitations about initiating treatment, youth and providers described overall strong engagement in the intervention once treatment commenced, although there were differences in retention between Goa and Delhi sites. The two groups of informants largely aligned on their perceptions of barriers and facilitators to engagement. The therapeutic relationship emerged as a key facilitator to engagement as reported by youth and providers, as did peer influence. Challenges were noted related to delivery in the school setting, such as competing academic demands and privacy. Youth discussed positive outcomes of participating in treatment, including functional improvements in their lives, while offering recommendations to increase acceptability and fit. Providers identified several implementation supports that could be improved, primarily training, supervision, and clinical decision making. Notwithstanding these identified challenges, results suggest that youth and providers largely perceived the treatment to be engaging, acceptable, and appropriate for the context. The findings provide preliminary evidence to guide optimization and scale up of this transdiagnostic treatment across India, increasing adolescents' access to evidence-based mental healthcare for a range of problems and narrowing the treatment gap in LMICs.

Many of the facilitators and barriers to treatment identified by providers and youth are consistent with the literature on engagement. Engagement has been conceptualized as a multidimensional, dynamic process comprised of cognitive, behavioral, and social dimensions.

Findings from the current study align with Becker et al.'s 2018 REACH framework, which proposes five domains of engagement: Relationship, Expectancy, Attendance, Homework, and Clarity. The therapeutic relationship has consistently been found to be critical in promoting engagement in therapy with youth (Shirk & Karver, 2011). Compared to adult clients, who typically initiate treatment after recognizing a need for support, children and adolescents are often referred by caregivers or teachers who perceive a problem. If referred youth do not believe they have a problem, they may be less motivated to participate in treatment (Hawley & Weisz, 2003). Even when youth self-refer, they may have limited insight into their problems and less knowledge about the therapeutic process, resulting in hesitations to engage in change-oriented activities (e.g., exposure) critical to optimal outcomes. A solid therapeutic relationship can promote buy-in through engendering trust, thereby increasing youths' willingness to try skills that lead to positive outcomes. Results from the current study illustrate the power of a warm, caring, and collaborative relationship, in alignment with findings from previous research that highlight the impact that providers' reactions, including verbal and non-verbal responses, can have on youth engagement (Lavik et al., 2018). Youth described providers' characteristics, such as their smiles and manner of speaking, as important to them feeling comfortable, along with the perception that providers were genuinely curious about their interests and invested in their wellbeing. Providers reported taking steps to help youth feel comfortable, including making adaptations to fit students' cultural backgrounds, spending time learning about youths' likes and dislikes, and inviting them to be active agents in their treatment. The strategy of cultural acknowledgement has been found to enhance engagement through improving the therapeutic relationship (Becker et al., 2018). Both student and provider responses demonstrate that the time invested in building a solid relationship facilitated youth engagement and their positive

perceptions of the treatment. The importance of the therapeutic relationship was further highlighted by providers' observation that some youth reported difficulties transitioning from their Step 1 to Step 2 provider and questioned why they needed to start over with a new therapist. The relatively high rate of dropout between steps might be explained in part by youths' reluctance to establish a new therapeutic relationship, suggesting that a single-provider model could be a way to reduce attrition and adding to the literature on the role of a strong alliance in retaining clients in treatment (Garcia & Weisz, 2002; Kazdin et al., 1997) and leading to positive outcomes (Horvath & Bedi, 2002).

The role of expectancy, the second REACH domain, emerged as another significant facilitator of youth engagement. Expectancy has been defined as the expectation that treatment will help and belief in one's ability to participate successfully in treatment (Nock & Kazdin, 2001). This attitudinal component of engagement has also been conceptualized as "buy-in" when combined with a client's investment in, or commitment to, treatment (Yatchmenoff, 2005). When clients believe that treatment will be helpful and have realistic expectations about the treatment process, they are more likely to stay in treatment and have better outcomes (Kazdin & Wassell, 2000). Previous research has demonstrated that preparatory techniques such as providing information on treatment prior to initiating treatment facilitate realistic expectations that lead to better engagement (Staudt, 2007). Results from the current study support this finding. Students reported that school-wide sensitization activities that included a video about mental health and a classroom discussion increased their knowledge about counseling and led to the expectation that counseling would help them learn to solve their problems. Peers' successful treatment experiences also facilitated youths' positive expectations about treatment. The power of social influence is well-documented. Rogers' (1995) model of diffusion of innovations

proposes that new ideas and practices are communicated and taken up among members of a social system, and that individuals are more likely to adopt an innovation when learning about it from a close and trusted source of knowledge, such as a close friend or relative. Youth responses in the present study substantiate this theory; youth reported that hearing about their friends' experiences in therapy made them curious about the process and fostered a belief that treatment would be effective for them as well. Parental support also played a role in youths' decision to seek treatment, with some describing how their parents' encouragement helped them feel more comfortable participating in treatment. Similarly, providers reported parents' perceived or actual disapproval of counseling negatively impacted engagement, illustrating the potential for innovations to be rejected based on close others' communication about it. While preparatory techniques and peer influence increased youths' positive expectations about treatment prior to initiation, youth shared that tracking their progress on measures at each session was motivating and provided concrete evidence that treatment was working. Given that attitudinal engagement can be conceptualized as a developmental process such that perceptions of treatment effectiveness during the course of treatment might impact expectancy and therefore engagement (Hock, Yingling, & Kinsman, 2015), the potential benefit of youth-facing progress monitoring tools on engagement should be explored in future research.

Attendance, another REACH domain, has long been one of the primary metrics of assessing engagement, as it is a behavioral indicator that is relatively easy to measure. While attendance alone does not fully capture an individual's engagement in treatment, it is a marker of participation and can signal poor engagement, most notably through premature termination from treatment, although inconsistent attendance is often a precursor and warning sign. In the present study, attendance as measured by early dropout from treatment differed greatly between the

Delhi and Goa sites. In Goa, 14 out of 16 participants completed treatment; in Delhi, two out of 16 participants completed treatment. Youths' reported reasons for dropping out were problem resolved (Goa: n = 1; Delhi: n = 1), competing school-related time demands (Goa: n = 1; Delhi: n = 3), and no longer interested in participating (Delhi: n = 7). In Delhi, two students did not respond to attempts to follow up, and one student declined to provide a reason. A major difference between the two sites that might explain the discrepancies in attendance was that treatment was delivered as planned in schools in Goa, while in Delhi, there was a shift from school-based delivery to an off-campus clinic due to extenuating circumstances. Providers in Delhi, who had previously seen students at schools for an earlier phase of treatment, noted that it was significantly more difficult to engage students in treatment outside of the school setting. They cited ease of accessibility as a primary benefit of school-based treatment. However, they also identified challenges associated with delivering the intervention in schools that might have interfered with students' ability or desire to attend sessions, such as limited space and privacy, extended holidays during which students were out of school for weeks at a time, and competing academic priorities, including exam periods and classes. Students, too, commented on the tension between attending sessions and missing classes. This was particularly a challenge for more advanced students preparing for competitive entry exams for grades 11 and 12, known as higher secondary school in India. While schools have been identified as an ideal setting in which to scale up delivery of mental health services in LMICs (Patel et al., 2013a, 2013b), the challenges reported by students and providers in the current study have been described as barriers in other studies (Meza et al., 2020) and should be addressed in order to allow youth to attend both treatment sessions and school classes. Getting buy-in from school administrators and staff and involving them in the process of balancing these priorities is essential.

The majority of youth who participated in the intervention had limited knowledge about and experience with psychotherapy. On interview, many mentioned initial hesitations about treatment rooted in lack of clarity about what to expect. Clarity as defined by the REACH framework encompasses an individual's understanding of the treatment rationale, approach, structure, goals, and roles. Based on findings from previous qualitative research conducted in schools in Goa and Delhi during the preliminary formative phase of research of PRIDE (Parikh et al., 2019; Michelson et al., 2002), the intervention development team aimed to increase clarity and address concerns about confidentiality through school-wide sensitizations that included psychoeducation about services in this phase of research. Despite these efforts, worries about confidentiality were frequently raised by youth in the current study and represented a potential barrier to engaging in treatment. This finding is consistent with the literature on the importance young people place on privacy and confidentiality in mental health treatment (Gulliver, Griffiths, & Christensen, 2010). Youths' desire for confidentiality related to their concerns about stigma, as they feared being teased or misunderstood if their participation in treatment were made known. Continued efforts to increase knowledge about mental health and clarify what treatment entails might reduce the stigma of help-seeking and related worries about confidentiality. Clarity on the purpose of skills taught and their relevance to the problem was described as a facilitator to engagement. Youth largely perceived skills as helpful for their problems, demonstrating their awareness of treatment targets and how activities related. Providers reported observing a decline in engagement when students did not understand why they were learning a skill or how it was relevant to their problem. They also noted that certain concepts seemed challenging for youth to grasp, speaking to the need to involve youth in treatment development in order to elicit feedback

on ways to facilitate understanding. Modeling shows promise as another way to improve clarity, both at the beginning of treatment and throughout (Becker et al., 2018).

Homework, fifth domain of the REACH framework, represents an individual's participation in treatment activities in and out of sessions. Completion of homework between sessions has been recognized as a means of facilitating skill acquisition and mastery and is associated with improved clinical outcomes across diagnoses (Clarke et al., 2015; Kazantzis et al., 2010). Practicing skills at home also gives individuals a chance to generalize therapy activities to real world settings and identify barriers to doing so (Persons, Davidson, & Tompkins, 2000) and has been hypothesized to increase self-efficacy (Detweiler & Whisman, 1999). Few youth in the current study commented on their experience with homework. However, their recommendations included increasing the feasibility of at-home activities by taking into consideration fit for context, as well as revamping the design of handouts used in session and for homework to make them more colorful and attractive. Similarly, providers suggested changes to materials to increase cultural fit and make them more accessible through modifications such as limiting the amount of writing required, in addition to reducing the number of materials overall because of the negative impact on engagement. These recommendations highlight the importance of collaborating with stakeholders to co-design treatment materials using a person-based approach (Yardley et al., 2015). While providers were part of the design process from the early stages of protocol development through implementation (Chorpita et al., 2020), youth were less involved. The intervention development team used youth feedback from earlier phases of the project to inform material design, taking into consideration expressed preferences for high-quality graphics that were colorful, shorter text, and simpler language (Michelson et al., 2020). However, both youth and providers expressed that the

materials used in the current study did not fully meet these benchmarks, pointing to a need for more frequent feedback from end users during the design process to ensure that the protocol and accompanying materials are, in fact, as enjoyable, usable, engaging, and effective as intended.

Although students identified barriers to engagement and offered ways in which the intervention could be improved, the barriers that emerged were not related to intervention content, highlighting the overall acceptability of the treatment for youth participants (O'Donnell et al., 2014). Additionally, youth responses indicated that they felt the treatment was effective and led to improvements in their lives. While the general tone of youth responses was positive, providers raised a number of concerns related to implementation supports and intervention complexity. These issues, while coded outside the barriers and facilitators categories, have implications for engagement. Providers felt underprepared to deliver treatment at the beginning of the pilot study and unsupported throughout. Their lack of comfort with the intervention and low confidence may have interfered with their ability to effectively engage students. Counseling self-efficacy, or the degree to which providers feel confident in their clinical skills (Larson & Daniels, 1998), has been shown to increase with training, supervision, and clinical experience (Bernard & Goodyear, 2014; Lent et al., 2009). However, the quality of these experiences and perception of support matter. Supervision that feels unsupportive has been found to lack the same buffering effects against burnout as supportive supervision (Poulin & Walter, 1993), and supervision experienced as difficult or harmful has been associated with lower levels of self-efficacy (Gray et al., 2001; Ramos-Sanchez et al., 2002). Given the evidence that positive, supportive supervision benefits both supervisees and clients by allowing providers to focus on their clients' needs rather that their own emotional processes (Vallance, 2004), it is essential to

identify ways to improve the training and supervision models of the Step 2 intervention in order to increase providers' self-efficacy and improve client outcomes.

Providers' expressed desire for additional training and support, as well as their reported challenges navigating clinical decision making processes, relates to a central theme that arose during the Step 2 treatment development process: how to balance complexity with utility (Chorpita et al., 2020). In an effort to maximize the impact of the intervention, the treatment development team included features (e.g., decision points for different treatment flows) to increase its effectiveness and reach youth with multiple problem types, adding complexity that was hypothesized to be feasible for the target workforce based on evidence (Buckingham et al., 2019) that community mental health providers in the US with similar training backgrounds have successfully delivered similar treatments including Managing and Adapting Practice (MAP), which provided the building blocks for the current protocol. However, throughout the development process, the India-based implementation team suggested that the level of complexity was too great for local providers with limited training in modular, transdiagnostic treatments, raising questions about scalability and sustainability. Discussions amongst team members regarding these concerns resulted in a version of the protocol that aimed to address issues of utility and complexity and was thought to be acceptable prior to commencing the CCS. Results from the current study reveal that despite these efforts, providers felt unprepared, indicating that the treatment development team fell short in either the design of training and supervision models, communicating the professional development path to help providers anticipate expected challenges, or both. This finding is despite the treatment team's assessment of providers' skill and comfort in delivering the intervention via the pre-training survey and efforts to tailor the training to address gaps in experience. At the same time, the design team took

a developmental approach to protocol design that anticipates providers feeling overwhelmed early on. The hope is that over time, providers might get less frustrated as their experience and confidence grows. Designing an intervention that can lift people who have minimal skills at the beginning, but brings everyone along and keeps them challenged, rather than aiming for the baseline competencies of the workforce, prevents later boredom in providers and allows for inclusion of important features are missing that maximize utility.

Returning to the theory that informed development of the protocol is instructive for solving challenges reported in interviews. Chorpita and Daleiden's 2018 model of coordinated strategic action (CSA) offers a framework for managing implementation and related activities using the relevant knowledge bases and a system of management that coordinates their dependencies. Within the service system context, which is comprised of multiple layers of organization, direct clinical services occur within the service layer and represent a dynamic interaction between provider and client. Clients and providers bring with them unique skills, competencies, perspectives, and preferences into each interaction, and throughout a treatment episode, they progress in these areas within the therapeutic context and in their lives more broadly. Although clients largely rely on providers to foster growth through teaching skills and encouraging rehearsal outside of session, providers turn to supervision and consultation for their learning and support. As described above, good supervision is crucial to providers' sense of self-efficacy. The CSA model regards supervision as a social practice that facilitates growth and performance of providers through a developmental and supportive lens, recognizing that progress can be incremental and requires scaffolding. In the current study, providers' responses suggest that training and supervision lacked the necessary intermediary steps to help them get to the next level of proficiency and confidence. This resulted in anxiety about potentially being judged for

what they perceived as their own underperformance as clinicians when, in fact, it was developmentally appropriate to experience challenges as they encountered increased complexity. Additionally, given that engagement is a dynamic process, if a therapist is unprepared or has reservations about their ability to implement an intervention, it is possible that their lack of confidence in session might elicit certain responses from the youth indicative of poor engagement, further reinforcing providers' sense of incompetence in a vicious cycle that further disengages the youth.

In the next phase of implementation of the PRIDE study, supervision and training protocols can be revised to include more supports, such as incorporating more modeling into the training to prepare providers to engage in role plays; coming up with a more structured supervision format that reserves time for positive feedback; and creating resources to help with particularly complex components of the intervention. One such resource was created during the CCS in response to providers' reported difficulty with clinical decision making (Knudsen et al., under review). This one-page guide was evaluated in an open trial and found to increase providers' ability to make expert-aligned decisions about treatment flow and significantly improve their confidence in doing so. Another proof-of-concept evaluation of a coordinated knowledge system (CKS) to address low treatment engagement in India was found to be feasible and acceptable, with high ease of use and utility (Becker et al., in preparation). Through adding such supports and clearly communicating expectations around the professional development path, providers will be better equipped to handle complexity and manage their own emotions without compromising the dynamic and diverse nature of the treatment that renders it effective, engaging, and far-reaching.

Limitations and Future Directions

The current study has a number of strengths, including its rich qualitative analysis of multiple stakeholder perspectives on the high-intensity component of a stepped care intervention in India, which to our knowledge has not previously been evaluated in this context. However, these findings need to be considered within the study's limitations. First, the sample size of providers and students was small, limiting generalizability of results despite one strength of the study being that the research was conducted in two diverse sites, Delhi and Goa. The small sample size also limited our ability to draw quantitative conclusions about potential differences between sites, as analyses would have been underpowered. Similarly, while the diversity of provider backgrounds shed light onto the sorts of challenges that might arise depending on levels of training and experience, the small number of providers did not allow us to quantitatively test how provider characteristics might factor into their experience delivering the intervention and engaging youth. The change in service delivery setting in Delhi is another limitation. The treatment was designed to be a school-based intervention, and providers in Delhi faced unanticipated barriers to engaging students when the setting was changed to an off-campus clinic. This challenge likely contributed to poor engagement of students in Delhi. Delhi students' low rates of participation in the behavioral and optional modules represents another limitation, as youth perspectives on those later modules were reported primarily from Goa. Additionally, of the 19 youth whose interviews were included in analysis, only five were from Delhi despite the study team's efforts to follow up with all Delhi students who had initiated treatment. It is possible that youth who dropped out prematurely were not motivated to engage with study staff or may have encountered other barriers, such as being on summer holiday by the time they were contacted about participating in interviews. To address these limitations, future

research may focus on increasing the student and provider sample size to test quantitative differences and examine how contextual factors (e.g., urban vs. semi-urban settings, language, culture) as well as participant characteristics (e.g., provider background, youth age) impact engagement. Future investigations might also consider ways to follow up with hard-to-reach study participants to obtain their impressions of treatment by anticipating and addressing barriers that could interfere with their ability to be contacted.

Conclusion

Despite these limitations, the present study is a valuable contribution to the relatively nascent literature on engaging youth in mental health care in LMICs. While providers and youth identified barriers to treatment engagement and highlighted areas for improving fit and acceptability, they also described numerous facilitators to engagement and reported high satisfaction with the intervention overall. Recommendations offered by both providers and youth are feasible, consistent with the literature, and already being incorporated into the next iteration of the protocol to improve engagement, bolster implementation supports, and enhance treatment effectiveness in upcoming phases of research within the PRIDE project. Involving stakeholders in treatment design and being responsive to their needs and preferences paves the way for more culturally and contextually aligned interventions to be developed, implemented, and sustained within settings that have traditionally lacked the evidence base and resources to meet the needs of youth experiencing mental health challenges.

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Table 1. *Provider and Youth Characteristics*

Provider Characteristics	Overall Sample	Goa Sample	Delhi Sample
Gender, *N* (%)			
Female	5 (100)	3 (60)	2 (40)
Age, M(SD)	30.8 (4.55)	33 (7.07)	29.33 (2.89)
Years of clinical experience	7.8 (2.39)	8.5 (3.54)	7.33 (2.08)
Setting of service delivery, *N* (%)			
Clinic	5 (100)	3 (60)	2 (40)
Hospital	5 (100)	3 (60)	2 (40)
Secondary school	4 (80)	2 (40)	2 (40)
Research study	3 (60)	1 (20)	2 (40)
Community mental health	3 (60)	2 (40)	1 (20)
Primary school	2 (40)	1 (20)	1 (20)
College	1 (20)	1 (20)	0 (0)
Education, *N* (%)			
Below Master's	1 (20)	1 (20)	0 (0)
Master's	2 (40)	1 (20)	1 (20)
Doctoral	2 (40)	0 (0)	2 (0)
Language of service delivery, *N* (%)			
English	5 (100)	3 (100)	2 (100)
Hindi	5 (100)	3 (100)	2 (100)
Konkani	1 (20)	1 (20)	0 (0)
Marathi	1 (20)	1 (20)	0 (0)
Youth Characteristics [a]			
Gender, *N* (%)			
Female	12 (63.16)	10 (71.42)	2 (40)
Male	7 (36.84)	4 (28.57)	3 (60)
Age, M(SD)	14.8 (0.81)	14.5 (0.73)	15.6 (0.39)
Grade, *N* (%)			
Grade 8	3 (15.79)	3 (21.43)	0 (0)
Grade 9	13 (68.42)	9 (64.29)	4 (80)
Grade 10	3 (15.79)	2 (14.29)	1 (20)
Grade 11	0 (0)	0 (0)	0 (0)
Grade 12	0 (0)	0 (0)	0 (0)
Interview language			
English	8 (42.11)	8 (57.14)	0 (0)
Hindi	8 (42.11)	3 (21.43)	5 (100)
Konkani	3 (15.79)	3 (21.43)	0 (0)

[a]Youth interview participants

Table 2. *Student Themes*

Category	Theme	Sub-theme	Select exemplar quotes
Facilitators to engaging in treatment	Sensitization activities increased awareness and positive perceptions of counseling	Sensitization video resonated with students	"When you showed that video like the person is angry and then teacher came and talked with her and he is okay. So, then I thought I am also like this irritating quickly with everyone. So, I think I have to go there, so I went to the counseling."
		Expectation that counseling will solve problems	"I will tell about my problem properly and then after I join it would be solved."
	Youth engagement was impacted by others' support	Peers' successful experiences with counseling encouraged youth to seek support	"My friends were going first, and they told me to go, and they will sort my problems. I was like, 'Will they really do it?' I was thinking if they would understand my problems because they were adults. So, then I said I will also try. Then I went for it."
		Parental awareness and approval of counseling made youth feel comfortable engaging	"Sir told him that if you are interested in counseling for your kid, so Papa was okay with it then he said, 'Let's do it.' So, we did that. I liked [the idea of counseling] a lot and Papa also told me to do it. If I did it without informing him, then I don't like it, I feel scared inside that I am doing it without informing him. So, when Sir asked him then it was a good decision."

	Positive relationship with counselor facilitated treatment engagement	Youth perceived counselors as friendly, which helped them feel comfortable	"I liked her smile, and like, she is a very happy person so it was like very comfortable, and I was thinking I can talk with her comfortably, I can share my problem.".
		Youth appreciated counselors taking time to learn about their interests	"She was very friendly. We didn't directly start discussing with the problem, like she told me where she was from and I was asking about her, then she was asking about my likes, dislikes, and then suddenly she was asking me like, 'You like this subject?' or 'What you want to do?' That way she came to know about my problem, and I told her, which she didn't directly discuss. So, I found that she was very friendly and kind."
	Skills taught were relevant and enjoyable	Youth perceived specific skills as relevant to their problems	"It was something like, you know, looking for the negative, unhappy guessing. I would understand it better with the examples, whatever she gave. Like for example, for my problem, there was unhappy guessing or self-blaming. I always used to say, 'I am bad, and I am not good. I am not good looking. I don't have any friends.' So, it was like Miss told to try out these exercises and then see. So, I tried, and I made some of my classmates as friends, and then later she asked me that how I am feeling now, and I said I am feeling good. A great thing about her was she would give me examples based on my own life."

		Youth expressed varied preferences for relaxation activities depending on which skills they enjoyed and found most useful	"When we think about happy place then my stress gets reduced, and yesterday Miss introduced me to deep breathing, so when I get angry, I do that."
		Youth shared session content with friends and family	"One thing I shared with my sisters was exercise of relaxation of muscles and deep breathing. One sister was asking where I learned that. I told her that one of the teachers gave me this exercise. So, we did nicely. Three sisters did nicely. We were sitting in triangle shape and did this exercise. If there is some new exercise, we like to share our things."
	Enjoyed tracking improvement via progress monitoring tools		"Actually, you are filling that form, no? After that my problems were going less, less, less. And whenever I am filling this, I am feeling very happy because the problems are going less."
Barriers to engaging in treatment	Youth initially had a limited understanding of counseling that contributed to hesitations about engaging in treatment	Lack of knowledge about what counseling is and how it might help	"I never heard about it before. I never knew that there were counselors and all going school to school, or that there is something called counselors and they give some help and all. I was thinking that only parents may help and some friends or some teachers."
		Concerns about confidentiality presented a barrier to initiating treatment	"I was afraid of it, actually, that my secret will be revealed to someone."
	Worries about stigma from friends/family made students hesitant to be open about seeking counseling		"Actually, I didn't tell my parents that I am going to counseling. They will think that I am a fool. And my brother and

		sister are very young. So, they will not understand a word of this."
	Sessions interfered with classes, which was especially problematic for older students	"Now I will take off my name from counselor sessions because I am in class 10th and I want to concentrate on your studies. Yes, I am in 10th standard and studies are tough. I don't want to take risk as students often get compartment and failure in this class."
Impacts of the intervention	Treatment resulted in functional improvement in youths' lives	"Life is changed. I was angry first. Because of my anger, my friends were not talking with me. Other friends were talking for five minutes or two minutes. They were not coming close to me and sharing anything. After doing that counseling, my anger came down. Everyone was coming and telling me about this. I did understand when they noticed that change. I knew how to control the anger. Then they say that I am not getting angry at all. I said I got angry but after knowing reason they are like teasing me and I told them I know how to control. Then they said, 'Now we see how much you can control.' These friends came close, parents came close, and teachers also came close to me."
Recommendations	Overall satisfaction with materials but suggestions for improvement included more color	"The colors should be more attractive and in variations."

	Desire for more treatment in order to spend more time with counselors	"I thought that they should keep it three days in a week. I love to go there and when she speaks, I just liked that style."
	Activities can be improved in various ways, including having more options and different formats	"I think the counselor should tell like whether you are accessible to that activity like she told me playing and all, but I was not having that opportunity."
	Improve the system for calling students to session to maintain privacy	"How counselor called students in the class loudly. There are other students also, so that thing should be changed. That should be changed by giving note. You can call for the first counseling but in the next counseling, you can give note that these students should come. We can show that note to teacher and they can come for counseling."

Table 3. *Provider Themes*

Category	Theme	Sub-theme	Select exemplar quotes
Facilitators to treatment engagement	Tailoring treatment enhanced engagement	Providers adapted their style of delivery according to students' cultural backgrounds	"With the second child I learned gradually in one or two sessions how to advise. She is typical person from Haryana, sort of people who talk in that tone, who wants you to be very concrete . . . It was more like, 'Okay, let's do this, let's do that, you should do this,' more of directive stance rather than more of a collaborative stance. The first student is more cooperative, more discussive. This one is coming from a different state, you know those people prefer that way of language."
		Going beyond the manual to build rapport facilitated engagement	"There were some students where I did make that kind of effort wherein I tried to get more examples, I tried to think little bit more about their interest and their likes and dislikes and incorporated that within the sessions, so if they liked something, I would try to read up a little bit about that, share some kind of facts about it and that kind of, I think, helped me feel more invested. I think it appeared like I was more invested more in them and they responded better."
		Taking a collaborative approach improved engagement	"I always found it from both sides very helpful to be starkly honest with them saying that 'Sometimes what I say might make sense to you and sometimes it may not make sense to you. Sometimes it may help your problem, like you might find that it is useful for your problem, and sometimes you might find that it is not useful for your problem. If you feel like I am calling you once again and you feel like there is no value in it, then you have to let me

		know so I am able to then inform you correctly about why you need to come back or why you don't need to come back. We can always end whenever you are comfortable.' It was just keeping a very, very open dialogue while I talk about the number of sessions you are coming in for. And that, in my opinion, helped with the student coming back."
	Relaxation was relevant, easy to deliver, and improved engagement	"I feel like for some students where they found relaxation very relevant to them, they enjoyed the occasion and they actually felt good at the end of the session, so that was a great way to build rapport with them and increase their engagement in the treatment program."
	Stronger engagement was seen in schools compared to the clinic setting	"If I had to compare the school to the satellite clinic, the school setting was definitely more helpful for follow-ups and was more helpful for getting students in sessions, having to buy them into the program, having them be more invested in coming back for sessions because they didn't feel like it was too much of a deviation from their day to come in and sit for a session. So that was very, very helpful."
	Parents can serve as facilitators or inhibitors to treatment	"The other child which I told you didn't commit proper . . . So that pattern became a bit irritating, you know, we spend entire session discussing why she want to drop out, and how she can manage the situation, how can she troubleshoot, and then if you ask her 'Are you sure you want to drop out?' and she says, 'No, maybe I want to come back,' and because obviously the reason is she didn't want to tell her family that she is dropping out because then she will get scolded, she is not following the advice being given by her family to her."

Barriers to treatment engagement	Some intervention content and materials interfered with engagement	Certain concepts were challenging to translate and seemed difficult for students to grasp	"There are some English words which cannot be translated to Konkani words. We had to explain students, like for example assertiveness, we can't give them the literal translation and we had to explain the meaning. We had to explain the technical jargons in the simplified way."
		The volume of materials interfered with student engagement	"So, sometimes it is disengaging because you are shifting from one assessment tool to another. You are telling the student to look at the flipbook. So, you are asking them to rate their mood. So, it may be disengaging. You are just skipping on, moving stuff. It is not a continuous flow. Maybe that could be changed, like."
		Materials could be improved to better fit the context	"However, it would have been nice to have more concrete examples of problems that students in our context might face. The training was somewhat, somewhat I wouldn't say unspecific to our context but could have been personalized a little bit keeping Indian schools, Indian adolescents, the culture here in mind because some of what works in the US and in the West might not work for us."
	School structure and setting negatively impacted engagement	Lack of space and privacy interfered with ability to deliver treatment	"The space was shared between three counselors. It wasn't ideal in that I could hear exactly what other therapists and students were talking about, and I was completely aware of that student's problems, what the counselor was saying. It wasn't the most private of settings for sure, and I was very aware during relaxation, it was noisy, and I couldn't really focus on my work and neither could the student. I actually had one student that said, 'Hey, I know, you are really trying very hard, but I am not feeling relaxed. I am going to leave. This is not working,'

		because it was a bad day at the clinic. There were too many people there. Environment was noisy. I couldn't convincingly do the relaxation module myself because it just was not possible. So, logistics were a huge challenge. Especially for Step 2 where problems may be of more severe and sensitive nature, it is very important that the environment is right."
	Going to therapy during class time was a barrier for students	"There was one student who refused, and he was from the other school. His main concern was whenever I used to call, he used to miss his lecture. He would miss his portion. Being a very smart and studious boy, he would say, 'If I am coming to counseling, I am missing my important periods there. Whatever teacher is teaching is also more important and I can solve my problem by my own self.'"
	Vacations and exam periods interfered with engagement	"I think [some] stopped attending sessions . . . it was just a gap of like maybe 15, 20 days with some students. That's because they were either not in school, they were ill, there was vacation, there was exams, so because of that there was sometimes an unusual gap between treatment, but it was otherwise okay."
Transition from Step 1 to Step negatively impacted engagement		"I think also the transition was a bit strange for the kids for sure. I don't think they saw a valid reason for why the therapist had to change. We know it. Like in our heads, it is very clear that it is because the Step One therapists don't have the training to deliver Step Two. But in the student's head, it is like, "Okay, the counselors are counselors, why can't they keep talking to me? They know me very

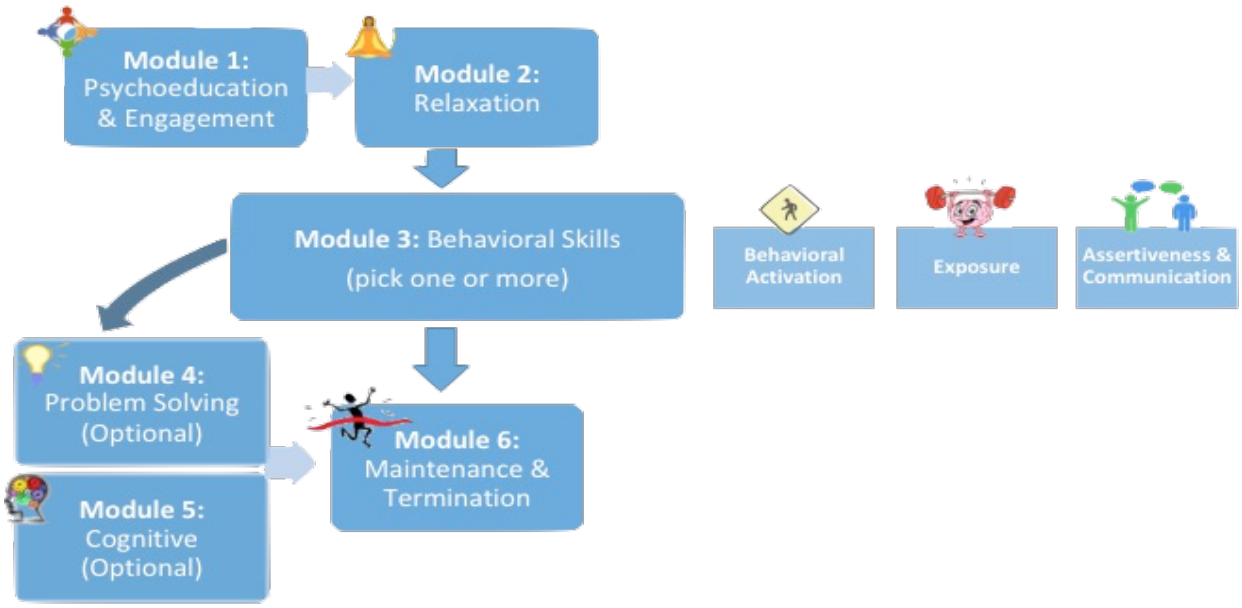
			well. They know my problems. I would rather just keep talking to them.'"
	Engagement was poor when students did not find the module relevant to their problem		"For example, there were some students where I had to take up behavioral activation which wasn't necessarily overlapping with their concern completely, and they did not find too much relevance in it, so now their engagement, adherence to homework, all of that was poor. They understood it, they understood why it was important for them, but they didn't find it relevant to their problem and their engagement was poor."
Training and supervision	Desire for more and different training	Training did not adequately prepare providers to deliver treatment	"Whatever training I got, I thought it was not that sufficient to deliver. Otherwise, if it had to be detail, that would have been helpful. Because some parts, I was new to it – the cognitive part. Basically, the behavioral skills and the cognitive part. I knew some of behavioral skills, like the communication and all, but not the cognitive part. So, I felt like we could have got more training."
		Dislike role plays in training	"I feel like lot of the therapy sessions that they were taking up in terms of role plays, I didn't think that they were necessarily sufficient. I felt like it would have been better if we had few more model examples for the training wherein we had, let's say, one modeling example done between two therapists, but I wish there were more such models wherein everyone had a chance to present therapist and student combination with different kinds of concerns."
	Supervision format and focus can be improved	Supervision felt punitive rather than supportive	"Sometimes it felt punitive. Sometimes it felt not very, non-directional. If the objective of supervision was for me to feel like I was receiving constructive feedback to be able to improve my

		treatment or my therapy program or the therapy that I am delivering, I don't feel like I felt supported during supervision."
	Supervision should be more structured in order to yield useful feedback	"I had written to people how it would be helpful to actually have supervision is maybe for the person who presenting the case to talk through their challenges that they faced and their successes they faced and make it more a reflective exercise rather than it being a feedback pulling exercise. Like now I am asking five people in the room, 'What do you think of my session? What do you think of my session?' I myself present the session and say that this is what was expected, this is what I found to be challenging, this is where I feel I could have done a lot better, this is where I feel like I need more training or more skill building."
	Multi-site setup presented barriers to communication between team members	"I feel like the perspectives of the two sides who were coming in for supervision might have been different. I think the expectations, or the objectives might have been different. I feel like again, the methods of communicating, for example, the way feedback was shared in Goa to the team in Goa was different from the way I assumed feedback was being shared in Delhi. I guess it was just a difference in rapport. Out here, I think here everyone is just a bit more free and open and more direct with what they want to say, whereas in Goa, they are far more sensitive and far more formal with their communication. They have their fun but when it comes to work, they are far more structured and constructive and sensitive to the other person's needs. So, there is nothing really right or wrong in either side, it's just a difference in their ways."

Complexity	Lack of enthusiasm for manualized protocol because it interferes with "good" care		"I feel like at some point in time, I was trying to cater a lot to the manualized treatment, which makes you tend to forget that you've actually learned a lot of counseling skills and you've learned a lot of therapeutic techniques that were outside of this manualized treatment, which you forget. At least I forget."
	Provider-facing materials were overwhelming		"I was ok with the treatment but the sheer amount of stuff that I had to carry that was overwhelming for me, especially because there was no place to store it, and I was terribly scared of what if I forget to do that, what if I forget to do this? And the manual itself had so many references to the appendix, this is handout four, this is handout five, so many modules . . . I am scrambling to find it in my folder among a million other things, it messes with your focus and the flow of the session. So that is what I was worried about that, the material itself I was quite confident of doing."
	Past experience helped providers with treatment delivery, along with increasing familiarity with the intervention	Prior education and training gave providers a foundation on which to build when learning Step 2	"Yes, it was a lot of information. I would be lying if I say that it was easy to take in. Again, it was fairly easy for us because the concepts are completely not alien. Maybe we haven't delivered them as part of therapy or treatment, but we have all been aware of the concepts and what the theoretical backgrounds are. So, in that sense, it didn't feel rushed, like the material did not seem tense but I can imagine how it may have been so for someone with less of a mental health background."
		Providers' sense of confidence and competence increased with experience delivering Step 2	"Like you get used to it, your brain gets used to it. I was much better, much faster after just like two or

			three students, so I understand that with any new material, it becomes easier."
	Clinical decision making was a challenge	Uncertainty about the process of identifying the "best" module for the treatment focus	"What I do find sometimes difficult is the idea of picking a treatment through the process of elimination. So, the student has a problem. We have 5 options. We are saying this will not go, this will not go, this will not go, so the only option left is this, therefore we will take this up. So, I don't see that as necessarily helpful. Some of the times student is saying, 'I am having difficulty with, let's say, some thoughts that are interfering with my work,' but she or he is extremely active, so assertiveness and communication is not going to work, exposure is not going to work, I am only left with BA."

Figure 1. *Step 2 Treatment Architecture*



Appendix A: Document Review Coding Framework

PROCESS CODES		
CODE	DEFINITION	EXEMPLARS
Challenges	A team member describes an anticipated/experienced challenge	Source: Email "Pooja and I were speaking today about our experiences delivering the relaxation module, and with the progressive muscle relaxation script in particular. I've only done this with one student so far. She was mostly okay with it, but I think it can be better. Pooja felt like this skill was somewhat difficult for her students to grasp."
Suggestions	A team member offers a suggested solution to an anticipated/experienced challenge	Source: Email "She suggested we modify the language of the script and also thinks it would be helpful to model for the student what it looks like to tense each muscle before starting the practice. Both of her suggestions seem very relevant, and I would like to hear others' thoughts on moving forward with these modifications. Also, please let us know if you have any other thoughts on how to make progressive muscle relaxation more suitable for our context."

Team Member	A member of the treatment development, implementation, or clinical team Refer to the Roles and Responsibilities document in Box if necessary. However, to code these roles, simply highlight the speaker/writer's name and assign the applicable code		
TREATMENT DESIGN CODES			
DIMENSION	DESIGN PREFERENCE	DEFINITION	EXEMPLARS
Resources: Assets and capital (e.g., materials, people, knowledge, funding, space, time)			
Funding	Treatment is intended to come at no cost to students, minimal or no cost to schools; grant-funded service and administrative personnel for project with eventual transition to publicly funded service personnel	Discussions involving how to consider the eventual transition of the study into a fully integrated program within schools	Source: Meeting notes "In the spirit of sustainability planning, we need to keep in mind that we don't want to burden schools by having them administer and score measures in a timely way and then triage to a certain level of care; easier for everyone to enter the lowest level and then non-responders step up. Even if counselors are completing the assessment, it remains a burden, especially if we are going to use lay counselors in the future that have not participated in research projects before. We should also keep in mind the national initiative to place counselors in the schools – which is already in place in Goa (which is why the study is happening in Catholic schools in Goa and in public schools in Delhi). Could this initiative allow for continuation of project beyond the grant?"

Time	Scheduling to be youth-and parent-centric and expert-guided, while respecting that academic success and school functioning is a priority; sessions need to fit within a school period (~35 minutes), and treatment episodes fit around school calendar, holidays, and exams	*Session Duration* Discussions involving the duration (number of minutes) of a session. May present in the context of suggesting that a session should fit within a class period	Source: Meeting Notes "The session duration should fit within classroom period. Given our context, it will be difficult for student to miss more than one period." *Double code with Challenges and Cultural/Contextual Considerations*
		Spacing of Sessions Discussions involving the optimal spacing of sessions (semiweekly to weekly sessions)	Source: Meeting notes "The session can be spaced so that initial sessions takes place twice a week and gradually on a weekly basis, as this allows adolescents more time for practicing what they have learnt." *Double code with Suggestions*

		Treatment Duration Discussions involving the duration of treatment episode (6-10 weeks)	Source: Other (Step 2 action items_SAG) "The current step to seems difficult to scale with the time it requires to deliver the intervention with multiple module. Such interventions are difficult to deliver in school context and may not be acceptable by School authorities. What we need to look for a most simple, short and scalable interventions." *Double code with Challenges and Cultural/Contextual Considerations*
		Impact of School Calendar Discussions involving the impact of the school calendar (e.g., exam periods, holidays) on treatment delivery	Source: Meeting notes "RG: didn't really try to do spacing near the end of treatment in Goa in an intentional way. Would be a good idea to do the psychoed and engagement sessions close together – might increase engagement; then spacing in behavioral to allow for practice; then could make sense to space out near the end, but we had to try to fit in sessions whenever we could because of the breaks for exams and holidays. Based on exit interviews, some students expressed an interest in coming more often."
Space	Safe, confidential, private space in school setting; no services in a hospital, clinic, or outside school	Discussions involving how to maximize privacy within semi-private space (e.g., curtain, positioning of seating, rooms)	Source: Meeting notes "Step 2 has a lot of material – able to find place for it in the clinic but need to think about where to store everything in schools; hard to find place/carry things"

People	10-19-year-olds, adolescents with non-specialist providers, but guardian/specialist involvement in case of serious issues; family and peer support desirable but aim to minimize collateral encounters other than information sharing with guardian; entire school involved to reduce stigma and enhance acceptance; referrals accepted from all sources; peer supervision for providers	*Demand for Services* Discussions about how to meet demand for services (e.g., school-wide sensitizations, other ideas for Step 0). May also involve discussions about referral numbers.	Source: Meeting notes "Question about Step 0 – should it be classroom presentation, worksheets, workbook? o Definitely need an approach, particularly for Delhi, for managing the demand; not just the four sessions of guided self-help Group-based problem solving" Source: Meeting notes "Update on referral numbers for Step 1 and implications for Step 2 Team is working on ways to increase referrals in Goa"
		Eligible Participants Discussions about eligible youth for consent, measurement, and treatment	Source: Meeting notes • "Determine whether case is severe enough to warrant treatment (SDQ) and then focus (Top Problems)" *Double code with Measurement → Assessment*

		Provider Experience Discussions about providers and experts: Providers with at least Master's degree for treatment; Psychologists for expert consultation. Also discussions about providers' level of experience more broadly, including training and education.	Source: Meeting notes • "KM: In Delhi, Step 2 will be delivered by psychologists per government requirements. In Goa, will be delivered by psychologists and counselors. VP: Need to assess competence of therapists" Source: Meeting notes "Struggling with material: We can try and make manual more structured, which can give the beginner therapist more structure but as they become experience they can have more flexibility." *Double code with Challenges, Suggestions,* and *Materials → Provider-Facing Manual*

		Guardian Involvement Discussions about including guardians (i.e., parents, caregivers) in treatment		Source: Meeting notes "Eric brought up that adolescent specific content is often family focused. How involved are parents going to be? Developers do a lot with family and parents. Individual-focused adolescent content can include functional analysis in stage 2. Other elements to consider are goal setting, educational support, antecedent management, guided imagery – which can all be done without parent involvement. These elements are more commonly used for adolescents than younger kids. Are we going to take parent feedback into consideration for assessment and treatment?"
Materials	Illustration rich, character-based client- and provider-facing material in Hindi, and English; step-by-step with explicit decision guidance of minimal difficulty and complexity; workbook	*Provider-Facing Materials* Discussions on developing provider-facing materials: manual,	*Manual* Discussions on developing the provider-facing manual	Source: Meeting notes "Daniel suggested that if the manual for Step 2 were written in the same style as Step 1 (self-help) it could be written for both youth and counselors at the same time (simple language, vignettes, visual guides) which are reviewed and activities conducted in session. In the future, video modeling?"

	plus one-on-one interaction; possible digital adjunct to support youth interest in video/chat with peer and provider but with the constraint of severely limited digital technology access, knowledge, and support	flipbook, clinical record form, appendices	*Flipbook* Discussions on developing the provider-facing portion of the flipbook; may be discussed in terms of putting an outline on the back of the flipbook illustrations	
			Clinical Record Form Discussions on developing the provider-facing clinical record form, which providers fill out with session information, including their perceptions of the student's engagement	

			Appendices Discussions on developing the provider-facing appendices	
		Student-Facing Materials Discussions on developing youth-facing materials: consent forms, youth measures, handouts, Youth Top Problems dashboard, and flipbook; illustration rich, culturally representative, and character-based analogue material in Hindi, and English	*Measures* Discussions on developing youth measures (e.g., Youth Top Problems dashboard, SxS)	
			Flipbook Discussions on developing the youth-facing component of the flipbook	Source: Email "I thought in addition to current pages, we can have one additional page- this page can be used across modules for students to indicate how emotions makes them feel in their body (see link below). E.g. for relaxation theorist can used with student to indicate where they feel tensed in their body, for anxiety student can mark where they experience anxiety in body and so. This can use used as flip book page to talk with students on physical sensation accompanying emotions but can also be used as handout if need be. The illustrator has send actors the chart but I was concerned whether these body charts would be culturally appropriate or should they be clothed figures? let me know what both of you think."

			Handouts/ *Worksheets* Discussions on developing youth handouts/worksheets	
Cultural/ Contextual Considerations		Discussions involving how to take culture and context into account when developing Step 2. This code will nearly always be double coded with something else, such as Materials, Measurement, Provider Experience, etc.		Source: Meeting notes "The session duration should fit within classroom period. Given our context, it will be difficult for student to miss more than one period." *Double code with Challenges and Session Duration*
Activity: The occurrence of behaviors and events (e.g., specific practices, service encounters)				

Measurement	Assessment individualized to youth goals balanced with standardized, validated, multisource measurement prioritizing clinical targets and outcomes likely to influence life functioning. Discussions revolving around measures/symptom monitoring that do not clearly specify whether the measures being discussed are for assessment or ongoing monitoring during treatment should be coded here.	*Assessment* Discussions revolving around what measures to include in the initial and outcome assessment battery (e.g., RCADS, YTP, SDQ) in order to assess a) eligibility, and b) clinical outcomes at the end of treatment	Source: Meeting notes 1. "Update on suggested progress monitoring a. YTP scores less than or equal to 4, SDQ Impact less than or equal to 1; could make this 0 instead; open to discussion b. Kanika, Daniel, and Resham to discuss further progress monitoring and termination criteria for Step 2."
		Monitoring Discussions revolving around what measures to administer as ongoing symptom monitoring during Step 2 treatment (e.g., YTP, SxS, mood rating with smiley face). In other words, youth and provider report of emotional, behavioral, and risk status across sessions.	Source: Email "How often do we want to administer the YTP? Every session seems like a lot, but is that standard/most informative? Maya suggested administering it at every decision point, which seems to make a lot of sense."

Planning	Requiring minimal provider expertise, prioritizing data-based algorithms for key decisions (e.g., eligibility, target selection, treatment selection); Target selection among high prevalence options based on screening with preference for maximizing coverage of all emotional and behavioral targets excluding high risk; Treatment selection among practices derived from the evidence base	*Clinical Decision Making* Discussions involving clinical decision making: how to guide providers with limited clinical experience to make decisions about which problem to target and which module to choose for that problem, as well as decisions about transitioning between modules, repeating content, and ending treatment.	Source: Other (PRIDE Step 2 Decisions & Justifications) "Decisions about whether to repeat content of a session, move onto the next flow/phase or interference module, or refer out are made through yes/no questions in order to easily translate to the eventual digitized version of the program and its algorithm. This model is similar to what is done in MATCH." Source: Other (Step 2 action items_SAG) "Continue testing the clinical decision making CARE worksheet during the formative case series to assess how much it helps clinicians makes decisions; evaluate the reliability of those decisions"
Treatment	Treatment using evidence-based procedures; prioritizing concrete behavioral over abstract techniques that address problem-solving, engagement, and skill development (coping, social, and self-management); guardian psychoeducation and	*Step 2 Practices* Discussions involving what practices (e.g., relaxation, behavioral activation, assertiveness and communication, exposure, problem solving, cognitive) to include in the protocol; will largely be in early documents in the pre-CCS phase.	Source: Meeting notes "May need a module to address trauma and domestic violence. Substance abuse is rarely a concern except for chewing tobacco. Current measures are not picking up on trauma although it is possible that the kids have experienced trauma. Bruce recommended the UCLA index. In US studies, although there were many cases of trauma history, trauma was never primary focus – usually still internalizing or externalizing problem was focus of treatment."

	parent management skill option desirable but not required; session management with step-by-step guide of limited difficulty; episode management and problem-solving not initially specified; adaptation minimized but guided by provider knowledge; relationship and change management with provider-driven contact that treats youth as equal, prioritizes	*Treatment Architecture*
		
		Discussion about treatment architecture (e.g., order of modules, number of sessions per module, which modules should be optional, optimal dosing)
			Source: Meeting notes
			
			• "Up to 4 practice BA sessions, depending on how client responds
			• Do we need to set limit/minimum of sessions in BA flow?
			  ○ If the child isn't understanding content after a certain number of sessions, could be important to move on to interference module/next module in the flow
			  ○ Stepped care model; won't move up to Step 2 unless you don't benefit from Step 1. Similarly, if you max out on number of practice sessions (4) in BA, move on to cognitive. "

	collaborative guidance, and ongoing support to maintain the relationship through step up to more intensive services	*Practice Content* Discussion related to development of practice content (Psychoeducation & Engagement, Relaxation, Behavioral Activation, Exposure, Assertiveness & Communication, Cognitive, Problem-Solving, Maintenance & Termination), including conversations about prioritizing concrete behavioral over abstract techniques. Not about deciding which practices to include, but rather how the practices should be taught (e.g., since we included relaxation, should it be deep breathing or muscle relaxation?)	Source: Other (Step 2 Refresher Training Feedback_RG) "Not to induce unpleasant mood before relaxation or BA (can ask student to think of something stressful or give example of what student has mentioned as stressful but inducing negative mood is not the goal)"

		Student-Provider Relationship Discussions on the nature of the student-provider relationship and how to balance a more collaborative style with some representation of provider as an "expert" due to cultural role expectations.	Source: Supervision notes "MK: child said he wants to minimize the amount of time he spends in a funk/not so happy mood. When he feels that way, he doesn't want to engage in activities. Parents don't get along; older half-brother and dad are always fighting with his mom. He wants to take his mom somewhere else but is too young and feels helpless about this. MK said he is calm and not angry – more sad. Currently does some things to feel better, like going on a walk. Smart, motivated child who wants to go to college; has lots of questions about treatment, so MK wants to be very collaborative when picking modules with him."
		Mode of Delivery Discussions about the ideal mode of delivery for Step 1 (self-help workbook vs. lay counselor vs. digital platform) and Step 2 (in-person, telephone sessions during breaks)	Source: Meeting notes "Original idea of kids doing workbook on own/with counselors isn't proving as easy as we originally thought. Need to reconsider this and alternative modes of delivery via digital platform – kids don't have much experience with smartphones, parents and peers would wonder why they got it; teachers raised concerns about smartphones/tablets being stolen or damaged."

Engagement	Therapeutic alliance, client satisfaction	Discussions about client engagement, i.e., how to keep student participants engaged in treatment and prevent dropout. May be brought up in relationship to the REACH domains (i.e., Relationship, Expectancy, Attendance, Clarity, Homework) or client satisfaction.	Source: Supervision notes • "Case discussion (PN): 9th grade female who self-referred for problems with classmates teasing her after spreading rumors about her being with a boy. Issues with engagement – student seems keen on describing her narrative and problem; not easy to reorient her to the topic/discussion – appears disinterested at that point, poor eye contact. Not sure if she is following what is being said."

Quality Assurance and Improvement	Service support and supervision routinely provided by peers with limited expert guidance; reasoning and review minimized except for peer supervision; implementation management by project team	Discussions about training, supervision, and expert consultation. Content regarding supervision will likely come up in the context of how to structure peer supervision.	Source: Email "In addition, particularly when thinking about how to prioritize supervision for multiple cases, it will be helpful to have a method for tracking and viewing the progress of all cases in order to select which ones should be discussed. Examples of these type of visualizations are on p. 340 of the attached 2005 paper ("Client Caseload Comparison"), as well as the attached Caseload Dashboard. As you can see, these graphs include a symbol indicating the client's baseline and most recent progress scores in order to show how much the client is improving, and the Caseload Dashboard has places to indicate crises or "critical events" as well as the practices that have been covered to date." Source: Other (Step 2 action items_SAG) "Continue developing a supervision model for peer supervision that serves important functions of emotional support, restorative burnout prevention, team morale, praise, normalization"
Coordination: Relations among resources and activities (e.g., sharing, fit, flow)			

Targets	Support multiple treatment targets in a single protocol with modular approach; unified or transdiagnostic approach possible, especially at lower steps (e.g., general cognitive-behavioral skills, relaxation)	Discussions about using a transdiagnostic/multi-problem approach for the three targets of mood, anxiety, and conduct, especially at lower steps (e.g., general cognitive-behavioral skills, relaxation)	Source: Meeting notes "Finally, team brainstormed thoughts about next steps: Consider using 3 "core" skills that everybody gets: problem-solving, communication skills, relaxation skills for all 3 flows (anxiety, depression, behavior problems) and then adding practices according to primary diagnosis: exposure, cognitive? Would make it easier for counselors to learn… but provide examples relevant to each flow to maximize utility." *Double code with Complexity, Step 2 Practices, and Suggestions*

Episodes	Stepped care model with (a) universal self-help or supported self-help, (b) intensive face-to-face, and possibly (c) specialist service (for suicidality, depression, temperament/personality disorders, other severe problems); step promotion based on impairment in addition to diagnosis with option to skip a step if needed	Discussions on episodes of care (i.e., Step 1, Step 2, referring out) and how to determine whether a youth participant goes into Step 1, Step 2, or is referred out; also discussions about how to transition between steps (i.e., episodes of care)	Source: Meeting notes "Need to start with identifying top problems; also need to test in real world. People in Step 1 may have practical problems and not sure how to transition to Step 2." Source: Meeting notes "Engagement – can we have "re-engagement" for kids moving to Step 2 from Step 1? Hard to predict if they would see the same counselor" *Double code with <u>Engagement</u>*

Theory	Risk and protective factors conceptualized within broad ecological-transactional framework with mechanism of change based on enhanced problem- and emotion-focused coping	Discussions regarding the theoretical framework behind both steps (i.e., Step 1 as a problem-focused coping intervention and Step 2 as primarily emotion-focused coping while building on problem solving skills)	Source: Meeting notes "Think about theory of stress-coping model; Step 1 is primarily about the problem/problem solving. Then there is emotion-focused coping and appraisal of the stressor *and* one's own coping ability (efficacy). Kids who need something beyond Step 1 will have a high level of distress and external locus of control/helplessness; problem solving might be very tough for them to learn or their problems are big." Source: Meeting notes "Both therapist and students are struggling to identify smart goal, as it requires change in orientation from problems to goals. this is quite different from what is used in step 1 and as well as what is being accessed through various assessment instruments. This can be simplified or can be removed based on consensus." *Double code with Challenges, Practice Content, Suggestions, and Complexity → Student*

Privacy	Pervasive support for privacy and confidentiality with clear coordination and boundaries for information sharing	Discussions about how to define and convey privacy and confidentiality safeguards in sensitization, consent, and treatment activities	Source: Meeting notes "Confidentiality concerns: youth do not want to take it home and do not want to be seen with it at school (stigma?). Fear that friends or siblings will see it and read it."
Complexity	Procedures and decision framework streamlined to increase feasibility and scalability, but the framework should support extensibility (e.g., "add on" features that could be introduced in mature versions post-implementation) and utility (e.g., the ability to handle a diversity of common cases or challenges	*Provider* Discussions about how to balance complexity of the intervention with making it simple enough to be used by non-specialist providers, thus making it scalable (i.e., able to be delivered by a large non-specialist workforce), while not compromising features that can be used by providers with increasing experienced. May discuss the importance of providing explicit guidance for clinical decision-making; using single framework with common design elements; limiting the number of modules and decisions to make about extending or repeating content, as well as transitioning between modules.	Source: Meeting notes "DM: could treat all modules as equal and pick the best, then add in as appropriate. Means that there could be four modules back to back, but more likely that they will respond after one, based on the current data and literature showing that if you do one element well, it will have generalized effects. Matching multiple elements to multiple problems will be impractical and not necessary for the majority of kids. Don't want to introduce complexity in terms of options for sequencing. Could do at least one module but no more than two – that decision can be guided by a supervisor. Constraint would be more about number of modules than type. Could also eliminate the modules that haven't been used or combine them in some way. Cognitive could be woven into the behavioral modules."

		Student Discussions about making Step 2 content and material appropriately complex for student participants.	Source: Meeting notes "Both therapist and students are struggling to identify smart goal, as it requires change in orientation from problems to goals. this is quite different from what is used in step 1 and as well as what is being accessed through various assessment instruments. This can be simplified or can be removed based on consensus." *Double code with Challenges, Practice Content, Suggestions, and Theory*

Appendix B: Student Interview Coding Framework

Level 1 Code	Level 2 Code	Level 3 Codes	Exemplars
Initial Engagement	Awareness of PRIDE counseling services <u>Definition:</u> Student describes how they first learned about PRIDE.	Formal sensitization activities (reference to video, laptop/computer, classroom sessions)	*"Sir like you guys came to our school and then explained us to take the counseling, that we can take the counseling, sir I didn't know about counseling that what actually counseling is, this year it was an addition, so I couldn't understand that, now I know all."*
		Peers (including friends, classmates, or others in their social circle)	*"In my school first I went to this church you know, this church we have there are some girls who were talking about counselor is very useful to us and I was thinking if also attend then my problem will also be sort out."* *Double code with <u>Expectation of Counseling → Get to discuss/solve problem</u>*
		Other	
	Reason for referral <u>Definition:</u> Student describes their presenting problem/reason for referral	High risk behavior/situation (suicidal ideation, self-harm, domestic violence)	*"Sometimes bad thoughts comes in mind to do something wrong to myself so she said we will invite your mother also as I share mostly everything with my mother so she will understand my problems and she can help me so Pooja mam invited my mother to tell that when she feels suicidal so then what mother used to do and what I need to do. I need to share with my mother freely that I am*

			not feeling good so my mother was called so that she can come and understand my problem." *Double code with <u>Experience with Step 2 → Involvement of others in treatment</u>*
		Other	*"I was not able to concentrate on my studies."*
	Mode of referral <u>Definition:</u> Student describes how they were referred to counseling. Referrals are typically self- or teacher-initiated.	Self	*"But I decided to go for the counselling sessions."*
		Teacher	*"Actually my teacher saw some changes in me which are actually very bad because I am very studious girl actually still because of some family ups and down which affect the study concentration and the activities which I used to perform in school and I used to bring many prizes and trophies for the school was totally lost. Then my teacher told me to go to the counseling. So she gives my name without my permission actually and then later she told me that I should see once. Actually I have taken counseling for seven times which was actually for no use actually. So my teacher told me to just try once and I was like ok fine but for the last time. It was like ok."* *Triple code with <u>Reason for Referral</u> and <u>Expectations of Counseling → Not helpful</u>*

		Other	
	Expectations of counseling <u>Definition:</u> Student describes how they felt about counseling or what they expected to get out of counseling before beginning of treatment or in the early phase of treatment.	Get to discuss/share/solve problem	*"It was useful to me I am also going there and my problem will also get sort out."*
		Nervous	*"I was scared that because the situation which I came with to Ms. Resham was actually in a very bad condition. So I was just hoping that if this situation gets cleared out then I will be back. So I was just nervous about my counselor. I was scared because I had a very bad time with some first but I was hoping this that for a last time at least that I get a good counselor and the treatment whatever that she is going to give me will be the best."*
		Curious	*"No I was asking that what happens in counsel. They were saying that I get angry to much so I said okay then you can give name to the counsel. Asked my then when you go what happens."*
		Not helpful	
		Get to miss class	*"I want to bunk the classes."*
		Private/confidential	*"I came to know from other kids that your issues will not be shared with anyone and it will be a secret."*
	Influence of others to initiate counseling <u>Definition:</u> Student describes the role others played in their decision	Peers (including friends, classmates, or others in their social circle)	*"I have a friend called Sweety. She told me that I should share my things with the teacher. First of all, I thought if I share my personal talks with her it will be beneficial for me still, I didn't go to the sessions. But when I was in 8th*

	to engage or not engage in counseling.		*standard my friend Sweety suggested me to tell your problem to counselor teacher in the school. I asked her what will happened if I share my issues with her. She told me that she is not aware what will happen after you share the issues as she had never done it. But I decided to go for the counselling sessions."*
		Family	*"Sir I liked it a lot and Papa also told me to do it. if I do it without informing him then I don't like it, I feel scare inside that I am doing it without informing him. So when sir asked him then it was a good decision."*
		Teachers	
		Other	
Potential Barriers to Initiating or Continuing Treatment <u>Definition:</u> Student discusses actual or potential barriers to treatment. For example, if the interviewer asks a	Confidentiality <u>Definition:</u> Student cites concerns about confidentiality or privacy as a reason for being hesitant to seek counseling.		*"I was afraid of it actually that my secret will be revealed to someone."*
	Scheduling/interference with class <u>Definition:</u> Student describes counseling as interfering with their ability to attend classes or vice versa, or discusses difficulty scheduling sessions due to other commitments (exams, family obligations, work, etc.)		*"No mam first my mother was telling me they are really helping you then you take it we don't have any objections ya but my father was telling because you were calling during school hours I was specially in 10th so my periods were missing it was like left so much for me to complete then again to just study it without explanation it was very difficult for me to study for that part he was*

question about stigma and the student denies concerns about teasing, etc., still code as Barriers – Stigma.			*little bit but after that when Resham mam started that time almost school was over the portion was completed actually."*
	Stigma <u>Definition:</u> Student describes concerns about the way they will be perceived by others as interfering with their decision to initiate or continue in treatment, or to disclose to others that they are in counseling. Any mention of stigma, even if the student is talking about others' negative perceptions, can be coded here.		*"There are lot many who don't share it openly that I go to counselling and if I say in the class that I go to counselling students have some other negative thoughts about counselling why she goes to counselling this and that but they don't know how much we improve by going to counselling."* *Double code with <u>Impacts of the Intervention → Belief that counseling is helpful</u>*
	Literacy <u>Definition:</u> Student describes their or other students' low literacy as a barrier to engaging in treatment or understanding the materials/content.		*"It was POD that she asked to fill. It was very difficult to fill in. it was too much."* *Double code with <u>Experience with Step 1 → POD booklets</u>*
	Language <u>Definition:</u> Student describes a mismatch in language between themselves and their provider as interfering with treatment.		*"She spoke English but her English was really tricky for me."* *Double code with <u>Experience with Step 2 → Relationship with provider → Provider characteristics</u>*
	Other <u>Definition:</u> Description of other barriers to treatment.		*"Actually I thought that if the results are not good then parents will say that you concentrated on these sessions*

			only. I stay n Delhi so I thought that I can do it there."
	Discussed with provider Definition: Student states whether or not they discussed their concerns/worries/barriers to treatment with the provider		
Experience with Step 1	Got to discuss problem Definition: Student states that being able to talk about their problem was part of their experience with Step 1.		
	Relationship with provider Definition: Student describes their experience with their Step 1 provider. They may reference their "first counselor." They may also mention POD, a booklet, or Priyanka and Ajay. Do not code if they are discussing Step 1 more broadly; only code if they are explicitly discussing their relationship with their Step 1 provider.	Provider characteristics Definition: Student describes specific characteristics or behaviors of their Step 1 counselor, such as smiling, joking, or being strict.	
		Understanding of problem Definition: Student describes feeling like their Step 1 counselor did or did not understand their problem.	*"It was like to certain things she was not giving importance. Either I am telling properly or she is not understanding me."*
		Social desirability Definition: Student reports behaving in a way they believe will make their Step 1 counselor happy/comfortable/like them.	
	Time spent with providers		

	Definition: Student describes their perception of the time spent with their Step 1 providers/in counseling. They may refer to the frequency of sessions (i.e., how many meetings per week), the time spent in session (i.e., number of minutes), or the treatment duration (i.e., total number of sessions or weeks/months spent in treatment).		
	Relevance to/impact on problem Definition: Student discusses how relevant Step 1 was to their problem and/or the impact Step 1 had on their problem.		
	Use of skills outside session Definition: Student describes use (or lack of use) of POD skills (Problem, Option, Do It) outside of session, including homework. They may describe making lists of advantages/disadvantages (or pros and cons).		*"No but only the advantages and disadvantages after generating options we see what are the advantages of doing that so like if there is one solution for me like I don't know that what will be the advantage or disadvantage who will take little time it was like minor."*
	POD booklets Definition: Student mentions the POD booklets. They may talk about Priyanka and Ajay, the characters in the booklets. If they do not mention booklets specifically but		*"Like after reading book. Like I read that book and understand that and like about Priyanka and Ajay, I get to understand more about it."*

	only reference POD, code Experience with Step 1, since they are talking about their experience learning the problem solving solving skills (POD) in the first step of the treatment.		
Experience with Step 2	Got to discuss problem Definition: Student states that being able to talk about their problem was part of their experience with Step 2.		*"I like the fact that I was able to share my problems and to talk in the assertive way. This is what I learned in my counselling also."*
	Relationship with provider Definition: Student describes their experience with their Step 2 provider.	Provider characteristics Definition: Student describes specific characteristics or behaviors of their Step 2 counselor, such as smiling, joking, or being strict.	*"When I was saying my problems, she was smiling. How she was smiling, I liked the smile. I tell my friends who have problems to go to Ms. Pooja. Everyone love Ms. Pooja, seeing her."*
		Understanding of problem Definition: Student describes feeling like their Step 2 counselor did or did not understand their problem.	*"I thought she is also feeling same problems like me. I asked her when she was young, was she also having these problems, she was telling that everyone has this problem."*
		Social desirability Definition: Student reports behaving in a way they believe will make their Step 2 counselor happy/comfortable/like them.	*"M: Were you able to share about these concerns with Resham?* *R: Yes, I was comfortable but what she replied was somewhat understandable and somewhat not.* *M: But did you tell about this to Resham?*

			R: No, no. She might feel hurt. *M: You thought she will feel hurt and upset. So you didn't share this.* *R: Yes.* *M: Were you able about this with anyone else?* *R: No.* *M: So you kept it to yourself because you didn't want to upset anyone.* *R: Yes."* *Double code with Barriers to Initiating or Continuing Treatment → Language*
	Relevance to/impact on problem Definition: Student discusses how relevant Step 2 was to their problem and/or the impact Step 2 had on their problem.		*"They help me to concentrate and the deep breathing exercise is fine. It helped me to concentrate and removing ignorance. It also helped me to control my anger. This helped me to control my anger and ignorance a lot. Earlier I used to get angry a lot."* *Triple code with Experience with Step 2 Content → Behavioral Activation and Experience with Step 2 Content → Relaxation → Deep Breathing → Positive*
	Use of skills outside session Definition: Student describes use (or lack of use) of Step 2 skills		*"She was giving me one form also but I didn't take it. I told her that I will do it the next time. And she gave me homework also regarding happy place,*

	outside of session, including homework.		*deep breathing, being (09:10-14). And I forgot about it."* *Double code with Happy Place and Deep Breathing*
	Involvement of others in treatment Definition: Student describes the involvement of other people (e.g., parents) in treatment, or choosing not to involve others in treatment.		*"Sometimes bad thoughts comes in mind to do something wrong to myself so she said we will invite your mother also as I share mostly everything with my mother so she will understand my problems and she can help me so Pooja mam invited my mother to tell that when she feels suicidal so then what mother used to do and what I need to do. I need to share with my mother freely that I am not feeling good so my mother was called so that she can come and understand my problem."* *Double code with Initial Engagement → Reason for referral → High risk*
	Time spent with providers Definition: Student describes their perception of the time spent with their Step 2 providers/in counseling. They may refer to the frequency of sessions (i.e., how many meetings per week), the time spent in session (i.e., number of minutes), or the treatment duration (i.e., total number of sessions or weeks/months spent in treatment).		*"M: The time you spent with Ms. Pooja, what do you feel about that time spent? How many times have you met the counselor, Ms. Pooja?* *R: 12-13 times.* *M: You met her 12-13 times?* *R: Yeah* *M: Was that too little time or was that lot of time?*

			R: Very little time. And now I am missing Ms. Pooja. *M: So, you are missing her now also. You met her 12-13 times you said. Every time you met her, for how much time did you met her?* *R: For half an hour.* *M: Do you think that time was not enough, was it enough or was it okay?* *R: It was okay, my problems were solved in 20 minutes. But for relaxation she was teaching muscle relaxation, then I use to do that.* *M: So, you are saying that the time you spent half an hour was fine. Or it was less?* *R: It was fine."* *Where relevant, double code with <u>Experience with Step 2 Content → Relaxation → Deep muscle relaxation</u> and <u>Experience with Step 2 → Relationship with provider</u>*
Step 1 vs. Step 2	Comparison between providers <u>Definition:</u> Student compares their Step 1 and Step 2 providers.		*"I can't say it was more for Mamta Miss or less for Resham Miss. They were equal and they were lovely."* *Triple code with <u>Experience with Step 1 → Relationship with provider → Provider characteristics</u> and*

			<u>Experience with Step 2 → Relationship with provider → Provider characteristics</u>
	Transition between steps <u>Definition:</u> Student describes their experience transitioning between Step 1 and Step 2. They may discuss their experience switching providers.		*"First time I met, I was feeling scary then she started talking, it was tension free . . . I was knowing Ms. Mamta but I was not knowing Ms. Pooja because she was new."*
Discussed Counseling <u>Definition:</u> Student mentions discussing counseling at all (including disclosing that they went to counseling at all; does not need to include session content) with others.	Family <u>Definition:</u> Student describes their experience discussing or choosing not to discuss counseling with family members.		*"Sir I asked papa about it. Papa was okay about it."*
	Peers <u>Definition:</u> Student describes their experience discussing or choosing not to discuss counseling with peers, which can include friends, classmates, or others in their social circle.		*"I am sharing with my friends how she explaining very nicely and how she will ask question and how she will tell muscle reaction or more things, for that I am spending 10 minutes for everyone."*
	Teachers <u>Definition:</u> Student describes their experience discussing or choosing not to discuss counseling with teachers.		

	Others <u>Definition:</u> Student describes their experience discussing or choosing not to discuss counseling with other people. They may not name a category of people with whom they did/did not discuss counseling; code here.		*"None, they don't connect with me."*
Experience with Step 2 Content Definition: Student describes their experience with the content of Step 2, including progress	Progress monitoring <u>Definition:</u> Student describes their experience with progress monitoring tools. • If they reference a bar graph or watching their numbers go down, they are referencing the YTP. If they talk about ratings on a scale from 0-10, that is another indication they are likely referencing the YTP. They	YTP	*"Actually, how she was doing it… you are filling that forms na, after that my problems were going less, less, less. And whenever I am filling this, I am feeling very happy because the problems are going less."*
		Other	*"No, Miss used to understand my mood. She first used to check what my mood is. What was the next session, better than before or worse than the last session?"*

monitoring, Step 2 modules, and intervention content delivered that seems to be off-manual (i.e., does not fit into the modules). NOTE: Only code "Neutral" if the student expresses a neutral opinion about a skill/module (e.g, "It was okay.") If they describe a skill or experience more generally, without expressing an opinion, assign the parent code. For example, "*Yes, she told*	may also talk about the numbers in relation to a goal; also code as YTP. Code Other if: • They talk about being asked how their problem interferes in different domains of life (home, school, etc.) – this is the SxS • They talk about "smilies" (they are likely talking about the mood rating tool). However, if they talk about circling/checking smilies before or after an activity such as relaxation, code under that activity. Only code Other here if they're talking about smilies at the <u>beginning</u> of a session.			
	Psychoeducation/Engagement <u>Definition:</u> Student describes their experience with the psychoeducation/engagement module of Step 2. This will likely not come up frequently, as students played less of an active role in this relatively brief phase of treatment.	Positive		
		Negative		
		Neutral		
	Relaxation	Deep breathing	Positive	*"Deep breathing was most helpful because at certain times you are sad and all you can't just think about happy*

me to breathe in and out sitting on a chair," is coded as Step 2 Exp - Relax - Deep breathing, not Step 2 Exp - Relax - Deep breathing – Neutral.	<u>Definition:</u> Student describes their experience learning and using relaxation exercises in Step 2.			*place it takes quite a lot of time to keep yourself at corner and be with yourself happy, deep break you can do anywhere so it was like very adjustable and comfortable for everything."*
			Negative	*"Deep breathing I was not able to concentrate."*
			Neutral	
		Happy Place	Positive	*"The Happy place activity was most helpful."*
			Negative	
			Neutral	
		Deep muscle relaxation	Positive	*"After deep breathing, how I felt? After anger I did deep breathing then I did deep breathing and I felt happy as all the anger goes away."*
			Negative	*"The muscle one was least helpful. It was boring to do that."*
			Neutral	
	Behavioral Activation <u>Definition:</u> Student describes their experience with BA in Step 2. They may reference being active, making a timetable, scheduling activities, helping others, or finding time to do fun things.	Positive		*"Whenever I am thinking about my tensions, I think about which I am told, I am being busy at work, whenever I am doing that I concentrate on that only. And I am forgetting all the tension that I have."*
		Negative		*"The activity of Being Active was not helpful as that of happy place."*
		Neutral		
	Assertiveness and Communication <u>Definition:</u> Student describes their experience with the Assertiveness and Communication module of	Positive		*"Talking in assertive and persuasive make a huge difference. If I talk in assertive way to others it will be useful to me and if I talk to others in passive way they used to think no one is there*

	Step 2. They may talk about passive/aggressive/assertive styles of communication.		*with her and she is like bored and other will feel like bored. Like if I talk to you in persuasive you will feel bored and if I talk to others in aggressive way then they will not like me therefore it was a huge difference and I like talk in assertive way."*
		Negative	
		Neutral	
	Exposure <u>Definition:</u> Student describes their experience with exposure in Step 2. They may talk about facing their fears. Note: Only one student completed the Exposure module, so this will come up rarely, if at all.	Positive	
		Negative	
		Neutral	
	Cognitive <u>Definition:</u> Student describes their experience with the Cognitive module. They may talk about negative thoughts, changing their thoughts, or learning about unhelpful ways of thinking. Note: Only one student completed the Cognitive module, so this will come up rarely.	Positive	
		Negative	
		Neutral	*"It was like a negative thought which was my kind of thought. I was always tending for feel an example. So my belief came and so I studied that and I learnt well. So later on she asked me so how did you pass? I said yes. So she said see the thinks are just a thoughts they should not interfere. So it was like you know. So she taught me about looking for the negative, unhappy guessing. So whatever negative thought I have was specially based on unhappy guessing and self living. So I was like this to my major problems which she*

			tried to make me understand and repair it out. So she made me understand that the negative things are just a thought and they should not stop way."
	Problem Solving <u>Definition:</u> Student describes their experience with problem solving in Step 2. To differentiate this from their use of problem solving in Step 1, look for references to their Step 2 counselor (see the "PRIDE roles" document on Box). Look for responses to this question: "Did you use the activities (POD) that you learned with your first counselor (*name*) with your second counselor *(name)?* If so, how?"	Positive	*"My experience was good. I used listen what Miss Resham is telling me about POD. It was easy for me."*
		Negative	
		Neutral	
	Maintenance and Termination <u>Definition:</u> Student describes their experience with the Maintenance and Termination module of Step 2. They may discuss reviewing what they learned in counseling or preparing for the future.	Positive	*"Like I did this for the last time that was day before yesterday and in this she asked me about the previous things like the start of the counseling like what I was and what I am now. So which helped me to just recover and recollect everything whatever we did in past twelve weeks. So it was like a good think about this. Planning for the future, she would make me confident about things what I have to plan for the future and she would make me like she would have encourage me that my future can be bright if I work on this."*
		Negative	

		Neutral	
	Other Definition: Other references to being taught skills in Step 2/counseling that do not fit with above codes.		*"She told me about relaxation and also told me how to be safe from that girl. She told me that if I fail in school number 3 and she gets to know that, she can come to meet me. So I told her that there is a guard who is always there. She also knows about this girl. So mam told me that she will teach me later what to do about this and what not. She told me to be in friends group as much as possible."* *Double code with Experience with Step 2 Content → Relaxation*
Experience with Step 2 Materials	Flipbook Definition: Student describes their experience with the Step 2 flipbook. They may talk about illustrations/drawings, especially for happy place. It might be challenging to ascertain whether they are referencing the flipbook or handouts. Please ask questions in the Google Question Sheet if you are unsure.	Positive	*"I liked it very much."*
		Negative	*"These drawings can be improved and over here you can write to think about happy place, how you are feeling. When I used to see this for first time I fail to understand what is this."* *Double code with Experience with Step 2 Content → Relaxation → Happy Place → Negative and Suggestions*
		Neutral	
	Handouts Definition: Student describes their experience with Step 2 handouts.	Positive	
		Negative	*"Many kids are not able to read properly. Some are not able to write also."*

	They may talk about doing mood ratings before/after activities, creating a timetable, or needing to write. It might be challenging to ascertain whether they are referencing the flipbook or handouts. Please ask questions in the Google Question Sheet if you are unsure.	Neutral	
Impacts of the Intervention	Positive <u>Definition:</u> Student describes the ways in which counseling has positively impacted them or solved their problem. The student may talk about using the skill to directly solve their problem (e.g., used assertiveness skills to reduce conflict with peers) or using skills to manage their distress (e.g., using Happy Place to relax/reduce anxiety)	N/A	*"See, boys used to irritate me, bully me and used to (01:55-57). I used to ignore them. But Miss Resham told me just ignore the thing what they are telling you about whatever which makes you hurt. I just ignored the thing and then they kept quiet. Boys kept quiet after that. That was the thing which was helpful."*
	Negative <u>Definition:</u> Student states that they were negatively impacted by participating in Step 2.		
	Neutral <u>Definition:</u> Student does not describe a strong positive or negative impact of Step 2.		*"It is not harmful but it has not helped me in any way."*

	Plan to use skills in the future/belief in ability to solve own problems Definition: Student states that they plan to use the skills they learned in the future or expresses a belief that they will be able to solve their problems.	N/A	*"Problems I will be able to solved because she has given tapes I can practice this in future. I don't feel good that I won't be able to meet mam later on. But one thing is good whatever I have learned I have written that and I will use that in future."* *Double code with Experience Ending Counseling*
	Belief that counseling is helpful Definition: Student expresses a belief that counseling overall is helpful. If the student is talking about a specific skill being useful/helpful, rather than a belief that counseling is helpful more broadly, assign a code for that skill – Positive rather than assigning this code.	N/A	*"Whatever we are unable to learn from our self and someone else teaches us the same; we can learn a lot with that."*
	Don't remember Definition: Student states that they do not remember something about the intervention – a skill, material, time spent with counselor, etc. This will *always* be (at least) double coded in order to know what the student does not remember. You may also need to code the interviewer's question if that context is needed.		*"M: Did she taught you how can you speak about your thoughts when you are anger? How can you present your thoughts in aggressive manner?* *R: I don't remember it."* *Double code with Step 2 Experience - Assertiveness and Communication*

Experience Ending Counseling	Definition: Student describes their experience ending counseling.		*"It hurt to say them bye. I am going to miss them and one thing I hated about counseling is that they are not allowed to give your number."*
Satisfaction with Treatment	Definition: Student discusses their level of satisfaction with the treatment.		*"M: So if you are to choose between 0-100 percent, how satisfied would you feel?* *R: 100."*
Suggestions	Definition: Student suggests ways to improve the treatment.	N/A	*"One of the ideas is Group Counselling . . . It should be done with the friends and the people who have the same problems. It will make you think lesser."*

Appendix C: Provider Interview Coding Framework

Level 1 Codes	Level 2 Codes	Level 3 Codes	Exemplars
Capacity Building Definition: Provider describes their experience preparing to deliver Step 2.	Training Definition: Provider describes their experience with the Step 2 training.	Negative	*"We received our training for Step 2 much early in the year. And then we started delivering Step 2 delivery treatments to place few months later. So that there is gap between training and delivery. The training itself was well structured but I do feel that the environment for training was not necessarily contusive for learning. Lot of modules that were actually in the manner that was intended for us to learn."* *"I felt like it would have been better if we had few more model examples for the training wherein we had one modeling done between two therapists but I wish there were more such models where everyone had a chance to present therapist and student combination with different kinds of concerns." Double code with Suggestions.*
		Positive	
	Pre-delivery expectations about Step 2 Definition: Provider describes their expectations about delivering Step 2 before seeing their first case, including how prepared		*"After the 1st session i was relaxed like finally i have done and it was the gap of after Diwali i had started seeing cases and i had been asked to take sessions before Diwali and soon the break started. So for that while i was preparing for my sessions and i was preparing for so long that you know there were first few refusals and you become nervous and anxious about the names. So basically, after seeing the 1st case i was relaxed and knew that i can deliver and you know when you try doing only you*

	they felt to deliver Step 2.		*will learn as where are your mistakes and all no. So that was my phase to learn how to deliver sessions in more better way."*
Supervision Definition: Provider describes their experience with peer group supervision or seeking informal consultation about Step 2 cases.	Peer group supervision Definition: Provider describes their experience with Step 2 peer group supervision (formal meetings once per week). Code Negative or Positive as indicated.	Positive	
		Negative	*"I don't think received lot of supervision at all. Most of the time I feel the supervision was organized, it was not very well structured. It is lot going on there but it didn't really feel what kind of feedbacks I am getting. Sometimes it felt not very directional. If the objective of supervision is to make me feel like I was receiving constructive feedback to improve my treatment over therapy program or the therapy I am delivering I don't feel I am supported during supervision. There could be certain factors to it being there were two sides. They are only listening to audio tapes. Different people's perception of just the audio tape might be different. I don't know. The treatment was also not clear to lot of people so then providing feedbacks will become little vague. I am not too sure but to be honest I don't look forward to supervision. I find that to be not very helpful. I find to be okay for updates of who is doing what."*

			"Then it really becomes collaborative approach towards improving supervision and that would help me or have me take home more points for me to improve the treatment vs me sitting there and just feeling like I am going to be assessed every time and then I am not feel like sharing any of my details because I feel like I am already charged or persecuted for the session." Double code with <u>*Suggestions*</u>
	Informal consultation <u>Definition: Provider describes seeking feedback on Step 2 cases informally (outside of peer group supervision) from colleagues.</u>		*"With my colleagues, of course, and Kanika, Resham, Madhuri, Pooja – they are all helpful and I discuss whatever issues were there, supporting, and giving their solutions, ideas."*
Relationship with Schools <u>Definition:</u> Provider describes their relationship with the staff at the schools where they saw students.	Teachers		
	Principals		
	Other school staff		
Logistics <u>Definition:</u> Provider describes logistics related to delivering Step 2.	Space for sessions <u>Definition:</u> Provider describes their experience finding places to hold sessions or describes something		*"Logistic concerns in the sense the seating arrangement. In one school the place was allotted to the counselor and the counselor itself was moving from one place to another and i had to shift between the rooms or have to wait in the library or the passage till the room gets vacant and then take the sessions there and there it was bit challenging and*

	about space for sessions.		*here in Santa Cruze school it was a huge balcony where you know there were lot of disturbance form the vehicles, church bell sound and the students were playing down." Double code with Challenges*
	Space for materials Definition: Provider describes their experience finding places to store Step 2 materials.		
	Calling students to sessions Definition: Provider describes their experience calling students out of class to come to a session. They may talk about physically going to a classroom to get a student, calling them with a note, or coordinating with a teacher.		*"Only in the Santa Cruz school i had to give the written note to the teacher saying that i want this student in this particular time because until or unless we give the written note the teacher wouldn't send for counseling asking why again and again the same student is being called because you know 5 sessions and again two more sessions and even the teacher was feeling like the student is just running around and missing the classes." Double code with Challenges*
	Setting	Schools Definition: Provider describes their experience delivering Step 2 in the school setting.	

		Delhi clinic <u>Definition:</u> Provider describes seeing students for sessions in the clinic in Delhi. They may talk about seeing students outside of the school.	*"The students had to come to an external location that wasn't a school. So, that was a huge challenge to overcome because summer vacation, a lot of them didn't want to make the effort. So, it was fairly ok logistically. The space was shared among three counselors. It wasn't ideal. I could hear clearly what other therapists and students were talking about and I was completely aware of those students. The problems said by the counselor were not private of settings for sure and I was very over during relaxation, it was noisy and I couldn't focus on my work and neither out the student. I actually had one student said, hey, I know, you are really trying very hard. I am not feeling relaxed. I am going to leave. This is not working because it was a bad day at the clinic. There were too many people. Environment was noisy. I couldn't convincingly do the relaxation module myself because that wasn't possible. So, logistics were a huge challenge. Especially, for step 2 where problems maybe of more severe and sensitive nature, it is very important that the environment is right. I think the happy place and the deep breathing was fairly easy to do. Progressive muscle relaxation was just not happening." Code with <u>Experience with Modules → Relaxation</u> AND <u>Challenges</u>*

		Delhi office <u>Definition:</u> Provider describes their experience delivering services in the Sangath office in Delhi	
Step 1 to Step 2 Transition <u>Definition:</u> Provider describes the transition between Step 1 and Step 2 and how it impacted students/treatment.	Positive		*"For some of the students we had the previous step one counselor come in and introduce the student to step 2 therapists. That was nice to have transition like that."*
	Negative		*"There was also some sort of miscommunication and I think one of them thought that the step one provider would also be the step two provider and was rather surprised to see me as a step two provider and then what a convincing that happen in order for him to even try me out and then no surprises. He preferred not to continue." Double code with <u>Student Engagement → Poor engagement</u>*
Self-Assessment <u>Definition:</u> Provider assesses their ability to deliver Step 2.	Competence rating <u>Definition:</u> Provider rates their competency before and after delivering Step 2.		*"6 or 7. I am more familiar with the treatment, protocol, with the program altogether and also little bit where my skills lie with the treatment program. It is limited number of cases. It is not like it's enough. But apart from that I would say that remaining 4-5 points are for improvement I am hoping I will be able to bridge that I feel this will is okay."*

	Therapist perceived change <u>Definition:</u> Provider describes if and how they feel they changed as a therapist as a result of learning and delivering Step 2.		
Experience Delivering Step 2 <u>Definition:</u> Provider describes their experience delivering Step 2. Do not apply this code if they are describing something more specific that falls into another category.	Facilitators <u>Definition:</u> Provider describes facilitators to delivering Step 2, i.e., things that made it easy to deliver.		*"I enjoy working with young people and I enjoy working with adolescence. I thought it was easier to build rapport with them and I thought it was easy to build relationship with them in which case it will be easy for me to deliver the treatment even though many times I was very anxious. I felt like maybe I could have done something differently or better. I had a feeling that I had good relationship with them and hence I felt that it wasn't really going to make a very poor impact if I miss out few things here and there in terms of treatment. Al though I would try to reflect and make sure it didn't happen the next time. At that point of time I thought it was comfortable environment for me to work with this population. I find them extremely adaptive and understanding of the treatment. That relationship was very helpful for me to work with this treatment." Double code with <u>Student Engagement → Student characteristics → Age/grade</u>*

	Ongoing revisions to Step 2 Definition: Provider describes how ongoing revisions to Step 2 (materials, manual, supervision structure, etc.) impacted their ability to deliver the intervention		*"Like I said there were lot of changes that the manuals was undergoing so that was a bit of confusion, ok, what is is exactly that has to be done?"* *Double code with Challenges and Manual*
	Nature of the treatment Definition: Provider discusses how having a manualized, flexible, and/or modular treatment impacted delivery		
	Easy to deliver Definition: Provider states that they found Step 2 or aspects of Step 2 easy to deliver		*"Even explaining the concepts I would say has not really been difficult."*
	Fit between intervention and student problems Definition: Provider describes the fit or lack thereof between		*"I don't find it to be a difficult intervention to deliver but I do feel like that like of cases of the instance that we are seeing maybe challenging and therefore molding the intervention to their needs can sometimes be challenging. So the intervention by itself is like you have to think of just exposure and as individual treatment is going to be very straight*

	students' problems and the intervention. Will often be coded with Clinical Decision Making.		*forward in case is easy to deliver or much easier to deliver but these cases are one require hire care and some of the problems which are come they are challenging, they are not straight forward simple problems. They have sometimes any other concerns so then working with that and making sure that you are able to adapt the program to their needs can be slightly challenging but again it think it is very adaptable."*
	Language <u>Definition:</u> Provider describes the language in which they delivered services and/or how language impacted intervention delivery. They may talk about needing to translate materials or content.		*"There are some English words which cannot be translated to Konkani and we had to explain students the same things like for example we can't give them the literal translation and we had to explain the meaning."*
	Time <u>Definition:</u> Provider describes their perception of the time needed to deliver Step 2.	Session duration <u>Definition:</u> Provider discusses their thoughts on the time needed to complete a session (typically ~35 minutes)	
		Treatment duration <u>Definition:</u> Provider discusses their thoughts on the	

		duration of the whole Step 2 treatment, including the number of sessions.	
	Progress monitoring <u>Definition:</u> Provider describes their experience administering progress monitoring tools (e.g., YTP, SxS, mood rating) to the students.		
Provider Characteristics	Provider background <u>Definition:</u> Provider describes their background (training, education, experience more generally) and how it impacts their experience delivering Step 2.		*"I really like exposure. It is a little bit complicated but that is something that I have the maximum experience in. I have done my Ph.D. in that area so I think it is personally really close to me and I think exposure is something that really helps all of us, it teaches us a lot of course, things like behavioral assertiveness, also what teaches you a lot but if you can do exposure - as a client I am saying not as a therapist - in which you really learn to face your fears in a healthy manner, all the other things will become easier for you to do."* *Double code with <u>Exposure</u> and <u>Facilitators</u>*
	Provider style <u>Definition:</u> Provider describes their counseling style, including how they		*"So the way I am talking to you right now that is how I would talk to the older student that is maybe one. Maybe there was one more slightly older student, but say to the younger children maybe I would talk to them, maybe more gently, I don't know, I would not like to treat them like a child, that's not what I was talking about but maybe*

	adapt it for different students.		*explaining things to them in a simpler terms by which they would understand. Yes, something like that."* *Double code with Student characteristics → Age/grade*
	Strategies for making students comfortable Definition: Provider describes their perception of what made students comfortable.		*"Maybe just like, this is all usual but just saying 'please interrupt me whenever, if you have any questions' or I think a lot of it had to do with scheduling at a time that was convenient to them which made it comfortable for them to attend. Other than that, I think, just acknowledging that this is, that this may be awkward and you might feel like you don't know what you're doing here, you know, there's a lot of uncertainty but don't worry, we'll figure it out."*
	Other		
Student Engagement Definition: Provider describes students' engagement with treatment. For example, their motivation, attitude, or willingness to attend sessions.	Relationship with student (e.g., alliance, rapport) Definition: Provider describes their relationship with their student clients, including having strong alliance/rapport.	Positive	
		Negative	
	Student characteristics Definition: Provider describes how students'characteristics	Age/grade	
		Gender	*"Mainly because of like less regulation from the parents like the boys who are able to come more freely because they could just like pick up and leave from home whenever they wanted. They had their*

	impacted their engagement with the intervention.		*own modes of transport. Some even coordinated with the staff."*
		Other	
	Student expectations <u>Definition:</u> Provider describes their perception of students' expectations for treatment.		*"With girls it's still there but with boys it's lesser – and I think overall both genders come with the expectation "We want advice, we want guidance." It's not a place they want to come and reflect and talk and bounce back."*
	Stigma <u>Definition:</u> Discussion of whether stigma impacted student engagement.		
	Strong engagement <u>Definition:</u> Provider discusses students with high levels of motivation/engagement.		*"They seem motivated to want to come in. I believe that time their concerns where rather distressing which is why they were motivated to come in and get help and that was nice to know. I think we checked in there was certain amount of expectations that was also done and what you expect from counseling and how that makes it beneficial for both of us."*
	Family involvement <u>Definition:</u> Provider discusses the role of family in a student's care in relationship to engagement.		*"All the children who were coming for counselling are the ones whose family members seems to be quite supportive. The children also seem to be supported. They did not seem to have concerns related to stigma or anything related to literacy or social class."* *Double code with <u>Student Engagement → Strong engagement</u>*

	Poor engagement Definition: Provider discusses students with low levels of motivation/engagement.	Competing time demands Definition: Provider describes students stating that competing time demands (vacation, exams, work, etc.) interfered with their ability to be engaged in treatment.	
		Other Definition: Provider describes reasons other than competing time demands that students cited for dropping out or otherwise being unengaged.	*"Challenges in terms of fall out with the students because earlier these are the students who had stepped up and they had moved from step 1 to step 2 and they complete 5 sessions and come to step 2. So there are queries at the start as why have i been stepped up or why i have to come to step 2 you know and at first there were students who refused step 2 because of time constrain and all. So that was the challenge just to make student understand that your one problem may be solved or may not be solved and we are just trying to teach you some skills apart from skills what you have learned. So that was little bit." Double code with Step 1 to Step 2 Transition → Negative*
	Homework completion Definition: Provider describes students' engagement in terms of homework completion.		*"Lack of time or just they would do some. I don't think not anybody did any part of the homework. They always attempted some part at least like if not for happy place, they would have at least done deep breathing. Like before they went to bed, they would have attempted some part of relaxation. I didn't have anyone who just flat outside that I didn't do anything. But yes, lack of time and sometimes they*

			just said they forgot to do it." Double code with <u>Experience with Modules → Relaxation</u>
Fidelity <u>Definition:</u> Provider describes their fidelity to the treatment protocol, i.e., whether they delivered the treatment as it was written/intended.	Delivered exactly as intended <u>Definition:</u> Provider reports that they delivered Step 2 with high fidelity (i.e., exactly as written)		*"Yes, 100% by the book. I was hyperaware of the manualized nature of this treatment and I did not frame in one or the other from the manual."*
	Deviated from the protocol <u>Definition:</u> Provider reports that they deviated from the protocol, demonstrating low fidelity.		
Step 2 Materials <u>Definition:</u> Provider describes their experience using Step 2 materials. *"It was just getting the material ready and anticipating what you would need in the preparation for the session. If there are 3 kids in one day, there is a whole bunch of*	Manual <u>Definition:</u> Provider describes their experience with the Step 2 manual.		*"The manual was good. I thought one didn't feel the need of more scripts. I think because I just say what my feeling is right for that particular student. It felt adequate. I didn't feel that they were too many loop poles. Again, like I think there was lots of cramp into a particular page because they did want manual to go into pages and pages like I appreciate that effort but it was just like too many little pieces of font like all staring at me and wobbling me. I would have rather appreciate even like a 50 page manual. I don't mind it as long as ease of readability is there. I don't mind flipping through pages if it's organized in a chronological manner like you do this first then space then do the next thing and then space. I am not like that. Like I don't*

permutation and combination of documents that you have to carry with you. So, that was a bit of a challenge and I had to spend at least half an hour in the previous day or an hour to go through the sessions and modules and the forms of single views and the forms that I need to carry because you use the same one every session. So, that."			*mind flipping through pages. I don't want to be everything on the same page and all cramped and I don't know which line I am on. I don't know what I am doing. So that was a little bit strike out." Double code with Suggestions*
	Appendices Definition: Provider describes their experience with the Step 2 appendices		
	Flipbook Definition: Provider describes their experience with the Step 2 flipbook.		*"Some part of the flip book you know the pictures, sometimes the students couldn't relate like you know one picture says the student is simply sitting and there is an picture of counselor and that could be replaced and there could be some relaxation which could be changed." Double code with Suggestions*
	Handouts Definition: Provider describes their experience with the Step 2 handouts		*"Like rather than handout 1, 2, 3, 4, and 5, I would have rather said handout for module BA, handout for communication and assertiveness or whatever. In that minute if the manual says ok, now, it is time to give handout 5A and I am scrambling to find it in my folder among millions of things, it messes with your focus and flow of the session. So I was worried about that. I was very confident about the material."*
	Clinical Record Form Definition: Provider describes their experience with the Step 2 Clinical Record Form, also referred to		*"In particular, it was very difficult to fill up the module vs. the session and that was quite a mess because even for data entry purposes, when you combine modules, you don't know which one to fill in the session record form. So, if you have done the first session of psycho end and you don't know you need another whole session on psycho ed and you*

	as session record form, which they completed at the end of each session with a student and which contains information about the session/student.		*decide to teach some of the relaxation in session 2. What do you fill in the session record form? Is it psycho ed or is it relaxation or is it both? So, these sort of certain details to be filled in the session record form were a bit . . .”*
Clinical Decision Making <u>Definition:</u> Provider describes their experience with making clinical decision in Step 2. This includes determining a student’s problem, deciding which modules to deliver, deciding when to transition between modules, deciding if/when to repeat/extend/combine modules or presentations, deciding on number of sessions and deciding when to terminate treatment.	Challenges <u>Definition:</u> Provider describes challenges they faced when making clinical decisions.		*“And especially when it is the matter of therapist choosing a module for a student. While I was doing it, it wasn’t a participatory activity wherein the students were informed about the choices and the therapists got to choose together about the module. I felt so responsible that the course of treatment I chose for the student could either make or break the treatment course.”* *“There are times I find it difficult to understand when to initiate maintenance and termination module that is the last module. So for one of the students what happened was scores had reduced it seems like you could definitely initiate like as per the paperwork it feels like that you should definitely initiate until and unless termination. As I started it I feel like I could have done one more session of the previous module before initiating because I felt at that point of time she still had not fully understood the skill that was required to be learned like it was not complete. Her understanding for that skill in terms of application it was partial understanding which is sometimes worse and that happened when we began delivering the skills. So we spend more time with them maintenance and termination, where we spend more time in role-play as well like it was*

			still doing the maintenance and termination and we spend a little bit more time in understanding that communication module with maintenance and termination but that kind of part where you feel that the student has learned enough to be able to initiate termination can get a little tricky and to what extent he want to review and revise things within that maintenance and termination would be helpful to have some guidelines."
	Ease <u>Definition:</u> Provider describes how easy it was to make clinical decisions.		
	Change over time <u>Definition:</u> Provider describes how their comfort making clinical decisions changed over time.		
	Process for making decisions <u>Definition:</u> Provider describes their process for making clinical decisions (e.g., discussed in supervision, decided with student). May also		

	include mention of the CARE worksheet.		
Effectiveness of the Intervention <u>Definition:</u> Provider describes their perception of how effective Step 2 was, including what they felt made the intervention effective or not effective.			
Experience with Modules <u>Definition:</u> Provider describes their experience with the various modules of Step 2.	Psychoeducation & Engagement <u>Definition:</u> Provider describes their experience delivering psychoeducation and engagement. They may discuss goal setting (may refer to SMART goals).	Positive	
		Negative	*"Actually the treatment at that point of time required us to prepare something like smart goal for student and in my mind the idea was to get the problem from there. When you get the problem from them I was little stuck because I have to convert this problem into a goal which is more positively framed. And to me that was confusing because how do you make teasing a goal? Teasing was the problem that the student mentioned. Getting details about teasing was not necessary helping me to develop goal for the student. I was not sure how to do that at all. That was becoming little challenging session in terms of what details to gather. I don't think I gathered enough details either teasing or how to set the goals because it was slightly confusing for me. That stage of treatment was slightly confusing for me."*
	Relaxation	Positive	*"Relaxation as a module. That was relatively easy to deliver."*
		Negative	

	Definition: Provider describes their experience delivering relaxation. They may mention deep breathing, happy place, or deep muscle relaxation.		
	Behavioral Activation (BA) Definition: Provider describes their experience delivering BA. They may discuss activity scheduling or being active.	Positive	
		Negative	
	Assertiveness & Communication Definition: Provider describes their experience delivering assertiveness and communication. They may discuss passive, aggressive, and assertive styles of communication.	Positive	
		Negative	*"One was definitely the fact that the terminology was difficult for them to understand that what passive communication is. It was very difficult for them to follow what passive communication was. They understood it but they understood assertive well. But many times passive took little longer for them to follow."*
	Exposure Provider describes their experience delivering exposure. They may	Positive	
		Negative	

	discuss "facing your fears" or a fear ladder.		
	Problem Solving Provider describes their experience delivering problem solving. They may discuss POD, pros and cons, or advantages and disadvantages.	Positive	
		Negative	
	Cognitive Provider describes their experience delivering cognitive. They may discuss unhelpful styles of thinking.	Positive	
		Negative	
	Maintenance & Termination Provider describes their experience delivering maintenance and termination. They may discuss reviewing material, planning for the future, and looking ahead.	Positive	
		Negative	
Suggestions <u>Definition:</u> Provider offers suggestions for improving Step 2.			*"Suppose if we don't have time, these are two sides of handling. It can be tapes are sent across, each one gets equal opportunity to rate each other's tape so that there is lot of learning and wherever we can improve on can be dealt with that particular time*

			instead of finishing the session with the students and then you see the new students with the same mistakes." Double code with <u>Supervision</u>
Challenges <u>Definition:</u> Provider describes challenges they encountered delivering Step 2. If the challenge more neatly fits into another category, code there.			*"The treatment being very fluctuating or moving in terms of changes was dynamic about that. They will be constantly thinking of changes which are good thing. Many times I was unable to attribute whether the changes has to be made because of the structure of the manual or because of my scale. That distinction being very difficult to make was sometimes bothersome because sometimes it could have been the structure of the manual." Double code with <u>Experience with Materials → Manual</u>*
Cultural/Contextual Considerations <u>Definition:</u> Provider describes their perception of how well Step 2 (materials, design, etc.) fit with the context/culture or other cultural/contextual factors.			