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ORIGINAL PAPER

Community Recommendations for Adapting an Evidence-Based Mental Health Intervention for Racially/Ethnically Diverse Schools: A Qualitative Study

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Abstract

The goal of this qualitative study was to understand the perspectives of school community members (adolescents, parents, school administrators, teachers, mental health providers) regarding the adaptation of an evidence-based transdiagnostic mental health treatment, known as the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders in Adolescents, for delivery in racially/ethnically diverse schools. Thirty-three school community members ($n=9$ adolescents, $n=4$ parents, $n=5$ school administrators, $n=10$ teachers, $n=5$ mental health providers) participated in a series of focus groups or individual interviews. We used a rapid qualitative analysis to summarize their recommendations for adapting our intervention across seven themes: (1) consider social determinants of health, (2) include content related to social media and digital literacy, (3) provide teachers and staff with training on identifying and referring to mental health services and basic psychoeducation, (4) build trust and reduce stigma, (5) use qualified mental health providers to conduct culturally relevant sessions in person during school hours, (6) consider flexible format offerings and extended intervention delivery window, and (7) anticipate low parental engagement. These data were critical for informing systematic content and procedural modifications to our adapted intervention, such as scheduling sessions for school lunch hours and identifying coaches (e.g., teachers, school administrators) to support students with check-ins regarding session attendance and skill practice. These adaptations may be applied more broadly to the implementation of evidence-based mental health interventions in diverse school settings.

Keywords Transdiagnostic · Depression · Anxiety · School-based prevention · Intervention adaptation · Qualitative

Introduction

Youth mental health has become an increasingly urgent public health issue in the USA. COVID-19 social distancing measures, including school closures and remote learning, resulted in a substantial rise in psychological distress in youth, especially those already struggling with mental health difficulties (Theberath et al., 2022). Compared to pre-pandemic rates, significant increases in anxiety and depression in youth, including comorbid anxiety and depression, have been reported, as well as decreases in life satisfaction (Figas et al., 2023; Magson et al., 2021; Panchal et al., 2023). Older adolescents have been especially vulnerable to declines in mental health, with at least one in three high school students reporting persistent feelings of sadness or hopelessness during the lockdown period, an increase of 40% since 2009 (Office of the Surgeon General, 2021; Panchal et al., 2023). While some have recently argued that dramatic increases in youth anxiety and depression during the pandemic may be overinflated due to concurrent maturational changes (Wright et al., 2023), it is well known that racial and ethnic minority youth were at particular risk for mental health challenges due to reduced connectivity to peers and poor attendance at school resulting from limited internet access (Running Bear et al., 2021), greater likelihood of loss of a caregiver to

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COVID-19 (Hillis et al., 2021), and high rates of loneliness and poor mental health (Rogers et al., 2021). These youth are also prone to experience multiple risk factors which require additional support (e.g., poverty, discrimination) and may be less likely than their white counterparts to engage in mental health services (Office of the Surgeon General, 2021). Overall, there is a critical need for effective, accessible, and culturally relevant mental health care for racially and ethnically diverse adolescents.

There are a wide range of evidence-based treatments for anxiety and depressive disorders in adolescents, including transdiagnostic cognitive-behavioral interventions, or those that address key mechanisms targeting anxiety, depression, and related emotional or internalizing problems in a singular, manualized approach to psychotherapy (Ehrenreich-May et al., 2017). One of these, the Unified Protocol for Transdiagnostic Treatment of Emotional Disorders in Adolescents (UP-A; Ehrenreich-May et al., 2018), has been found to be efficacious in improving adolescent internalizing symptoms across open-trial, multiple-baseline, and randomized controlled trial formats (Ehrenreich et al., 2009; Ehrenreich-May et al., 2017; Trosper et al., 2009). The UP-A has also led to reduced diagnostic severity and greater global improvement compared to waitlist conditions at mid- and post-treatment (Ehrenreich-May et al., 2017) and has been adapted for use with a number of related youth samples and settings (see Ehrenreich-May & Kennedy, 2021). The UP-A is unique in its flexible, modular structure, and framing of evidence-based strategies in the general context of youth emotions. This modular structure makes it especially useful for practitioners who may be pressed for training time or who require an evidence-based approach that allows for personalization to a wide array or combination of youth internalizing concerns (Ehrenreich-May et al., 2018). Yet despite this appealing structure and the progress made in treatment efficacy, widespread access to the UP-A or similar evidence-based mental health interventions remains a substantial problem, particularly among racial and ethnic minority adolescents.

Racial and ethnic minority adolescents are less likely than their white counterparts to receive services for anxiety and mood disorders, even when they experience severe impairment (Georgiades et al., 2018; Merikangas et al., 2011; Rodgers et al., 2022). Their low rates of engagement in treatment have been explained by perceptions of stigma associated with mental illness and service utilization (Misra et al., 2021), the limited availability of mental health services, lack of time or resources to dedicate to the treatment process, and preferences toward self-help (Gulliver et al., 2010). Youth who do initiate help-seeking for emotional disorders face significant capacity issues in specialist mental health services leading to lengthy wait times for assessment and treatment and high clinical thresholds for entry (Crenna-Jennings & Hutchinson, 2018). Furthermore, among youth who successfully access care, high premature termination rates and the lack of accessible empirically supported interventions remain barriers to effective mental health care (de Haan et al., 2013, 2018). Given these many challenges, gaining greater insight into the perspectives of the communities to which these adolescents belong may help increase the accessibility, relevance, and responsiveness of mental health interventions.

One key environment for accessing and providing evidence-based mental health care to diverse adolescents is the school setting. As adolescents spend much of their time in school and typically attend the same school over a number of years, school-based interventions have become increasingly prevalent and effective for providing support to students with elevated symptoms of anxiety and depression (Feiss et al., 2019). In a review of school-based interventions for internalizing disorders, significant small effects on both anxiety (Hedges $g = 0.20$) and depression symptoms (Hedges $g = 0.23$) were found at postintervention, with evidence of effects maintained (Werner-Seidler et al., 2017, 2021). The familiarity of the environment and extended contact with school staff can facilitate trusting and consistent relationships that allow adolescents to feel more comfortable disclosing their mental health difficulties. Further, school-based treatments are often integrated with the providers already available to students (e.g., school counselors, administrative support teams) which can help reduce stigma in the help-seeking process (Gee et al., 2020). Intervention delivery in schools reduces logistic burden for engaging in services, including time and cost, and affords parents with greater access to support their youth's care. Indeed, the utilization of school-based mental health services has been shown to be more equitable across racial and ethnic groups compared to community settings (Kataoka et al., 2007). With these advantages, schools provide a promising environment for delivering timely interventions to diverse students at risk for mental health disorders.

There have been increasing efforts to implement evidence-based mental health interventions in schools. Evidence-based treatment modalities (e.g., cognitive-behavioral therapy, dialectical behavior therapy, etc.) have been adapted for schools to better support students in coping with psychosocial challenges (Mazurek Melnyk et al., 2014; Mazzone et al., 2023; Michael et al., 2016; Reaven et al., 2022), with modifications to number of sessions and session length (i.e., dosage), exposure tasks, and types of interventionists (Kendall et al., 2023). Other evidence-based interventions, such as Social and Emotional Learning (SEL) programs, are often designed specifically for delivery by school staff and have shown promise in bolstering youth academic, emotional, and behavioral competencies and improving overall mental health and well-being (Durlak

et al., 2011). There have been several adaptations of SEL programs (e.g., Strong Teens; Carrizales-Engelmann et al., 2016), including those featuring cultural adaptations (Castro-Olivo, 2014; Cramer & Castro-Olivo, 2016) and those better fitting the alternative school context for students with behavioral concerns (Ohrt et al., 2020).

Few evidence-based transdiagnostic interventions for internalizing concerns, at least those originally designed for clinic-based delivery, have been delivered in a school context, and even fewer have incorporated the lived experiences of youth, families, and school personnel in the process of adapting such interventions for this context. Martinsen et al. (2019) evaluated the effectiveness of a preventive transdiagnostic intervention (EMOTION, adapted from two cognitive-behavioral therapies for youth anxiety and depression, respectively) delivered in schools to 8–12-year-old children and found that those in the intervention condition self-reported nearly twice the reduction in anxiety and depressive symptoms compared to children in the control condition. In a follow-up mixed methods evaluation of facilitators and barriers to the implementation of this program, authors highlighted the importance of school investment as a key contributor to providers' likelihood to continue with the program (Rasmussen et al., 2020). They recommended that future work focus on gathering information from the school community on how to best implement the intervention. Notably, a framework by Domitrovich and colleagues (2008) suggests that the quality of intervention implementation in schools is influenced by factors at the macro-, school, and individual levels. As such, developing an understanding from multiple perspectives related to the implementation of school-based interventions to address adolescent mental health needs is warranted, especially for racially and ethnically diverse youth.

Overall, despite efforts to translate evidence-based interventions for internalizing concerns to the school setting, important considerations such as the attitudes, preferences, and lived experiences of key members of the school community may not be systematically incorporated as interventions are adapted for a new context. There are numerous existing frameworks that guide the process of cultural adaptation (e.g., ADAPT-ITT Model (Wingood & DiClemente, 2008), Cultural Adaptation Process Model (Domenech Rodríguez & Wieling, 2004), data-driven adaptation (Lau, 2006), heuristic framework (Barrera & Castro, 2006)). Notably, Barrera et al. (2013) consolidated several of these frameworks into five stages: (1) information gathering, (2) preliminary adaptation design, (3) preliminary adaptation tests, (4) adaptation refinement, and (5) empirical testing of the cultural adaptation within a randomized controlled trial. The present study reflects the information gathering and adaptation design stages in the process of adapting an evidence-based transdiagnostic mental health treatment, the UP-A, for delivery in racially/ethnically diverse schools. Specifically, it serves to understand the perspectives of adolescents, parents, and school personnel (i.e., administrators, teachers, mental health providers) regarding unique stressors faced by racially and ethnically diverse students as well as school-based factors that should be considered in the adaptation process. Qualitative methods are especially useful for engaging with communities around issues of intervention adaptation and implementation and further understanding how individuals and their families make decisions about their care; they may also aid in ensuring the appropriateness of interventions delivered in a new context or on a larger scale (Hamilton & Finley, 2019). Below we report themes we generated from discussions with members of diverse school communities to provide recommendations on enhancing the accessibility, visibility, cultural and contextual relevance, and appeal of the UP-A. Importantly, the goal of this qualitative analysis was not to adapt the UP-A for one particular ethnic or cultural group, but to enhance its relevance, feasibility, sensitivity, and appropriateness for delivery in school settings that were highly diverse from both socioeconomic and identity-based perspectives. We highlight key adaptations to our revised intervention, known as the Unified Protocol for Preventing Emotional and Academic Challenges in Education (U-PEACE).

Methods

Participants and Setting

Participants included 33 school community members purposively sampled from two high schools in Miami-Dade County, the nation's third largest school district. Miami-Dade County includes 2.7 million residents with varied lived experiences, including 68% who identify as Hispanic and over half born outside the USA. The two high schools from which we sampled have a student population of ~ 970 to 2,000 students, with approximately 99% identifying as racial or ethnic minorities and 89–91% receiving free/reduced lunch. Participants were eligible if they (1) were affiliated with a participating high school, (2) were either a high school student, parent, teacher, school administrator, or school mental health provider, and (3) spoke and understood fluent English. Most students in this study were engaged in after-school activities (e.g., clubs related to improving school mental health, team sports) and well-regarded by the school community. See Table 1 for participant demographic characteristics.

We leveraged an established relationship with the school district through the University of Miami's School Health

Table 1 Participant demographic characteristics

	Total ($N=33$)	Adolescents ($n=9$)	Parents ($n=4$)	School administrators ($n=5$)	Teachers ($n=10$)	Mental health providers ($n=5$)
Mean (SD)						
Age (years)	35.88 (15.73)	16.89 (0.60)	46.25 (4.11)	47.60 (6.11)	43.40 (16.83)	35.00 (7.68)
N (%)						
Gender						
Male	9 (27.2)	3 (33.3)	0 (0)	2 (40.0)	3 (30.0)	1 (20.0)
Female	24 (72.7)	6 (66.7)	4 (100)	3 (60.0)	7 (70.0)	4 (80.0)
Ethnicity						
Hispanic	11 (33.3)	2 (22.2)	2 (50.0)	2 (40.0)	4 (40.0)	1 (20.0)
Non-Hispanic	22 (66.7)	7 (77.8)	2 (50.0)	3 (60.0)	6 (60.0)	4 (80.0)
Race						
African-American or Black	20 (60.6)	8 (88.9)	1 (25.0)	1 (20.0)	8 (80.0)	2 (40.0)
White, Caucasian, or European American	6 (18.2)	0 (0)	2 (50.0)	3 (60.0)	0 (0)	1 (20.0)
Other	1 (3.0)	0 (0)	0 (0)	0 (0)	0 (0)	1 (20.0)
Did not report	6 (18.2)	1 (11.1)	1 (25.0)	1 (20.0)	2 (20.0)	1 (20.0)

Initiative (SHI) to recruit from participating high schools through flyers, advertisements in school wellness clubs and faculty meetings, and word of mouth. The SHI provides medical care to over 12,000 children per year in nine of Miami-Dade County's most under-resourced public schools. The mission of the program is to provide integrated high-quality school healthcare services to meet the unique needs of the diverse school communities they serve while promoting lifelong healthy living and learning. All SHI schools are in high-need, low-resource neighborhoods where 25% of the population lives below the poverty line and the median household income is $15,000 below the national median. In these areas, violent crime is 68% higher than the state average and 87% higher than the national average.

Procedures

Our study protocol was reviewed and approved by the University of Miami's Institutional Review Board and Miami-Dade County Public Schools' research review board.

Prior to completing a brief sociodemographic survey and participating in either semi-structured focus groups or individual interviews, participants provided written informed consent (adults) or assent (adolescents). We initially set out to conduct five focus groups (one per school community member type); however, due to scheduling challenges, namely among parents and school mental health providers, we used a combination of group-based and individual interview approaches. The location and modality of focus groups and interviews depended on the school community member(s) being interviewed, with school personnel/the SHI team assisting with scheduling and logistics. For instance, the student focus group took place in-person during lunch. Parents' interview dates and times were generally coordinated by phone, and the team accommodated whether parents wanted to be interviewed in-person on school campus or via Zoom. The school administrator focus group occurred in-person during school hours. Teacher focus groups took place during a teacher planning day, around the teacher's lunch breaks. Mental health providers were interviewed individually; some were interviewed in-person during teacher planning days, and some were interviewed via Zoom.

For in-person data collection, participants completed paper and pencil sociodemographic surveys and our team subsequently hand-entered their responses into the Research Electronic Data Capture (REDCap) system. These interviews were recorded using EVISTR L157 digital recorders. Participants received a free meal as well as a $50 gift card. For virtual data collection, participants completed sociodemographic surveys using REDCap and had their interviews audio recorded via Zoom. The research team ordered meals to be sent directly to these participants' homes and sent $50 electronic gift cards.

Our team transferred all audio recordings to a HIPAA-compliant departmental server and permanently deleted them from recorders and local computers. We then sent them to a professional transcription service (Datagain©) for verbatim transcription. To ensure accuracy of the data, we reviewed all transcripts we received against the original audio files. Our team conducted a total of four focus groups and 11 individual interviews throughout the fall semester of 2022. There was no overlap of participants in focus groups and individual interviews. The focus groups included one

group of eight adolescents, two groups of five teachers, and one group of four administrators. They ranged from 33 to 83 min, with an average of 67 min in length. We conducted individual interviews with one adolescent, four parents, one administrator, and five school mental health providers; these ranged from 36 to 84 min, with an average of 58 min in length. Our decision to stop interviewing was informed by the following: a systematic review of empirically based studies of sample size saturation in qualitative research which showed that 9–17 interviews or 4–8 focus group discussions reached saturation (Hennink & Kaiser, 2022), evidence that ideas and suggestions were recurring within and across focus groups and interviews, and practical considerations related to staff time and study timeline.

Three study investigators—one of whom is the primary developer of the UP-A, another of whom has expertise in qualitative and mixed methods, and a third who serves as the SHI leader of mental health services—drafted the initial question guides (see Table 2). These guides were then reviewed by an external consultant with expertise in qualitative methods as well as master's level clinicians with experience delivering UP-A and adapting it for other settings. Questions differed based on the type of school community member being interviewed, with all guides including two parts: (1) general questions related to challenges that students today face, and (2) specific questions regarding adaptations to consider for successful implementation of an evidence-based mental health intervention in a racially/ethnically diverse school setting. Prior to asking about participants' suggestions for adaptation of the UP-A, we provided them with a brief overview of the intervention using presentation slides that explained cognitive behavior therapy and the typical structure of the UP-A (e.g., session length, modules). Slides also included an example of a condensed session outline (i.e., module on opposite action) and a demonstration video used in that session.

Qualitative Analysis

We conducted a rapid qualitative analysis (RQA) to analyze interview data (Hamilton, 2013, 2020; Hamilton & Finley, 2019). RQA is a method of rigorously and efficiently analyzing qualitative data needed to address immediate and/or pressing issues, including health equity issues, such as the timely adaptation of an evidence-based intervention for racially/ethnically diverse schools (St. George et al., 2023). RQA involves using a team to summarize key points from qualitative data into matrices, which are then used to explore relevant themes. We followed previously published

Table 2 Qualitative interview guides

Question	Student	Parent	School administrator	Teacher	Mental health provider
Tell me about your experience (and role) as a [school community member type].	X	X	X	X	X
What are the biggest stressors and challenges that teens in schools face today?	X	X	X	X	X
What unique strengths do you think teens today have?	X	X	X	X	X
Tell me about your experience with anxiety and/or depression / raising a high school student with anxiety and/or depression.	X	X			
If any, tell me about your experiences with mental health services.					X
Tell me about the types of mental health services you provide.					X
What successes have you had as a mental health provider in the schools?					X
What challenges do [school community member type] face in supporting students with anxiety and depression?		X	X	X	X
What do you see as your role in addressing students' mental health concerns?			X	X	
What do you do when you think a teen may have symptoms of anxiety and/or depression?			X	X	
When should we deliver U-PEACE in schools?	X	X	X	X	X
How should we deliver U-PEACE in schools?	X	X	X	X	X
Who would be the ideal people to help deliver U-PEACE in schools?	X	X	X	X	X
What type of training do the people who deliver this program need?					X
What, if any, would be the role of [school community member type] in offering a program like this in schools?			X	X	
What would it take for a program like this to be offered in schools that do not have a school mental health infrastructure in place?			X		X
How can we make U-PEACE more relevant to teens in your school?	X	X	X	X	X
What would help to engage teens from your school in U-PEACE?	X	X	X	X	X

recommendations for assuring quality, rigor, and trustworthiness throughout the RQA process, including: establishing a large and diverse study team prior to data collection, providing thorough training for all team members that includes a combination of didactic and hands-on exercises, developing a collaborative auditing/feedback system that includes all team members, engaging interviewers in both data collection and analysis, and following an established RQA approach closely (St. George et al., 2023).

One of the study PIs with expertise in qualitative and mixed methods provided training on the relevance of using RQA and reviewed procedures specific to Hamilton's approach (Hamilton, 2013, 2020; Hamilton & Finley, 2019), including the use of summary documents to extract key points from each of the transcripts. Nine trained team members participated in the analysis process. Team members were mostly women from diverse racial/ethnic minority backgrounds (e.g., Hispanic, non-Hispanic Black) who had obtained a graduate-level education in the field of psychology. Notably, both study PIs and a Co-I grew up in the local area and were familiar with social norms of the community and its cultural diversity. This dual identity—as both community members and researchers familiar with the school system—uniquely positioned the team to interpret qualitative data. Each transcript was assigned to two team members (at least one of whom participated in conducting the original focus group or individual interview, where possible). The first team member summarized key points from the interview using our summary template. These summaries were 1–2 pages in length and included bulleted main points that corresponded to each interview question. The second team member subsequently audited the summary document for accuracy and then transferred key statements into a matrix summary for review by one of the PIs and further analysis.

The matrix displayed all participant responses that correspond to each domain (or in our case, interview question). Specifically, each focus group or interview transcript was represented by a unique row in the matrix, and each domain was represented by a unique column. A postdoctoral trainee added five summary rows to the matrix—each a summary of comments from the different school community members (e.g., adolescents, parents, school administrators, teachers, mental health providers). The study PI who reviewed the final matrix then generated preliminary themes using information gathered across the full interview (including general questions related to student challenges and specific questions regarding adaptations). To ensure that voices of all school community members were reflected in our results, this process involved reviewing the full matrix by domain for each unique school community member type, one at a time, while making notes on recurring ideas. With information from each additional "batch" of school community members, notes were revised and consolidated into preliminary themes. Themes were reviewed, refined, and finalized through group discussions at meetings that involved PIs, Co-Is, interviewers, and all team members involved in the RQA process.

Our team subsequently engaged in member checking by presenting themes to a community advisory board comprised of seven school community members who participated in the original interviews and focus groups ($n = 3$ adolescents, $n = 2$ school administrators, $n = 1$ parent, $n = 1$ mental health provider; a teacher was invited but did not attend). Overall, the consensus from the community advisory board was that the list of themes was reflective of their conversations and captured the local school community's needs. They provided additional input on logistical considerations for delivering the intervention in the school setting (e.g., lunch schedules, provision of snacks). We used the consolidated criteria for reporting qualitative research (COREQ) checklist to guide the reporting of study methods and results (Tong et al., 2007).

Results

We generated seven themes that summarized school community members' recommendations for adapting our evidence-based mental health intervention for use in diverse high school settings: (1) Consider social determinants of health, (2) Include content related to social media and digital literacy, (3) Provide teachers and staff with training on identifying and referring to mental health services and basic psychoeducation, (4) Build trust and reduce stigma (subthemes: (4a) Maintain a consistent presence in schools, (4b) Take a strengths-based approach), (5) Use qualified mental health providers to conduct culturally relevant sessions in person during school hours, (6) Consider flexible format offerings and extended intervention delivery window based on symptom severity and school logistics, and (7) Anticipate low parental engagement. We present each of these themes and corresponding supporting participant quotes in the text below. We present additional supporting quotes and specify school community members who contributed to each theme in Table 3.

Theme 1: Consider Social Determinants of Health

School personnel (i.e., administrators, teachers, mental health providers) commented that some of the biggest stressors and challenges facing teens in their schools were related to their economic stability and social contexts. For example, teachers discussed how some teens in the community have become emotionally desensitized to extreme acts of violence (e.g., gun violence, murder) among their

Table 3 Themes and additional participant quotes

Theme	School community members who endorsed theme	Sample quotes
1. Consider social determinants of health	School Administrators Teachers Mental Health Providers	• "I've been at another school with the socioeconomic level was different. It was better. The parents had like, you know, lawyers, doctors, professionals. Their stresses would be that their phone got taken away, right?…These kids stresses are, am I going to eat today?" ***—School Administrator*** • "… the students who are dealing with homelessness and then having to come to school and see people with $2000 shoes on. That's stressful. I have students… you can tell even though they wear uniforms, you can tell when students are wearing the same white shirt every single day …This school has the highest homeless rate." ***—Teacher*** • "Many of them are just coming to this neighborhood and even coming to this country. So they are really trying to like adapt, learn the language, learn the culture, trying to fit in where they feel that's best for them. Um, so there's—there's challenges there. Of course, some of our students also have been victims of violence as far as the family members getting killed or injured. Um, them seeing it right in front of them. So those traumatic experiences definitely impact the way our students move and operate." ***—Mental Health Provider***
2. Include content related to social media and digital literacy	Students Parents School Administrators Mental Health Providers	• "...to go off the social media aspect: So many things going on in the world and so many people to compare to, um, looking at yourself and how you're doing compared to everybody else around you." ***—Student*** • "I believe that so much information out there, and they don't know how to cope with that. And they get so much things in their minds that they not able to do. Like for example, they're doing fine. But they see this Youtuber that is struggling mentally. They already looking those signs in their own person and then, oh, I feel like this too. You didn't feel like that a week ago. Where is this coming from?" ***—Parent***
3. Provide teachers and staff with training on referring to mental health services and basic psychoeducation	Students School Administrators Teachers	• "So like working with the staff and and saying, hey, you know, here's some of the warning signs, here is some of the things that, you know, we wanna support kids with and if you see this, that kid may have a need." ***—School Administrator*** • "As far as training is concerned, I think if, you know, if [U-PEACE] gonna be within this setting and of course as teachers, it would be beneficial for us to get some type, you know, of a training …because then we can become more effective on how we assist the students in the process." ***—Teacher***

Table 3 (continued)

Theme	School community members who endorsed theme	Sample quotes
4. Build trust and reduce stigma Subtheme 4a: Maintain a consistent presence in schools	Students Parents School Administrators Teachers Mental Health Providers	• "There needs to be time spent like building trust, like getting to know the community because there might be issues even just getting people to enroll." —***Mental Health Provider*** • "Sometimes maybe better like somebody they know in school. They're used to that person, they're probably more, more, what should I say? More happy to open to them. But if you don't know nobody, you know, you just come in and they don't know you, uh, they might not be open that much."—***Parent***
• Subtheme 4b: Take a strengths-based approach	Students Parents School Administrators Teachers Mental Health Providers	• "People are gonna be quick to put you down if you mess up or if you're doing something wrong. If you're doing something right, people may not even say anything at all…"—***Student*** • "I think first we have to make it, you know, like there's no stigma to this, right? Like… you're not crazy. You're not not well. You're not emotionally imbalanced, you know? Like you want to make yourself better, right? You want to pitch it to like it's like a growth mindset situation." —***School Administrator***
5. Use qualified mental health providers to conduct culturally/linguistically relevant sessions in-person during school hours	Students Parents School Administrators Teachers Mental Health Providers	• "Therapist or nurses. With lots of experience with the age that we're talking about. Because they definitely know how to address them. You can be really good in what you do. But if you work with adults most of the time, kids things so much different. You need to have a different approach." —***Parent*** • "…if you're gonna do a group, I think a group is most appropriate during lunch."—***Mental Health Provider***
6. Consider flexible format offerings and extended intervention delivery	Students Parents School Administrators Teachers Mental Health Providers	• "So there are obviously some issues that kids would rather deal with independently, you know, individually. Um and then there are others that they would benefit from like being in a group, because they see that there are other kids having the same issues as they are and they kind of form, you know, some kind of solidarity. So I think it depends on the specific situation." —***School Administrator***
7. Anticipate low parental engagement	Students Parents School Administrators Teachers Mental Health Providers	• "One thing that I can think of that might get in the way is not having enough support from parents. That would be crucial there." —***Teacher*** • "We working so much. And, and we give them so little. The time we give them is so small. It's not enough to know each other. It's not that we just don't know our kids, it's our kids don't, they don't know us, so they don't know what they can talk to about with us. Time is the key here. We're too busy addressing so much things … And our kids that should be the first in our, in our list, and they are being our last, because we're working for them. To do better for them. To have a, a good household, to have a good home, to have everything they need, to have, but they don't have us."—***Parent***

loved ones and community members. School personnel also described youths' unstable housing, with one mental health provider referencing "some students that are homeless that live in the local shelters" and who "don't have a home of their own." A school administrator pointed out that even when students were not homeless, they were still "living in a cycle of poverty." School personnel expressed concern for students they depicted as parentified children, or those "who have been made to be like young adults already" and "may not necessarily have that strong high school support system that you feel a child would have." Teachers described an effective mental health program in their schools as one that would have the community knowledge needed to connect students to relevant social services, noting "community resources would go a long way." Overall, a consistent message, especially from participating school personnel, was that adaptations to the program should address relevant social determinants of students' mental health.

Theme 2: Include Content Related to Social Media and Digital Literacy

Students, parents, school administrators, and mental health providers described students' use of social media as a major challenge faced by students today and a barrier to improving their mental health. Students and parents discussed how social media facilitates social comparison as well as unreasonable standards of beauty and wealth among adolescents. When asked about unique stressors that teens today face, one school administrator noted youth are "trying to meet certain social expectations brought about by social media and just media in general," and that "those expectations of being prettier, having more… it causes stress in students." Students described the prominence of social media use among their generation as an invasion of privacy, and as a result, a source of anxiety for them. School administrators and teachers also described teens' susceptibility to misinformation and misguidance on social media platforms. One teacher explained, "They have a lot of influences that are not true influences, but that's what they lean toward." There was concern that this problem also extended to teens' understanding of mental health. Overall, those who contributed to this theme encouraged the research team to consider social media-related stressors and digital literacy when adapting the program.

Theme 3: Provide Teachers and Staff with Training on Referring to Mental Health Services and Basic Psychoeducation

School administrators and teachers remarked that certain staff members at the school could benefit from psychoeducation on adolescent mental health, and students felt most comfortable discussing mental health concerns with "somebody who is able to understand" and had knowledge of the topic. One student said: "For example, if I was to talk to Mr. [school administrator]… I wouldn't be able to necessarily relate to him opposed to having a meeting with coach [school guidance counselor]." Teachers noted that school personnel often lack the time and resources to provide quality mental health support, and thus viewed their role as: providing referrals, following up on referrals to mental health services, fostering self-awareness of mental health issues, and providing encouragement. The primary challenges they expressed were identification of students' behavioral symptoms and timing of referral (i.e., at what level of concern should they refer the student to mental health services). They indicated interest in being trained in how to effectively identify and approach mental health concerns with students to provide more appropriate support. One teacher explained, "I do agree some type of training to identify, like what anxiety and depression looks like in order to … refer students to the clinic who desperately need it." School administrators agreed that mental health training would benefit teachers given their potential role identifying and referring students to mental health services. They also mentioned that providing mental health training for the staff would simultaneously strengthen the referral process at the school and build better rapport with students and the community.

Theme 4: Build Trust and Reduce Stigma

Subtheme 4a: Maintain a Consistent Presence in Schools

Students, parents, and school personnel highlighted the importance of building trust and reducing mental health stigma among the student population, and they suggested two key strategies. The first strategy involved building and maintaining a consistent presence in the schools to build trust with students. One school administrator emphasized the importance of clinicians integrating themselves into the school community:

> If you provided a staff member that would, or should, or could be eligible or available to be a part of something else in the school to where the kids don't see, oh, if you're going to this person, you got a problem.

Others commented that the degree of trust clinicians build with students will be related to "how much time you get out [into the community]" because "that's where you're building relationships." A school mental health provider highlighted her intentional and successful integration into the school community, stating:

> When we say we care about you as a human, we, we include academic performance, behavioral performance as well as mental health performance, right? ... We're not just in a room that you can't come and see us and you don't know who we are and you don't want to tell anybody right? We're at the lunch room, we're handing out candy..., they-- and, you know, students are like, that's my therapist, right? ...We're just providing accessible care and helping to eliminate barriers and stigma.

Students' comments suggested that they valued these efforts and underscored the importance of having program leaders whom they could trust and relate to; they cited school staff members who were consistently present for them and who empathized with their unique stressors and needs (e.g., "…mak[ing] sure that whoever is doing it, is aware of the current events and how things are going with us now").

Subtheme 4b: Take a Strengths-Based Approach

The second strategy for building trust and reducing stigma involved taking a strengths-based approach when advertising and delivering a school-based mental health intervention. One school mental health professional reflected on the impact that a mental health group's name can have on student interest:

> I know we've found with groups when they're worded in like a more positive way, I think kids are more likely to engage in them... I did a self-compassion group that, like, we had other options for groups that we were thinking about offering, like coping with stress, trauma, grief, but we had way more kids sign up for self-compassion... which sounds a lot less, like, pathologizing, and maybe more like empowering.

Parents and teachers also underscored how "kids now are really strong" despite dealing with stressors such as intergenerational poverty, violence, homelessness, and bullying, and that it was important to frame the program in a way that capitalized on the strengths that contribute to students' resilience.

Theme 5: Use Qualified Mental Health Providers to Conduct Culturally Relevant Sessions In Person During School Hours

Students, parents, and school personnel mentioned a need for qualified mental health providers to provide mental health interventions in schools, noting they should have training and experience with both the intervention and local community. Teachers collectively described the ideal mental health provider as someone who "needs to have the clinical skills and expertise," is "part of the culture," and more specifically, "somebody that's experienced working with Black and Brown children." School administrators reported that students would be less likely to engage in a program without a mental health provider who met these qualifications.

Students, parents, and school personnel also stressed that consistent attendance and accessibility to students would be strained if sessions could not occur in person during school hours. Both students and school administrators mentioned that after-school sports would impact students' abilities to attend a program after school. Similarly, a school mental health provider noted that "after school, [she doesn't] have luck typically with [meeting] students" due to bus schedules and other factors. Parents felt that "all the classes are important" for their children and did not want to have their children pulled from class to attend a mental health program. A clear preference for holding sessions during the lunch hour became evident, particularly given students, teachers, and administrators all recommended bringing food to sessions.

Theme 6: Consider Flexible Format Offerings and Extended Intervention Delivery Window Based on Symptom Severity and School Logistics

Students, parents, and school personnel favored flexible format offerings that provided students with the option of participating as part of a group or individually depending on their needs and circumstances. One administrator highlighted a concern shared by other participants that some students may struggle with mental health stigma: "I've seen groups before, you know…especially teenagers talking about themselves in front of peers sometimes it's very taboo." On the other hand, a parent voiced another popular point that a group format fosters student solidarity: "they go to a group, they you know, all has the same, you know concerns or that can, you know, help them a lot, because he's gonna say okay, I'm not alone with this you know, I got somebody else." Some suggested that students who have complicated presenting problems or more severe symptoms may benefit from an individual format.

Due to conflicting in-school activities, school closures, and unanticipated student absences, students, parents, and school personnel agreed that it would be unreasonable to assume that students would consistently attend sessions. For example, one mental health provider stated: "Schools close, kids are absent, right? So that kind of like contributes to [missing sessions]." As such, they recommended an extended intervention delivery window to mitigate the impact of students missing sessions due to absences or competing school activities.

Theme 7: Anticipate Low Parental Engagement

Parents and school personnel described how many parents in the community did not have the bandwidth and/or ability to engage in their children's school-based activities. They cited both practical/logistical and attitudinal/cultural barriers as reasons to anticipate low parental engagement in school-based mental health services. One school administrator shared her experiences trying to provide mental health referrals to students in the past:

> It is hard for some parents to understand what is happening with their child or they don't have the time or resources to follow through on like, outside of school services or they don't want to accept in some cases that their child may need, you know, some [mental health] help.

Similarly, a parent reflected on the way in which stigma hinders parents' engagement in mental health services:

> We need to normalize, start normalizing the mental health to parents and more kids will be able to get the help they need. Because sometimes, kids are afraid to tell their parents how they feel, because they're gonna think they're crazy or they're being, um, drama queens.

Students shared stories of family members who were not accepting of mental health issues and instead labeled these issues as being "lazy."

Discussion

This qualitative study summarizes the recommendations of school community members, including adolescents, their parents, and school personnel (i.e., administrators, teachers, mental health providers) regarding the adaptation of an evidence-based transdiagnostic, cognitive-behavioral mental health intervention, the UP-A, for delivery in highly diverse, lower-resource high schools. School community members suggested that our team consider social determinants of health and include content related to social media and digital literacy. They noted the importance of providing teachers and staff with training on identifying and referring to mental health services and basic psychoeducation as well as building trust and reducing stigma. Regarding intervention delivery, they recommended that qualified mental health providers provide culturally relevant sessions in person during school hours and that we consider flexible format offerings and an extended intervention delivery window. Finally, they prepared us to anticipate low parental engagement. Overall, these findings provided the basis for our adapted transdiagnostic school-based intervention, U-PEACE, and may be applied more broadly to the delivery and implementation of evidence-based mental health interventions in diverse school settings.

Themes generated in our analysis process informed adaptations to our intervention content (see Table 4 for sample modifications by theme). For example, we acknowledged adaptive avoidance and limitations of cognitive-behavioral strategies such as "flexible thinking" and "opposite action" given the role of social determinants of health in shaping students' daily lives and mental health. Tall and Biel (2023) recently reviewed the effects of social determinants of health on child and family mental health, emphasizing their role in exacerbating mental health disparities. Social determinants of health are defined as "the conditions in which people are born, grow, live, work, and age" and are grouped into five domains: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, and social and community context (Tall & Biel, 2023). In response to a question about stressors and challenges that teens face today, our participants' remarks referenced three of these, economic stability (with comments on parents' employment challenges, food insecurity, housing instability, and poverty), education access and quality (with comments describing low high school graduation rates, low enrollment in higher education, and language and literacy barriers), and neighborhood and built environment (with comments related to crime and violence as well as low-quality housing). These comments highlighted the extraordinarily challenging life circumstances of students in our partnering schools. Although cognitive-behavioral interventions do not directly address social determinants of health, it was important for us to weave in examples throughout sessions that presented skills in the broader context of students' daily lived experiences.

Interestingly, although exposure to social media is not currently considered a social determinant of health, Tall and Biel (2023) suggest that it be considered as such given its role in shaping the daily lives of youth and growing evidence linking it to poor mental health, particularly among adolescent girls. Participants in our study were highly concerned about the role of social media in contributing to youth mental health outcomes. We thus revised our intervention content to include examples specific to social media use and digital literacy (e.g., soliciting examples of reactive behaviors when using social media, highlighting potential negative patterns of thinking when using social media and how to challenge those thoughts, including examples of how to regulate emotions during social media use).

Beyond content adaptations, themes generated in our analysis process informed adaptations to our intervention procedures. Findings from our study map on well to Domitrovich et al.'s (2008) model on the role of factors at the macro-, school, and individual levels on the quality of

Table 4 Themes and sample U-PEACE modifications

Theme	Sample U-PEACE modifications
Consider social determinants of health	- Acknowledge limitations of cognitive-behavioral strategies such as "flexible thinking" and "opposite action" given social context - Acknowledge adaptive avoidance given unique stressors - Focus on interpersonal vs. individual-only problem solving
Include content related to social media and digital literacy	- Solicit examples of reactive behaviors when using social media - Highlight potential negative patterns of thinking when using social media and how to challenge those thoughts - Include examples of how to regulate emotions during social media use in discussion on interpersonal problem solving
Provide teachers and staff with training on referring to mental health services and basic psychoeducation	- Partner with the school mental health team to provide psychoeducational workshops for teachers on diverse mental health topics (e.g., suicide awareness, anxiety, depression) to aid in their ability to refer students to mental health services - Identify coaches (e.g., teachers, school administrators) to support students with check-ins regarding session attendance, skill practice, and problem-solving barriers that impede engagement - Provide materials summarizing U-PEACE skills and students' assigned practice, as well as consultation meetings to keep an open line of communication with coaches
Build trust and reduce stigma	- Maintain presence in school's counseling office to recruit students and provide information about U-PEACE - Incorporate tenants of the U-PEACE program that highlight the resilience of participating students - Praise the positive in their current methods of emotional and behavioral regulation while highlighting that everyone has room for growth - Frame behavioral change strategies as a means for students to exercise control and agency over their choices; emphasize students' resilience in the face of obstacles during behavioral change
Use qualified mental health providers to conduct culturally / linguistically relevant sessions in-person during school hours	- Schedule U-PEACE sessions for lunch hours during the school day - Identify and utilize program facilitators who are trained in evidence-based service delivery - Train program facilitators in UP-A model, U-PEACE intervention modifications, and how to maintain cultural sensitivity
Consider flexible format offerings and extended intervention delivery	- Attempt make-up sessions for students who miss scheduled meetings - Explore potential of U-PEACE groups conducted via telehealth over summer break - Exercise flexibility in the weekly frequency of U-PEACE sessions
Anticipate low parental engagement	- Provide hard copies of session materials that students can share with parents as needed/desired - Use coaches to check-in with parents if students' session attendance is low

implementation in schools. In under-resourced schools, or in any schools that contract mental health providers to provide services within a school setting, Eiraldi et al. (2015) went on to propose that a fourth level, the school mental health team, be added to the model. We received detailed participant feedback regarding mental health team- and school-level considerations for intervention delivery. Regarding the mental health team (e.g., staff allocation, expertise, functioning), participants emphasized the need to train teachers and staff on referral practices and basic psychoeducation and recommended that qualified mental health providers conduct sessions during school hours. To address these recommendations, we utilized program facilitators trained in evidence-based service delivery to deliver sessions on school grounds during students' lunchtime and provided students with food at these sessions. We additionally identified "coaches" at the schools (e.g., teachers, school administrators) to support students by checking in regarding their session attendance and skill practice. At the school level (e.g., school characteristics, climate), participants recommended that the team become part of the school culture and that we consider flexible format offerings. We leveraged our existing partnership with the University of Miami's SHI to maintain a presence in school counseling offices, where we could provide information about the intervention and recruit students. We also exercised flexibility in the weekly frequency

of sessions (starting with two sessions/week and tapering down to one session/week) and attempted make-up sessions for students who missed scheduled meetings.

As a final consideration, participants' comments signaled our need to be flexible regarding parental involvement. Low parental engagement has been cited as a barrier to the implementation of mental health evidence-based practices in under-resourced schools, with recommended engagement strategies including reinforcing parents for efforts to change and providing them with options for meeting the goals of the intervention (Eiraldi et al., 2015). Some of our strategies to proactively address these noted barriers included providing hard copies of session materials that students could share with their parents and using coaches to check-in with parents if students' session attendance was low.

This study has several notable limitations and strengths. Because we included only those students, parents, and school personnel who spoke and understood fluent English, we did not capture other important voices in this study. Our findings may thus not fully reflect the experiences of the local population, which includes many refugees and immigrants who speak other languages such as Spanish or Haitian Creole. To overcome barriers to scheduling, we used a combination of focus groups and individual interviews, which may be both a limitation and strength of our approach. Focus groups promote group discussion and brainstorming but require more intensive resources, while individual interviews foster deeper dialog. Although we conducted interviews with participants sampled from only two high schools, we triangulated data from five different community member types (students, parents, school administrators, teachers, mental health providers) to generate our themes (Eiraldi et al., 2015). Notably, at least three different community member types contributed to all themes, with four of our seven themes generated with input from all community member types. We employed a rapid qualitative analysis to make timely and systematic adjustments to an evidence-based intervention to address health equity challenges in youth mental health (Thurmond, 2001). While rapid qualitative analyses have been critiqued for potentially lacking "depth" and may be inappropriate to address other research questions, we employed recommended procedures for assuring quality and rigor throughout the process.

Overall, this study provides important insights regarding the initial adaptation of an evidence-based intervention, the UP-A, in diverse, low-resource school environments. Our next steps, in accordance with the cultural adaptation steps outlined by Barrera et al. (2013), include conducting a case series, delivering our adapted U-PEACE intervention to a small group of students from the school communities in the present study and making additional revisions to the intervention content and procedures prior to evaluating the adapted intervention in a randomized controlled trial. Flexible and widely applicable, evidence-based approaches like the UP-A have much potential to serve youth with internalizing concerns in multiple contexts outside of the clinic-based one for which they were originally designed, and adaptations made based on qualitative feedback will likely make the resulting U-PEACE approach more appealing for wider dissemination in school settings. Although our adaptations are specific to one evidence-based intervention, it is possible that the lessons we learned extend well beyond this one cognitive-behavioral approach and may be used to avoid implementation or scale-up problems that often occur when the lived experiences of school community members are not systematically considered. Given that lived experience and pragmatic barriers will vary somewhat from school to school and some level of school- or district-level tailoring will always be necessary to ensure optimal implementation when such interventions are brought to scale, routinely incorporating community member feedback is necessary to ensuring appropriateness and fit to the school context in which the intervention will be received.

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Declarations

Conflict of interest Jill Ehrenreich-May, Ph.D. receives a royalty from the sales of the Unified Protocols for Transdiagnostic Treatment of Emotional Disorders in Children and Adolescents from Oxford University Press. She also has grant funding related to this intervention from the National Institute of Health, Patient Centered Outcomes Research Institute, Institute of Education Sciences, the Children's Trust, and the Batchelor Foundation. She is also paid for clinical training and implementation support services related to this intervention by a variety of institutions. All other authors have no conflicts of interest or financial relationships relevant to this article to disclose.

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