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TREATING ADOLESCENT DEPRESSION IN MULTI-PROFESSIONAL SCHOOL HEALTH AND WELFARE SERVICES WITH IPC-A: IMPLEMENTATION RESULTS FROM A NATIONAL PILOT TRIAL

ABSTRACT

Background: Implementation of research-based interventions for adolescent depression to primary level services is important, given the need for treatment among depressive youth. Knowledge of factors facilitating or hindering implementation in multi-professional school health and welfare services (SHWS) is needed. Method: A national pilot project implemented IPC-A to SHWS in upper secondary schools of Espoo in 2016-2017. Fifty-five professionals (psychologists, social workers, nurses), 28 delivering IPC-A and 27 comparison intervention, were trained in the first year. Process and individual level implementation variables, and trainees' clinical IPC-A skills were examined with basic statistical methods and qualitative analyses. Results: Over half of adolescents were identified by nurse referral, 24% self-referred and 22% had been advised to seek support by teacher/friend. No additional cross-profession referrals were observed. Adolescents reported equal rates of interpersonal/family-related (49%) and emotional (51%) problems when specifying the reason for needing help. SHWS professionals reported multiple roadblocks in introducing the new intervention to the school context, including identifying adolescents with severity of symptoms targeted by the intervention, assessing depression and time constraints. Those providing comparison intervention without a specified model, supervision or support perceived it as difficult. As implementation facilitators, SHWS professionals relied on health checks, screenings and informing teachers and other professionals. Professionals trained in IPC-A delivered on average one IPC-A intervention per year, those delivering comparison interventions even less. IPC-A counsellors self-reported mastery of most IPC-A delivery skills in their first interventions. They experienced IPC-A as widely beneficial for adolescents and themselves as professionals. Supervisors' assessments of counsellors' competence indicated that delivery skills related to basic principles of IPC-A were relatively well mastered, but skills related to specific IPC-A techniques were inconsistent and poorly mastered. Conclusion: Implementation efforts should take into account issues related to identification and assessment of mental health disorders. Inconsistent mastery of IPC-A intervention skills by trainee counsellors suggests that a systematic approach to clinical training and supervision, and protected time for professionals to learn skills are of key importance.

KEY WORDS: INTERPERSONAL COUNSELLING, DEPRESSION, ADOLESCENTS, PSYCHOTHERAPY, IMPLEMENTATION, MENTAL HEALTH SERVICES

1. INTRODUCTION

Depression is a major mental health challenge for adolescents. It is prevalent, affecting 5 to 12 per cent of the adolescent population during a one-year period (1,2). Some recent data suggest depressive symptoms and disorders may even be increasing among adolescents (3,4). Incidence of depression is highest between 12 to 17 years of age, and median age of onset is around 15 years. From puberty onwards, a female preponderance is found (2,5). In clinical studies, adolescent depression is concurrently associated with academic and social impairment, increased risk for subsequent health and social impairment (1,6) and increased risk of suicidal behaviour (2,5,7). In Finland, a 12-month prevalence of major depressive disorder is around 5 per cent (8), comparable with international studies.

In recent years, advances in increasing adolescents' access to early mental health interventions have been made in some countries by launching new services specifically designed for this age group (9), in others by services operating as part of primary healthcare and conducting collaborative work with schools (10). Challenges faced in several countries include adolescents getting lost between child and adult services, service gaps and lack of primary level services (11).

There are examples of mental health services and programmes which have extended intervention delivery to schools. In Australia, the headspace service (12) has created links to schools to arrange help in a suicide crisis and to provide direct counselling for mild to moderate mental health problems among students. In Britain, the Link Programme has initiated systematic training of school-based professionals to increase interventions for highly prevalent mental health problems (13). In the dissemination and implementation of mental health interventions, arranging high-standard, competency-based training and clinical method supervision is considered crucial. However, at the same time adaptability and fit of an intervention to the service context cannot be overlooked. Thus, a principle of "flexibility within fidelity" is considered important in mental health practice implementation (14).

Implementation research indicates that implementation of evidence-based interventions to real-life services is a complex and long-term effort. Expert approximations suggest it takes on average seventeen years for an evidence-based medical practice to become sustainable in routine general healthcare service (15). Theoretically diverse, multi-discipline and multi-professional mental health services,

such as those provided by schools (10), may represent even more challenging contexts than healthcare service systems.

In a meta-analysis, Williams and Beidas examined variables associated with the efficiency of implementation of evidence-based mental health interventions to community/primary level organizations. They divided variables into organization level factors and individual/therapist level factors (16). Of the organization-level factors, the organization's prioritization of evidence-based practice (EBP) and its flexibility/rigidity were found most consistently to be significant, less systematic evidence was found for effects of the organization culture (e.g., systematic approach to recovery orientation, organizational leadership), implementation climate, organizational resources available for implementation and organization climate. Of the individual level variables, professionals' knowledge of EBP and their attitudes and beliefs about EBP were most often identified as predicting effective implementation. Their effects were found to be greater than the effects of an individual's mental health skills and competence, motivation, intentions and self-efficacy. Large-scale implementation studies show that, even in coherently designed and structured mental health services, local organizational level factors account for 20–40% of the treatment outcomes (17).

Questions related to which professional groups should be trained, which training elements are needed and what kind and how frequently method supervision is needed are central to method implementation (18). Furthermore, method training and supervision require professionals' time. The challenge of finding time for method learning and practice is often faced by professionals working in school contexts (10). In addition to time invested into learning and delivery of an intervention, assessment, or learning of assessment, of mental health disorders may require professionals' time and acquisition of new skills.

A Finnish pilot project, in which a substantial part of school health and welfare service (SHWS) professionals, working in the upper secondary schools of the City of Espoo, were trained to deliver a brief psychosocial intervention, Interpersonal Counselling, adolescent version (IPC-A) for treatment of adolescents with mild or moderate depression, was conducted in 2016-17 (19,20). Some professional reports of the use of IPC-A in smaller Finnish primary level service units have been published since the pilot project, including the use of IPC-A primarily by social workers (21,22) and by nurses in student healthcare (23).

Surma-aho (21) interviewed nine SHWS social workers, trained in IPC-A, in three cities. Participants found the

structure of the intervention, focusing on one interpersonal problem, the techniques of IPC-A and the method's overall focus on communication and interpersonal interaction on multiple levels to be strengths. However, the participants expressed concern as to whether their work orientation would transform into being too person-centred as a result of implementation of IPC-A to their organisation. Maukonen (22), conducted an email survey for professionals working at the primary level adolescent welfare unit in Jyväskylä. Respondents identified the structure of the intervention and focusing on one problem area as strengths of IPC-A. The counsellors stressed the importance of method supervision for effective delivery of the method, and for the counsellors personally. As challenges to the use of IPC-A, participants reported encountering adolescents whose depression symptoms were more severe than those targeted by IPC-A and needing longer treatment. They also reported challenges in setting the focus area, and of having sufficient time resources for delivering IPC-A.

Arppe (23) conducted a qualitative study interviewing a small number ($n = 6$) of student healthcare professionals trained in IPC-A and delivering it in their work. Participants experienced IPC-A as a suitable intervention method for working with adolescents with mild depressive symptoms clear and in non-complicated situations. They reported the method's structured approach bringing a needed structure to their mental health work; setting of interpersonal focus was also seen as beneficial. Reported challenges included availability of time resources, professional flexibility required by working with IPC-A and the need to ascertain management support.

In a broader view, scarce knowledge is available on variables related to implementation of mental health interventions to multi-professional SHWS in Finland. Such data are of key importance for effective planning of implementation support measures and resource allocation. They are also relevant to the present Finnish national initiative, stated in the National Finnish Mental Health Strategy 2020-2030 (24), to increase availability of short interventions such as IPC-A in primary level services, and also for dissemination and implementation of other structured interventions to the school context.

The aim of the present study was to gain knowledge on the factors related to the success of implementation when training professionals at Finnish schools to provide brief depression interventions for adolescents. We examined both organization-related and individual/professional-related implementation variables in the national pilot project of

implementing IPC-A in the multi-professional SHWS of the City of Espoo in 2016 (19,20).

Of organization-related implementation variables, we examined adolescents' pathways to intervention in the schools, their reported reasons for seeking support and the rate of delivery of interventions by the SHWS professionals during a school year. Of the individual implementation variables, we examined the school professionals' experiences of identifying depression in adolescents, of providing interventions in the school, their experiences of IPC-A as a clinical method, and both self-assessment and supervisors' assessment of their competence in providing IPC-A during their first interventions.

2. METHOD

2.1. PARTICIPANTS: THE SCHOOL PROFESSIONALS

During the first year of the Finnish IPC-A pilot project (i.e., between August 2016 and June 2017), 57 SHWS professionals were initially involved. Of them, 29 were randomized to provide six-session, weekly IPC-A, and 28 to provide a comparison intervention, six-session brief psychosocial support (BPS), which represented an enhanced form of counselling, focused on depressive symptoms, using repeated, weekly assessment of symptoms and professionals' routine working methods, see Parhiala et al. (20). One SHWS professional from from each group discontinued early on, leaving 55 professionals. One of the trained professionals was involved in the research team, participated in supervision and delivered interventions; these interventions were not included in the effectiveness trial. However, self-assessment and supervisor assessment of the professional's skills are included in this study.

All SHWS professionals involved in the project were trained in identification of depression and its severity (half-day lecture), and use of depression assessment measures and monitoring of depressive symptoms (half-day workshop). Both of these were open to all SHWS professionals. The IPC-A-trained professionals attended a 3-day training, first containing 1-day didactic training by a Finnish expert method trainer, then a 2-day simultaneously translated clinical workshop by an international expert trainer, concentrating on delivering clinical components and techniques of IPC-A. The IPC-A manual (25) and training materials were used as reference materials in supervision sessions. First language small group exercises were facilitated by Finnish IPT-A therapists.

The professionals initiated 55 IPC-A/BPS interventions between August 2016 and June 2017. Of these interventions, 49 were completed. See Parhiala et al. (2020) for intake and exclusion criteria and clinical assessments (20).

Six modality-specific supervision groups were formed for professionals delivering IPC-A. In four groups supervision was provided by one supervisor, in two groups by two supervisors. Supervision was provided for them every second week for 2.5 hours in groups of 4-6 trainees. The decision to provide supervision either alone or in pairs was negotiated with supervisors as they wished. All supervisors had more than two years' experience of working in secondary psychiatric services, prior Finnish training for interpersonal psychotherapy for depressed adolescents (IPT-A) and more than one year's experience of providing IPT-A in secondary services. The supervisors participated in the three-day IPC-A training alongside the IPC-A counsellor trainees from SHWS.

The study was reviewed and approved by both the Medical Ethics Committee of Hospital District of Helsinki and Uusimaa (HUS) and the Ethics Committee of City of Espoo.

2.2. PROCEDURE

The implementation model. The framework used in the planning of the implementation model (19) used data from several sources: 1. scientific data from clinical trials, meta-analyses and expert recommendations for evidence-based treatment of adolescent depression (26,27); 2. prior Finnish experiences of working collaboratively between secondary level and primary level professionals to enhance mental health interventions (28); 3. international implementation models (17); and 4. prior Finnish experiences of development projects targeting interventions in primary level services (29). It stressed close collaboration with the lead of SHWS professional groups, support for all SHWS professionals in general mental health assessment and work, and for the IPC-A delivering professionals, supervision in the clinical delivery of the intervention.

During the first months of the project, a service provision analysis was done in collaboration with the middle management of SHWS, reviewing type and length of interventions which realistically could be implemented in the routine context of SHWS. As it was known from prior collaborations that systematic mental health assessments and interventions were uncommon in primary level services (28), it was considered necessary in the implementation model to use the expertise of professionals from secondary

services in detection and assessment of depression, thus bringing needed, general mental health expertise (10). This support supplemented the IPC-A method training and clinical supervision.

2.3. ASSESSMENTS AND MEASURES

2.3.1 Variables assessed to examine implementation factors at organization/process level

The clinical trial data was used to examine adolescents' pathways to intervention, their perceived initial problems/reasons for seeking help and the delivery of interventions in SHWS. These data were collected systematically during a research interview. Data was collected from adolescents treated with IPC-A and the control depression intervention, BPS, in order to gain knowledge on organization level factors operating when the short, structured depression interventions were introduced into the school environment.

Pathways to intervention. Pathways to intervention were identified according to who initiated an appointment with a SHWS professional due to mental health reasons. Possible pathways were identified beforehand in pre-implementation project meetings. The pathway was defined according to who initiated the referral, covering the following initiators: 1. the adolescent him/herself (self-referrals), 2. teacher, 3. family member, 4. friend, 5. another SHWS professional. During data analysis the teacher, family member and friend were combined to arrive at reasonable group size.

Primary problems/reasons for seeking help from SHWS. Adolescents were asked about their primary reasons for initially seeking help/being advised to seek help. The verbatim responses were analysed by thematic content analysis. Reported reasons were categorized into four groups: 1. problems related to interpersonal relationships/friendships (e.g., bullying, conflicts or loneliness); 2. problems related to family (e.g., arguments with parents, divorce); 3. emotional problems (e.g., low motivation, stress related to school or other life areas, feelings of worthlessness); and 4. emotional problems associated with self-acknowledgement of impairment in functioning.

Reach: implementation outcome as number and rate of delivered treatments. The reach of implementation was examined by counting the number of professionals delivering the interventions (i.e., IPC-A, and BPS for reference), and number of interventions delivered by them across SHWS professional groups (school psychologist, school social worker, school nurse) within a school year.

2.3.2 Variables assessed to examine implementation factors at individual/professional level

Professionals' experiences of identifying adolescents and providing interventions in the school

An email survey was sent to all participating SHWS professionals in October 2016 asking: 1. How has finding adolescents in the intervention been for you since the research project started? 2. What has either helped or hindered you to find suitable adolescents for intervention? 3. What kind of feedback have you got from adolescents, or parents, who you have suggested for the intervention? 4. Have you other comments or suggestions relating to the research project? Thematic content analysis was used to analyse the data.

The responses were first read through several times. As most responses dealt with either treatment pathways, professional roles or identification of depression, responses to all questions were pooled and treated as one source. The responses to questions 1 and 4, which clearly referred to factors having either a helpful or hindering effect to identification of depressive adolescents, or to doing/arranging mental health work in school, were combined with answers to question 2 in the thematic content analysis. In the final coding, answers from this single pool were categorized into three groups: A. Descriptions related to prevailing/current identification, pathways to care or professional role division of mental health work in school; B. roadblocks to identification, intake in interventions or doing mental health work; C. helpful factors in identification, intake or mental health work.

IPC-A counsellors' self-assessment of their IPC-A competence

IPC-A counsellors' self-evaluations of possessing skills to deliver IPC-A were assessed with a shortened, dichotomized version of the IPC Competences List (30). It requires the respondent to state his/her ability of working with each described IPC skill/competence in the first person (e.g., "I am able to engage the adolescent in IPC"). The modified instrument covers 13 basic competences, 4 IPT technique use competences, and 3 overarching, specific IPT competences (see Parhiala et al. 2020) (20). For content of items, see also [Table 5](#).

IPC-A counsellors filled in the modified form after each completed IPC-A session. Only questionnaires from counsellors' last sessions in completed interventions were included in the analysis. Such forms were available from 19 IPC-A counsellors, reflecting 25 completed IPC-A

interventions. Although the dichotomized IPC competences list offers only two responses ("yes" or "no") placed on two separate vertical columns, 32% of counsellors responded to at least one queried skill by marking on the line between the "yes" and "no" columns. These responses were coded as representing the counsellor's uncertainty about her/his mastery of the skill in question. Due to the high number of answers with uncertainty, self-assessed mastery of IPC-A competences was coded to two classes representing either perceived mastery or perceived lack of mastery/uncertainty of mastery.

IPC-A counsellors' experiences of IPC-A as a clinical intervention - interview

A sub-sample of nine IPC-A counsellors were interviewed three months after treatment ended to assess their perception of adolescents' satisfaction with treatment and clinical change, and to also assess their perception of beneficial/non-beneficial aspects of IPC-A, and their learning. The interview was modified from Elliot Client Change Interview (31,32). Interviews were conducted by two University psychology students who were trained to conduct the interview and blind to the treatment condition. Four interviews were conducted face-to-face, five by telephone. See Parhiala et al. (20) for content of the themes, and key questions covered by the interview. Questions of the interview were otherwise identical to those presented to adolescents to assess the feasibility of IPC-A for adolescents, but were presented in the form to assess the professionals' view (e.g., "What changes, if any, have you noticed in the adolescent since counselling started?").

Supervisors' evaluations of IPC-A counsellors' method competences

Supervisors' evaluation of IPC-A counsellors' mastery of clinical IPC-A competences and ability/adherence to working with the clinical principles of IPC-A were evaluated by supervisors' rating scale version of the IPC Competences List (30). The original version of the IPC competences list is derived from IPT Audio Recording Rating Scale (33), and contains 34 competences. In the IPC-A pilot trial the original IPC competences list was reduced to 20 competences, consisting of 13 basic IPC skills, 4 skills in using IPC-A techniques, and 3 skills related to overarching, specific principles associated with working with IPC-A (e.g., ability to balance being focused and maintaining the therapeutic alliance). See Tables 4 and 6 for items.

Supervisors rated counsellors' mastery and adherence to each IPC-A competence/skill on a 5-point scale: 0 = skill was not used/was not relevant during this session(s), 1 = skill was not mastered at all, 2 = skill was mastered only to a small amount, 3 = skill was mastered relatively well, 4 = skill was mastered well. The recorded competences concerned the last sessions of completed treatments. If the supervisor rated that the skill was not used/not relevant during the last session, all previous sessions were examined for use of the skill. If use of the respective skill was missing throughout all sessions, the mastery of the skill was defined to be absent. The evaluation was based on the counsellor's report and discussion of interventions used during the session, and was thus not a direct review of recorded session content.

BPS counsellors' experiences of delivering depression intervention in the school

Altogether three target group meetings were arranged throughout the school year 2016-17 for the BPS group. Already at the start of the trial, the BPS group expressed a need for support, and only few comparison treatments were started during the first months of the trial. The number of participating professionals represented roughly 40 to 60% of the BPS group (i.e., 41%, 56%, and 48% of the whole group).

The function of these meetings was to support this group, and to resolve possible roadblocks to initiating interventions. Target group meetings followed an open agenda in which participants were given the opportunity to express themes related to intake of adolescents, the project and to doing mental health interventions in the school in general. Detailed written records of the meeting were kept, systematically coding each presented theme. The subjects brought up were treated by qualitative content analysis to identify key themes. The responses provided data on how SHWS professionals experienced providing mental health intervention in the school without specific, imported method training, using their professional skills. BPS was defined as a six-session, targeted comparison intervention for depressive youth, using the methods that they possessed on the basis of their prior professional training and experience, supplemented by instructed session-by-session monitoring of symptoms, with measures they had been trained in and targeting the meetings for depression.

2.4. STATISTICAL ANALYSIS

Numerical data on intervention providing professionals, interventions, initiators of referral, adolescents' primary reasons for seeking help, data from the structured survey for professionals and professionals' self-rated and supervisor-rated competency ratings, were treated with basic statistical methods. Categorical variables were analysed using frequency counts, percentages and Chi-Square tests in group comparisons between the intervention types. Variables on interval level were examined by calculating means, and by performing t-test analyses for comparison between groups, such as comparison of the mean number of completed IPC-A and BPS interventions in the professional groups delivering either IPC-A or BPS.

Qualitative analysis was used to categorize the verbatim responses from interviews of SHWS professionals. The data were coded by one author (P.P.) using the technique according to conventional content analysis as described by Hsieh & Shannon (34). The categorized data were then analyzed by examining frequency counts within each category and comparing frequencies of responses between the categories.

SPSS 28.0 statistical software was used in the analyses.

3. RESULTS

Among the 28 SHWS professionals trained in IPC-A, 9 were school psychologists, 11 school social workers and 8 school nurses, and numbers in the BPS group were 10, 14 and 3, respectively. During the school year 2016-2017, 33 IPC-A interventions and 22 BPS interventions were started, and of these, 29 IPC-A and 20 BPS interventions were completed.

Pathways to intervention

Pathways to intervention were largely similar among adolescents who received either IPC-A or BPS in their respective schools. Among all adolescents who were taken into interventions, the role of the school nurse was central for taking the initiative for arranging intervention in cases where the adolescent did not self-refer. Concerning adolescents in the IPC-A group, the school nurse initiated referrals in 58% of cases, the rest were divided evenly between self (21%) or friend/teacher (21%) referrals. A similar distribution was observed in the BPS group with no between-group (IPC-A vs. BPS) difference between the three referral types (Chi Square = 0.358, df = 2, ns.). No cross-referrals over professional groups were made in

IPC-A or BPS treatment arms, other than the school nurse acting as the referrer. (See [Table 1](#)).

Table 1. Pathways to intervention: initiators for arranging an appointment in SHWS

Initiator of appointment	Group		
	IPC-A (n=33)	BPS (n=22)	Combined (n=55)
The adolescent (self-referral)	7 (21.2%)	6 (27.3%)	13 (23.6%)
Parent/friend/teacher	7 (21.2%)	5 (22.7%)	12 (21.8%)
Another school health and welfare service professional*			
School psychologist	-	-	-
School social worker	-	-	-
School nurse	19 (57.6%)	11 (50%)	30 (54.5%)

*comparison between groups, Chi Square test, ns.

Adolescents' primary problem/reason for seeking help from SHWS services

Adolescents who continued to interventions reported their main problem, when seeking or being referred for help, related to either interpersonal/familial issues (problems in relationships or within the family) or emotional problems (stress, low mood). Presenting problems were evenly distributed between these two main classes (49% and 51% respectively). These primary problem types were also divided similarly in the IPC-A and BPS groups (Chi Square = 0.437, df = 1, ns.). A somewhat higher frequency of emotional problems associated with impairment was found in adolescents who were referred to IPC-A than to BPS (27% vs 14%), however, this difference was not statistically significant (Fisher's Exact test, p=0.20). (See [Table 2](#)).

Reach of implementation: number and rates of completed interventions

Roughly equal rates of completed interventions were observed across the SHWS professional groups. The 28 professionals trained in IPC-A delivered 29 completed IPC-A interventions over the school year 2016-2017, the mean number of completed interventions during the school year was thus 1.04. Of the trained IPC-A counsellors, three (11%) did not deliver an intervention during the school year, while 25 (89%) delivered at least one intervention and six

counsellors (21%) delivered two or more interventions. Percentage rates of started and completed IPC-A interventions were similar across the professional groups. In comparison, the number of started and completed BPS interventions was fewer. The 27 professionals who were randomized to deliver BPS in their respective schools delivered 20 completed interventions, the mean number of completed BPS interventions per year being 0.74. There was a significant difference between the mean delivery rates of IPC-A and BPS (t-test, equal variances not assumed, $t = 3.169$, $df = 35$, $p=0.02$, two-tailed). In this analysis, range of delivered interventions among those delivering IPC-A was 0-3, and among those delivering BPS it was 0-2, distributions showing no marked outliers preventing the comparison of means. (See [Table 3](#)).

SHWS professionals' views on mental health work in school – email survey

Altogether 29 SHWS professionals (18 trained in IPC-A and 11 from BPS group) replied to the email questionnaire aimed to identify their perceptions of the detection of depressive adolescents, pathways to intervention, current working model between professionals and of doing mental health work in school.

Table 2. Primary problems/help-seeking reasons reported by depressive adolescents

Primary problem/reason	Group		
	IPC-A (n=33)	BPS (n=22)	Combined (n=55)
1. Problem in interpersonal relationships/friends (e.g., bullying, argument, loneliness)	10 (30.3%)	7 (31.8%)	17 (30.9%)
2. Problem in the family (e.g., divorce, conflict)	5 (15.2%)	5 (22.7%)	10 (18.2%)
3. Emotional problems/symptoms (stress about school, low motivation, worthlessness) emotional symptoms	9 (27.3%)	7 (31.7%)	16 (29.1%)
4. Emotional problems/symptoms associated with impairment in functioning	9 (27.3%)	3 (13.6%)	12 (21.8%)

Table 3. Production of interventions across professional groups

	All	Psychologist	Social worker	School nurse
IPC-A counsellors	28	9	11	8
Did intervention	25 (89.3%)	9	9	7
2 or more	6 (21.4%)	2	1	3
Interventions started	33	13	10	10
number of dropouts	4	1	2	1
BPS counsellors	27	10	14	3
Did intervention	20 (77.8%)	8	10	2
2 or more	4 (14.8%)		3	1
Interventions started	22	6	13	3
number of dropouts	2	1		1

Descriptions related to the current way mental health works. Fifteen (52%) professionals stressed the role of the school nurse/health screenings for identifying adolescents and referring them to intervention. Seven (24%) SHWS professionals replied that adolescents came to intervention by the same route as they had usually come to service in SHWS. These figures reflect the central role of school nurses in the treatment path as initiators.

Roadblocks. The following factors were named as roadblocks to detection of adolescents with a need for intervention, or to doing mental health work in general. Ten professionals (34%) described that the adolescents had either too severe or too mild symptoms to be taken into the intervention, four (14%) reported that assessing depression was difficult and three (10%) reported not having enough time to concentrate on detection/intervention.

Helpful factors/facilitators. The new screening system, containing the systematic depression measures being introduced, was mentioned most frequently, by four (14%) professionals, and increased information about the project was mentioned by three (10%).

Relatively few, nine answers in total, were received for question three on feedback. In the IPC-A group, four professionals had received positive responses from adolescents and parents when suggesting intervention, all these professionals described asking for participation as easy. In the BPS group, five answers were received. Of the three professionals who had suggested BPS as an intervention, one had not received an answer, one had got a positive response and the third a neutral response.

IPC-A counsellors' self-evaluation of their IPC-A skills

Due to the small number of counsellors and rate of interventions per counsellor in each professional group, only a very rough frequency comparison is possible. Examining the IPC-A interventions delivered by the trainee counsellors and mastery of individual IPC-A skills in these interventions, a relatively positive pattern is seen. Individual basic and overarching IPC-A skills were perceived to be mastered by counsellors in between 72% to 97% of interventions. The IPC-A technique skills were perceived being mastered unevenly by the trainee counsellors; the ability to use decision analysis was reported by them in 64% of interventions, and the ability to use role play in only 48% of the interventions.

Looking at the counsellors, roughly 40 to 50% of them perceived themselves as either lacking or being unsure of their mastery of at least one IPC-A skill; of the basic skills

the proportion was 48%, of the specific technique skills 52%, of overarching skills 37%. This indicates a somewhat uneven mastery of skills. Observing self-perceived mastery between professional groups shows, very tentatively as the numbers are small, that of nurse counsellors, a higher proportion reported being unsure with respect to basic and overarching IPC-A skills, while all three groups expressed relatively similar levels of perceived mastery of IPC-A technique skills. (See [Table 4](#)).

Table 4. IPC-A counsellors' self-assessment of their IPC skills: percentage of perceived skills mastery in completed interventions, and proportion of professionals with perceived non-mastery of skills in basic IPC competence, IPC techniques and overarching IPC competence

	All counsellors	Psychologists	Social workers	Nurses
Experienced mastery of basic IPC skills	Per Intervention n = 25	n = 12	n = 8	n = 5
5. Ability to engage the client in IPC	23 (92%)	12 (100%)	7 (87%)	4 (80%)
6. Ability to reframe client's presenting problems as part of her/his depression	24 (96%)	12 (100%)	7 (87%)	5 (100%)
7. Ability to identify an interpersonal problem area providing the focus	21 (84%)	11 (92%)	7 (87%)	3 (60%)
8. Ability to maintain a focus on an IPC interpersonal problem area	21 (84%)	10 (83%)	7 (87%)	4 (80%)
9. Ability to identify and explore difficulties in communication	24 (96%)	12 (100%)	8 (100%)	4 (80%)
10. Ability to facilitate the expression and acceptance of a range of emotions	22 (88%)	11 (92%)	7 (87%)	4 (80%)
11. Ability to encourage interpersonal change in between sessions	21 (84%)	10 (83%)	8 (100%)	3 (60%)
12. Ability to engage the client in preparation for ending	23 (92%)	10 (83%)	8 (100%)	5 (100%)
13. Ability to use questionnaire measures to guide intervention	24 (96%)	12 (100%)	8 (100%)	4 (80%)
One or more basic IPC skill experienced lacking during delivered interventions	Per counsellor n = 19 9 (48%)	n = 8 3 (38%)	n = 6 2 (33%)	n = 5 4 (80%)
Experienced mastery of IPC techniques	Per intervention n = 25	n = 12	n = 8	n = 5
1. Ability to use clarification, summaries and questions	24 (97%)	12 (100%)	8 (100%)	4 (80%)
2. Ability to use communication analysis	22 (88%)	11 (92%)	8 (100%)	3 (60%)
3. Ability to use decision analysis	16 (64%)	6 (50%)	7 (87%)	3 (60%)
4. Ability to use role play	12 (48%)	6 (50%)	3 (37%)	3 (60%)
One or more IPC technique skill experienced lacking during delivered interventions	Per counsellor n = 19 10 (52%)	n = 8 5 (63%)	n = 6 3 (50%)	n = 5 2 (40%)

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	All counsellors	Psychologists	Social workers	Nurses
Experienced mastery of overarching, specific IPC competence	Per Intervention n = 25	n = 12	n = 6	n = 5
1. Ability to adapt core IPC strategies to the client's individual needs	19 (76%)	10 (83%)	8 (100%)	1 (20%)
2. Ability to balance being focused and maintaining the therapeutic alliance	18 (72%)	7 (58%)	8 (100%)	3 (60%)
3. Ability to establish an appropriate balance between counsellor activity and non-directive exploration	24 (96%)	12 (100%)	8 (100%)	4 (80%)
One or more overarching IPC skill experienced lacking during delivered interventions	Per counsellor n = 19 7 (37%)	n = 8 3 (38%)	n = 6 0 (0%)	n = 8 4 (80%)

Interview: Counsellors' perception of clinical change and IPC-A as an intervention

As a whole, the interviewed IPC-A counsellors experienced IPC-A as widely beneficial for the adolescents and themselves as professionals. Of note is that the most frequently reported interpersonal change happened in relationships with parents, reported by five (56%) counsellors. Of the intervention's strengths, the most frequent observation was the generally positive experience of intervention and collaboration with adolescents, reported by five (56%) counsellors. Most frequently reported challenges/problems for IPC-A or its use were of time constraints and the difficulty of learning new working methods, both reported by three counsellors (33%). Most counsellors were able to set an interpersonal problem area as a focus according to IPT theory. Several different helpful aspects of IPC-A for the adolescents were reported. The most frequently reported benefits for themselves as a professional were learning new ways of working, reported by four (44%), and learning of focusing and setting of limits to counselling work, reported by three (33%) counsellors. (See [Table 5](#)).

Supervisors' assessments of counsellors' IPC-A skills

Of the 29 completed IPC-A interventions, supervisors' skills ratings from the last session were available from 27 (93%). Two additional interventions were included by similarly trained and supervised SHWS professionals. Of the supervisors' rated interventions, all basic IPC-A skills were mastered in four out of five interventions. No marked professional group differences were marked in basic IPC-A skills. Each of the three overarching skills were mastered in over 90% of the interventions. Both figures show good mastery in individual skills and generally across these skills.

In contrast, many of the IPC-A counsellors did not master the specific IPC-A techniques of communication analysis, decision analysis or role play. Particularly evident was the lack of mastery of role play. Mastery of this skill was observed in only 10-20% of interventions, also showing in the low rate of 10-20% of professionals who mastered this skill in all their interventions. This suggests that lack of skill mastery was not due to accumulation to one counsellor's interventions. Mastery of decision analysis was observed in 38% of interventions, and there was some inconsistent variation in mastery between the professional groups. Communication analysis was not mastered in 34% of the interventions. Evaluated from quite small numbers, mastery of this skill was more frequent among psychologists than among social workers in the sample. (See [Table 6](#)).

Table 5. Interview. IPC-A counsellors' perception of change and IPC-A as a working method

Items	Counsellor's response (total n = 9)
Changes observed in adolescents' interpersonal relationships during IPC-A	Contact with parents improved (n = 5) Contact with friends improved (n = 1) Recognizing and expressing own opinions (n = 1) Learn to set boundaries (n = 1) Trust in relationships and self-confidence improved (n = 1)
What was good about/working well in IPC-A	Went well, collaboration was good (n = 5) Working was like described in the manual, easy (n = 2) Finding the focus area helped the intervention process (n = 2) Whole family got help (n = 1)
What was not working	Not enough time, too much work and different forms (n = 3) New working methods made it difficult (n = 3) Finding one interpersonal focus area (n = 1) Too mild depression symptoms (n = 1) Homework assignments (n = 1)
Setting of interpersonal focus area	Foci as defined by IPC theory: Interpersonal conflict (n = 3), Loneliness (n = 1), Role change (n = 1); Grief (n = 1) Other/more complicated foci described: Disappointment (n = 1), Social relationships generally (n = 2)
What was most helpful	The adolescent got to talk (n = 1) The adolescents' situation was described and understood (n = 1) Monitoring of mood and communication analysis (n = 1) Adolescent learnt from the process how to set own boundaries (n = 1) Adolescent learnt that she/he can make the change (n = 1) I learned methods how to facilitate expression of grief (n = 1) The intervention boosted self-esteem (n = 1) The adolescent learned concrete ways how to act in challenging situations (n = 1) Home assignments and role play (n = 1)
What have you learned	New working methods (n = 4) To set limit to intervention, aiming at focus (n = 3) Clinical work from supervision (n = 2) How to set clear aims, in collaborative fashion (n = 2) How to set a focus (n = 1) How the young mind works (n = 1) Evaluate my own work (n = 1) Learning of the process, that benefits do not just appear right away (n = 1)

Table 6. Supervisors' assessment of IPC-A counsellors' skills: percentages of skill mastery in interventions and across professional groups

	All counsellors	Psychologists	Social workers	Nurses
Mastery of basic IPC skills				
Percentage of interventions in which all basic skills were mastered (%)	22/29 (81%)	11/13 (85%)	5/8 (63%)	6/8 (75%)
Percentage of professionals mastering all basic skills in all their interventions (%)	14/21 (67%)	7/9 (62%)	3/6 (50%)	4/6 (60%)
Mastery of IPC techniques				
1. Clarification, summaries, questions				
- percentage of interventions with mastery	28/29 (97%)	13/13 (100%)	8/8 (100%)	7/8 (88%)
- percentage of professionals with mastery in all their interventions	20/21 (95%)	9/9 (100%)	6/6 (100%)	5/6 (80%)
2. Communication analysis				
- percentage of interventions with mastery	19/29 (66%)	11/13 (85%)	4/8 (50%)	4/8 (50%)
- percentage of professionals with mastery in all their interventions	13/21 (62%)	7/9 (78%)	2/6 (33%)	4/6 (67%)
3. Decision analysis				
- percentage of interventions with mastery	11/29 (38%)	5/13 (38%)	2/8 (25%)	4/8 (50%)
- percentage of professionals with mastery in all their interventions	4/21 (14%)	2/9 (22%)	1/6 (17%)	4/6 (77%)
4. Role play				
- percentage of interventions with mastery	4/29 (14%)	2/13 (15%)	1/8 (12%)	1/8 (12%)
- percentage of professionals with mastery in all their interventions	3/21 (14%)	1/9 (11%)	1/6 (17%)	1/6 (17%)
Mastery of overarching IPC competence				
1. Ability to adapt core IPC strategies to the client's individual needs				
- percentage of interventions with mastery	28/29 (97%)	13/13 (100%)	8/8 (100%)	7/8 (88%)
- percentage of professionals with mastery in all their interventions	20/21 (95%)	9/9 (100%)	6/6 (100%)	5/6 (83%)
2. Ability to balance being focused and maintaining the therapeutic alliance				
- percentage of interventions with mastery	28/29 (97%)	13/13 (100%)	8/8 (100%)	7/8 (88%)
- percentage of professionals with mastery in all their interventions	20/21 (95%)	9/9 (100%)	8/6 (100%)	5/6 (83%)
3. Ability to establish balance between activity and non-directive exploration				
- percentage of interventions with mastery	29/29 (100%)	13/13 (100%)	8/8 (100%)	5/5 (100%)
- percentage of professionals with mastery in all their interventions	21/21 (100%)	9/9 (100%)	6/6 (100%)	6/6 (100%)

Comparison analysis: BPS counsellors' experiences of delivering depression intervention in the school

On the basis of qualitative, thematic content analysis, four broad themes emerged: 1. the perceived difference between professionals' routine, traditional SHWS work and doing a clinical intervention for depression was experienced consistently as a difficulty; 2. difficulties in identifying and assessment of depression, and taking up issues related to mood with the adolescent (e.g., using measures, talking about depression); 3. difficulty in delivering a mental health intervention without a method or supervision; 4. difficulty in understanding the relevance of meeting adolescents repeatedly, and repeatedly assessing and monitoring their mood.

4. DISCUSSION

The main results of this study are summarized as follows. On the organizational level, we found that in Finnish secondary schools, depressive adolescents presented with their main problem being an interpersonal/familial issue as often as an emotional problem. Adolescents' pathways to intervention seemed narrowly defined, cross-professional referrals were uncommon and delivery rates of structured interventions, such as IPC-A, were low. However, they were still lower for the brief psychosocial support intervention delivered without a structured method or methodological support. On the individual/professional level, school professionals reported difficulty in identifying adolescents with mild/moderate depression, and lack of time allocated to mental health work as roadblocks to intervention delivery. As facilitators they had to rely on future improvements in health checks and communication with teachers and school staff to identify depressive youth. As evaluated by the IPC-A delivering professionals themselves and their clinical supervisors, clinical competence assessed during first interventions seemed to have developed relatively well across the professional groups, however, some IPC-A-specific procedural skills remained relatively poorly mastered.

Looking at the organization level results more closely, we found that the SHWS professional groups operated rather independently of each other in their mental health work. School nurses acted as initiators of referrals to help adolescents with their mental health needs. The distinct professional roles and the modest level of delivered IPC-A interventions were both expected, on the basis of Finnish

healthcare data and prior development projects aimed at advancing mental health work in primary level services (19,28,35). It was predicted that routine delivery of systematic mental health interventions would be relatively infrequent in the SHWS. Thus, the role of secondary services' mental health professionals was considered an important element in the implementation model, supporting not only IPC-A interventions, but also assessment of mental health and mental health work in general in the schools.

This finding is accordant with experiences and service development initiatives from several countries, reflecting the important role of public mental health providers as supportive partners for the professionals who are delivering school-based mental health work (13,36). Of note, the rate of delivery of BPS interventions was still lower than that observed for IPC-A, suggesting that factors intrinsic to the clinical method may not wholly, or even primarily, account for the low delivery levels for IPC-A.

Although the total number and the rate of delivered IPC-A interventions per professional were not high, figures were relatively even across the professional groups, supporting the notion of IPC-A as a potentially suitable and feasible intervention for use by several professional groups in primary level services (37). Furthermore, observed, equal rates of delivered IPC-A interventions across professional groups is accordant with the initial aim of the implementation project, and with the broader, national aim to widen access to early intervention (24,38). The significance of pre-implementation collaborative activities for a successful mental health intervention has been noted in school implementation programmes, for example, in enhancing organizational engagement (39). In this project, discussions and negotiations between the school professional lead and implementing organization before the launch of detection workshops and clinical intervention training.

The two most frequently presented roadblocks to identification and intervention delivery involved perceiving the intensity of an adolescent's symptoms as being not accordant with IPC-A (either too mild, too severe), and perceived difficulty in assessment of depression. Most frequent reported facilitators were reliance on nurse health checks, or on the new, comprehensive health screening tool being implemented for identification purposes. These findings may reflect effects of a relatively sectorized organization of mental health work. In a review of implementation of school-based mental health services, Richter and colleagues (40) identified drawbacks in internal collaboration between different administrative sectors and professional groups

(i.e., social care providers, healthcare providers) as one main challenging factor for mental health intervention implementation.

Regarding mastery of IPC-A interventions, all professional groups were able to deliver IPC-A, and produced it at even, but low rates of roughly one intervention per school year. IPC-A counsellors were evaluated as having acquired most IPC-A delivery skills by the end of delivering their first interventions. However, they experienced lack of mastery in skills to certain specific IPC-A techniques, such as role play and decision analysis. The counsellors experienced IPC-A as broadly beneficial for both the adolescents and themselves as professionals. Also, supervisors' competence ratings indicated that more procedural IPC-A technique skills were not mastered/used in counsellors' first interventions. A large proportion of counsellors did not master role play or decision analysis, and 34% did not master communication analysis.

The clinical delivery of IPC-A as perceived by the trainee counsellors themselves showed relatively encouraging rates of the individual skills they perceived mastering in their interventions. The assessed interventions were the very first they delivered. As IPC was originally developed to be used in primary level services by various professional groups, the results can be interpreted to support the applicability of the method accordingly (37). However, the counsellors often reported specific IPC-A technique skills not mastered. Even though all skill areas were included and practised during the clinical training, the specific IPC-A technique skills such as role play and decision analysis may, being structured and procedural, differ from more traditional discussion-based counselling and supportive work in SHWS than other IPC skills, and require more time to learn.

Practical skill rehearsal during supervision, using role play and videos may represent an effective way to enhance skills acquisition. Unfortunately, such teaching methods couldn't be utilized in this study. Many supervisors, although clinically experienced, were providing their first supervisions (i.e., they were in the middle of their own learning process). Overall, the results stress the need for assigning sufficient time for practice of skills for both trainee counsellors and supervisors. It is likely that procedural, experiential skills training practices, as mentioned above, have rarely been part of these professionals' own background training, or even their psychotherapeutic training (41).

The supervisors' evaluations of the IPC-A counsellors' skills presented an approximately similar picture to that found from counsellors' self-evaluation of their skills. As the

evaluated interventions were the first interventions by the counsellors, mastery of all skills couldn't be expected to be complete. Regarding training, a question arises of how to build and maintain method supervisors' competence across all relevant areas, including maintenance of their IPC-A counselling competence (which require their own, active clinical practice), adding general teaching skills and skills for teaching skills. Regarding method supervisors' training, setting and following specific learning objectives for method supervision, and training and practicing such supervisory skills are considered crucially important in psychotherapy training research (42).

As the Finnish mental health policy is moving towards promoting dissemination and implementation of psychosocial and psychotherapeutic treatments, there is a need to develop sustainable, competency-based training programmes for evidence-based psychotherapies for practitioners, method supervisors and trainers. A closely related need is to maintain such programmes by assigning and funding training organizations which possess relevant methodological, clinical and scientific competence in the planning of the programmes, to provide the training, to further develop the programmes and to conduct clinical epidemiological research. Training conducted in a way which allows the development of clinical competence will turn provide effective interventions, given that the time resources for learning and teaching are realistically planned.

This study has some notable limitations. The main limitation is that the number of participants in the subgroups are small. Thus, for example, group comparisons between professional groups should be considered tentative. In some survey data, participation rates were relatively low.

The strengths of this study include that we present multi-method, systematically collected data from a study conducted in real-life conditions of the public healthcare system, involving largely participants who were involved in their normal full-time occupation. This adds to the ecological validity of the study. We were able to recruit an active comparison group. Experiences of providers of the comparison intervention offer a unique angle to school healthcare.

CONCLUSION

Our results lend further support to the training and use of IPC-A as a potential clinical intervention for treating adolescent depression by professionals working in Finnish school health and welfare services and in primary level settings. However, the observed low rates of completed interventions in the schools raise the question of whether the observed organizational factors, such as school professionals' experienced difficulties in the detection of depression and clinical assessment, narrowly defined pathways to intervention and their multiple role assignments might cause barriers to the delivery of interventions. In spite of school professionals' perception of IPC-A largely as a beneficial method, development of specific intervention competence should be allowed time, and a realistically negotiated time resource should be available for the trainees to learn clinical skills in the context of clinical supervision.

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