

Provider Readiness to Deliver a Solution-Focused Single-Session Consultation Following Brief Training in Community Settings

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Abstract

Persistent barriers to accessing mental health care, including workforce shortages and limited service availability, constrain the reach of evidence-based interventions. Single-session interventions (SSIs) offer a scalable approach to expanding access to care, and the Single Session Consultation (SSC) is a provider-delivered SSI with demonstrated feasibility across applied settings. Prior research found that brief SSC training improved trainee clinicians' attitudes and preparedness, but whether these findings generalize to licensed community-based providers remained unknown.

In this study, we evaluated a 90-minute SSC training delivered to licensed community-based mental health providers across seven organizations in six U.S. states. Providers (N = 126 pre-training, N = 101 post-training; n = 70 matched) completed measures of SSC attitudes, preparedness, confidence, and knowledge before and after training. Attitudes became significantly more favorable ($r = .79$), and preparedness increased ($r = .31$). Providers also reported lower estimates of the minimum number of sessions needed for meaningful clinical improvement across seven of eight presenting problems, suggesting greater openness to brief intervention. Most providers (79%) reported increased confidence in delivering the SSC, and post-training knowledge was high (87.6% correct). Approximately one-third endorsed implementation concerns, most commonly related to time constraints, billing, and workflow integration.

Our findings extend prior trainee-focused research by demonstrating that brief SSC training improves knowledge, attitudes, confidence, and readiness among licensed community-based providers. Results support brief, scalable training models for disseminating provider-delivered SSIs while highlighting the need for implementation supports, including practice opportunities and ongoing consultation, to promote adoption in routine care.

Introduction

Persistent barriers to accessing mental health care, including workforce shortages, cost, and limited-service availability, continue to constrain the reach of evidence-based interventions (World Health Organization, 2022; National Academies of Sciences, Engineering, and Medicine, 2024). Such challenges have intensified the need for scalable, low-burden models of care delivery that can extend reach without increasing demands on already strained service systems (Kazdin & Blasé, 2011). Single-session interventions (SSIs), defined as structured programs designed to deliver clinically meaningful support within a single encounter, represent a promising approach to expanding access to mental health services across diverse populations and settings (Schleider & Weisz, 2017; Schleider et al., 2025). Meta-analytic evidence supports SSIs as effective behavioral-health tools across problem domains, with effect sizes comparable to multi-session treatments despite delivering meaningful content in a single encounter (Schleider et al., 2025).

Although many SSIs are designed for digital self-guided use (Schleider et al., 2020; Schleider et al., 2025), a critical subset is delivered by trained providers within clinical or service settings. Provider-

delivered SSIs create opportunities for integration into existing care systems (e.g., filling gaps at intake, during crisis contacts, or while clients await ongoing multi-session case management, without requiring additional session capacity) while introducing new demands on clinicians, who must deliver brief, focused interventions that may depart from traditional multi-session models. Successful implementation of provider-delivered SSIs, therefore, depends not only on the strength of the intervention itself but also on the extent to which clinicians are prepared, willing, and supported to use these approaches in practice.

The Single Session Consultation (SSC) constitutes one such provider-delivered SSI, emphasizing rapid rapport-building, collaborative problem definition, and delivery of targeted, actionable strategies within a single encounter (Schleider et al., 2020; Sung et al., 2025). The SSC has demonstrated meaningful clinical benefit and feasibility across a variety of applied contexts. Pilot trials indicate that solution-focused, single-session consultations can lead to significant improvements in key outcomes such as perceived agency, hopelessness, and psychological distress among clients waiting for traditional therapy, and recipients rate the intervention as acceptable and useful (Schleider et al., 2020; Sung et al., 2020). A recent case series similarly documented the feasibility and acceptability of the SSC when delivered by providers in a gender-responsive community mental health program, with clients reporting the intervention as helpful and aligned with their goals (Irgens et al., 2026), and a telehealth-delivered SSC adaptation showed preliminary benefit among highly stressed parents (Capó et al., 2026). Beyond the United State community health settings, an open pilot trial delivered the SSC via training lay providers to 200 Ugandan adults with elevated depression upon initial outreach for group psychotherapy; clients reported significant reductions in hopelessness and depressive symptoms that were sustained up to a month later (Kasujja et al., 2026).

Empirical applications of the SSC span outpatient and school-based service settings, where brief, flexible interventions may be particularly well-suited to contextual constraints and operational demands (Irgens et al., 2026). Attitudes toward specific behaviors, such as delivering evidence-based practices, are positioned in implementation science as determinants that can shape intentions and uptake (Fishman et al., 2021). Evidence indicates that clinician attitudes toward single-session approaches may influence their integration into practice. In a recent study, Sung and colleagues (2025) trained student and trainee clinicians using a two-hour didactic and observed that student and trainee providers initially expressed hesitancy toward the SSC, yet demonstrated significant improvements in attitudes towards SSIs and greater preparedness to deliver the SSC following the brief, structured training. Sung & colleagues' findings highlight the malleability of provider perceptions and suggest that exposure to structured training may enhance readiness to deliver single-session care. However, the authors note that the trainee-focused sample evaluated in their manuscript limits the generalizability of their findings to licensed, community-based providers, and the study did not assess what supports trainees felt they needed to adequately deliver the SSC to fidelity. The present study administers the same confidence and preparedness measures used by Sung et al. (2025), and extends them by asking providers to identify requested supports, the training components they found most helpful, anticipated contexts for SSC

implementation, and any unaddressed concerns they may have about delivering the SSC at their community-based site to aid in future implementation and training efforts.

The generalizability of these findings to licensed, community-based clinicians remains insufficiently understood, particularly given that providers embedded within established service systems must navigate organizational workflows, documentation requirements, and setting-specific operational constraints that can shape adoption of new practices (Powell et al., 2015; Proctor et al., 2011). Outpatient and school-based providers encounter distinct, yet equally complex, service environments. Outpatient clinicians often operate within reimbursement-driven systems that prioritize session length and continuity of care, whereas school-based providers function within high-demand settings characterized by large caseloads, limited contact time, and competing academic priorities (Hoover et al., 2019; Weist et al., 2017).

Training constitutes a critical early-stage implementation strategy (Fixsen et al., 2005; Powell et al., 2015) for provider-delivered SSIs such as the SSC. Brief, targeted training may provide a scalable mechanism to support adoption if they effectively address both conceptual understanding and practical application. Such training may be conceptualized as a multi-component intervention that influences provider knowledge, beliefs, and perceived readiness to act (Fishman et al., 2021). Cognitive models suggest that hesitancy toward single-session approaches may reflect underlying beliefs regarding treatment effectiveness, appropriateness, and professional role expectations, which can be updated through targeted informational and experiential inputs (Aarons, 2004; Fishbein & Ajzen, 2011). Identifying which components of brief training are most influential and which barriers persist after initial exposure is essential for optimizing implementation strategies (Stirman et al., 2012).

Consideration of service context underscores the relevance of this work. Outpatient clinicians frequently navigate constraints related to reimbursement structures, session duration, and continuity of care, which can shape the delivery and adaptation of evidence-based practices (Proctor et al., 2011; Stirman et al., 2013). In contrast, school-based providers operate within high-demand service environments characterized by large caseloads, limited contact time, and competing academic priorities that influence both access to and delivery of mental health services (Hoover et al., 2019; Weist et al., 2017). Variation across these service contexts may shape baseline provider attitudes toward single-session interventions and influence how clinicians interpret, adapt, and apply brief intervention models in routine practice (Aarons, 2004; Powell et al., 2015).

The Current Study

The present study extends prior findings on provider hesitancy toward single-session approaches by evaluating a structured SSC training delivered to community-based clinicians across seven community mental health organizations (i.e., both school-based and outpatient mental health clinics) spanning six U.S. states, drawn primarily from mid-career and senior providers (see Table 1). Training was embedded within broader implementation efforts, including pre-training consultation with organizational leadership to align workflows, documentation practices, and service delivery structures. Training content was

tailored to each site, allowing for focused discussion of logistical considerations and anticipated barriers. In addition to examining changes in provider attitudes toward single-session approaches, the study evaluated providers' readiness to deliver the SSC and their knowledge of its core principles and components. Possible contributors to training effectiveness were characterized descriptively by asking about which training elements were perceived as most influential, anticipated implementation contexts, perceived barriers, and remaining questions following initial training. Conceptually, this work examines potential pathways in which training shapes provider knowledge and beliefs, which in turn influence readiness to implement and anticipate use of the SSC in practice.

By conducting a replication of prior work within an applied training and implementation context, the present study extends existing literature beyond attitudinal change to evaluate providers' knowledge and readiness to deliver provider-delivered single-session interventions in routine care settings. Findings are expected to inform the development of scalable training strategies that support both adoption and sustainability of single-session approaches.

Method

Recruitment

Training procedures replicated those described by Sung et al. (2025) and tailored for delivery in community-mental health settings. As in Sung et al. (2025), all pre- and post-training measures reported here were collected immediately surrounding the 90-minute didactic; one-on-one mock SSC sessions and individualized feedback, described below, followed the collection of post-training measures and are therefore not reflected in the outcomes reported in this study. Participants were community-based mental health providers recruited through the initial training conducted under contracts with various community mental health organizations. Providers were actively engaged in service delivery and were expected to implement the SSC in their clinical practice following training. Participation in the research component was voluntary. Training was delivered by experts in SSC implementation and delivery; all but one site was trained via Zoom. Delivery format varied somewhat by site: most sites received the didactic in a single two-hour block with a mid-session break, while one site received the SSI content and the SSC-specific content on separate days. Outcomes did not differ across these formats. Providers were invited to opt in and provide informed consent at the beginning of the 90-minute didactic session and had the option to decline participation in survey data collection while still receiving the full training.

Procedure and SSC Training

Providers participated in a structured, 90-minute didactic, delivered either virtually or in-person, covering the theoretical foundations of single-session interventions, the structure and goals of the SSC, and strategies for integrating the SSC into routine care. Following the didactic (and current study), providers completed one-on-one mock SSC sessions, during which participants practiced delivering the SSC and received individualized feedback from trained facilitators. The training emphasized practical application, including identification of appropriate clinical contexts for SSC delivery, integration into existing

workflows, and use of supporting materials such as scripts, checklists, action plans, and documentation templates. Participants were encouraged to reflect on their confidence, knowledge, and perceived readiness to deliver the SSC in real-world practice. Post-training consultation and discussion allowed participants to address lingering questions or context-specific challenges. All study protocols were reviewed and approved by the Institutional Review Board at [masked for review]. The study and all analyses were pre-registered on the Open Science Framework at [masked for review].

Single Session Consultation

The Single Session Consultation (SSC) is a provider-delivered single-session intervention (SSI) designed to help clients identify a personally meaningful challenge, develop a concrete, strengths-based action plan, and leave the session with practical next steps that can be implemented immediately. Although the SSC can be delivered as a standalone service or integrated into ongoing care, it is guided by the principle that meaningful therapeutic change can occur within a single encounter. The intervention draws on common therapeutic factors and evidence-based strategies from solution-focused brief therapy, motivational interviewing, cognitive behavioral therapy, and positive psychology, while emphasizing client autonomy, collaboration, and actionable goal setting. A typical SSC follows a structured yet flexible framework that includes identifying a focal concern, exploring existing strengths and resources, collaboratively developing an individualized action plan, and summarizing key takeaways. Providers are encouraged to adapt the consultation to the client's developmental level, presenting concerns, and service setting while maintaining fidelity to the intervention's core components. See <https://osf.io/xnz2t/> for all SSC materials.

Measures

Demographics

Participants reported their career stage (e.g., student/trainee, entry-level, junior, mid-career, senior), current provision of clinical services, gender, race/ethnicity, average age of clients served (e.g., ages 5–11, 11–14, 14–28, 18–24, 25–34, 35–44, 45–54, 55–64, 65+), service location (i.e., rural, suburban, urban), supervisory responsibilities, work setting (e.g., outpatient, school, telehealth, private practice, crisis center, ED, inpatient, drop-in), and professional credentials (e.g., BA/BS, LSW/LPC, PhD, MD, MBA, MA/CNA).

Minimum Number of Sessions Needed for Change

Providers were asked to estimate the minimum number of sessions they believed would be needed for a client to experience any clinical improvement across eight presenting problem types (i.e., anxiety and excessive worry; depression and mood problems; behavioral problems; attention problems and hyperactivity; autism spectrum disorder and developmental delays; peer relationship problems; family relationship problems; trauma and upsetting life events; and a combination of multiple problems). Providers responded openly with any number they deemed necessary. Responses were examined overall

and by presenting problems to characterize beliefs about the minimum treatment dose required to produce meaningful change, assessed at both pre- and post-training. Family relationship problems were assessed at pre-training only and were not included in pre-to-post comparisons. For responses indicating a range (e.g., "35–50" sessions), the minimum value within the range was used for scoring purposes.

Provider Beliefs and Attitudes About SSIs

Provider beliefs about SSIs were assessed pre- and post-training using 14 items adapted from Sung et al. (2025). Items captured perceptions of SSI effectiveness, appropriateness, and alignment with professional practice norms (e.g., "SSC seems easy to use"). Responses were recorded on a 5-point Likert scale (1 = Strongly Disagree, 5 = Strongly Agree). Item scores were averaged to produce a composite score reflecting overall beliefs about SSIs, with higher scores indicating more positive beliefs. Cronbach's alpha in the current study was 0.89 pre-training and 0.89 post-training.

General Perceptions of SSIs

To assess participants' perception of the SSI in general, all participants were asked to provide "yes" or "no" answers to the question, "Do you think a person's behavioral, emotional, or mental health problems could ever improve after one session or encounter with a clinician?"

Confidence in the SSC Post-Training

Participants reported on their overall confidence change in the SSC's ability to benefit their clients from pre- to post-training with categorical choices (less confident, the same, and more confident). When trainees reported that their confidence had changed, participants were asked to provide optional, open-ended responses on which training components led to any perceived confidence change in the SSC.

Preparedness to Deliver the SSC Post-Training

Perceived preparedness to deliver the SSC was assessed pre- and post-training, two items (i.e., "I feel prepared to address my client's mental health needs/deliver the SSC to clients", "There are options available for brief-contact clients.") Participants rated their preparedness on a scale from 0 (not at all prepared) to 100 (completely prepared).

SSC Knowledge Quiz

A 13-item multiple-choice quiz was created for this study to assess participant comprehension of SSC principles, session structure, and intervention components. Items were designed to evaluate knowledge of core training content, including session flow, collaborative problem definition, and recommended strategies for supporting clients. Each correct response received 1 point, producing a total score ranging from 0 to 20, with higher scores indicating greater mastery of SSC content.

Concerns about Delivering the SSC

Participants indicated whether they had concerns about delivering the SSC (yes/no/not sure) and provided open-ended responses describing perceived barriers, uncertainties, or anticipated challenges. Qualitative responses were later analyzed using content analysis to identify common themes and implementation-relevant factors.

Training Supports and Implementation Context

Providers rated which training elements were most helpful, including tips, case examples, walkthroughs of protocols, scripts for introducing the SSC, mock session videos, checklists and protocols, action plans adapted to their setting, example documentation notes, practice sessions, and exposure to the scientific evidence supporting SSIs and the SSC. Participants indicated anticipated clinical contexts for SSC delivery (e.g., during “stuck points,” intake sessions, crisis moments, pre- or post-referral encounters, first sessions, termination, small group or family sessions). Open-ended responses were used to capture additional supports needed to enhance readiness and facilitate successful implementation, as well as perceived factors that may facilitate confidence change.

Data Analysis

Data were analyzed using R (version 4.4.2; R Core Team, 2026) with RStudio (Posit Team, 2026). Significance was set at $\alpha = .05$. All tests were two-tailed and uncorrected for multiple comparisons; given the exploratory nature of the study, results should be interpreted accordingly. Descriptive statistics were computed for all participants to summarize demographic and professional characteristics, training supports rated as most helpful, and anticipated contexts for SSC delivery. Frequencies and percentages were reported for categorical variables; means and standard deviations were reported for continuous variables.

Pre-to-post changes in provider beliefs about SSIs, general perceptions of the SSC, and preparedness to implement the SSC were evaluated using Wilcoxon signed-rank tests on the matched subsample ($n = 70$ participants with complete pre- and post-training data linked via email address). This approach was selected given the ordinal and skewed nature of the outcome measures. Effect sizes were estimated using the rank-biserial correlation ($r = |Z| / \sqrt{n}$), where Z was back-calculated from the two-tailed p -value; values of approximately .10, .30, and .50 are interpreted as small, medium, and large effects, respectively (Cohen, 1988). The SSC Knowledge Quiz was administered at post-training only and is reported descriptively.

Changes in the binary SSI belief item (yes/no) were assessed using McNemar's test on matched pairs. Exploratory between-group comparisons examined whether pre-to-post change scores differed between school-based and counseling center providers ($n = 38$ matched) and outpatient and telehealth providers ($n = 29$ matched). Mann-Whitney U tests were conducted on matched difference scores for each outcome, with rank-biserial r as the effect size estimator. These comparisons were conducted with the recognition that the study was not powered to detect small between-group effects, and findings should be considered preliminary.

Pre-to-post analyses were restricted to participants with matched data on each measure. Descriptive statistics for all pre- and post-training outcomes are reported for the full unmatched samples (pre: $N = 126$; post: $N = 101$) to provide broader context. Open-ended qualitative responses regarding concerns about SSC delivery, mechanisms of confidence change, and implementation supports were analyzed using content analysis to identify recurring themes and complement the quantitative findings.

Results

Sample Characteristics

A total of $N = 126$ providers completed the pre-training survey (hereafter *pre*; after excluding one invalid response), and $N = 101$ providers completed the post-training survey (hereafter *post*). Email-based matching linked $n = 70$ individuals with complete pre- and post-training; this matched subset was used for all paired significance tests. Participants were drawn from seven organizations spanning school-based and counseling center settings (i.e., from South Carolina, Mississippi, and Illinois; $n = 70$ pre) and outpatient and telehealth settings (from Indiana, Illinois, Washington DC, and Montana; $n = 44$ pre).

The majority of participants identified as female (84.9%, $n = 107$). Among those who provided a birth year ($n = 104$), the mean age was 41.3 years ($SD = 13.7$; range = 24–80). Most participants reported mid-career (42.1%, $n = 53$) or senior (21.4%, $n = 27$) career levels, and 90.5% ($n = 114$) reported prior formal training in delivering non-pharmacological mental health interventions or psychotherapy. The most common work settings were outpatient clinics (58.7%) and school settings (47.6%), with many providers working across multiple settings. See Table 1 for full demographic characteristics.

Minimum Number of Sessions

Providers estimated the minimum number of sessions needed across eight presenting problem areas. Pre-training estimates ranged from a mean of $M = 4.06$ ($SD = 3.55$, $n = 110$) for family relationship problems to $M = 8.13$ ($SD = 6.49$, $n = 100$) for autism spectrum disorder and developmental delays across unmatched participants. Post-training, estimates were lower across all eight domains, suggesting that training was associated with a shift toward greater openness to brief intervention. For matched pairs (participants who completed both pre and post surveys), the largest absolute reductions were observed for depression/mood problems (pre: $M = 6.02$, $SD = 6.11$; post: $M = 2.28$, $SD = 2.55$), autism and developmental delays (pre: $M = 8.19$, $SD = 5.96$; post: $M = 3.66$, $SD = 3.28$), and behavioral problems (pre: $M = 6.34$, $SD = 5.17$; post: $M = 2.12$, $SD = 2.32$). Paired Wilcoxon signed-rank tests on the matched sample revealed statistically significant pre-to-post reductions in minimum sessions beliefs for seven of seven testable problem areas — anxiety ($p < .001$, $r = 0.96$, depression ($p < .001$, $r = 0.99$), behavioral problems ($p < .001$, $r = 0.94$), attention problems ($p < .001$, $r = 0.92$), autism/developmental delay ($p < .001$, $r = 0.89$, peer relationship problems ($p < .001$, $r = 0.80$), and trauma and upsetting life events ($p < .001$, $r = 0.88$). Family relationship problems could not be evaluated pre-to-post, as this item was not administered at post-training (see Table 2). Post-training means were uniformly lower than pre-training means across all seven domains with post-training data, suggesting broad shifts toward greater

openness to brief intervention following training. Full pre- and post-training means and standard deviations are presented in Table 2. Between-group comparisons revealed no significant differences in minimum sessions belief change scores between school/counseling center and outpatient/telehealth providers for any of the seven problem areas (all p s > .29), indicating that training was similarly effective in shifting these beliefs across setting types.

Provider Beliefs/Attitudes and General Perceptions

At pre-training, the average attitude score was $M = 3.49$ ($SD = 0.60$), indicating generally favorable but not uniformly positive attitudes toward the SSC before training. At post-training, the composite score was $M = 3.80$ ($SD = 0.63$). A paired Wilcoxon signed-rank test on the matched sample indicated that attitudes became significantly more favorable from pre to post training ($W = 237.5$, $p < .001$, $r = 0.79$). Item-level means pre- and post-training are presented in Table 3.

Pre-training, the majority of providers (93.6%, $n = 117$) endorsed the belief that behavioral, emotional, or mental health problems could improve after a single session with a provider. This proportion increased slightly post-training (98.0%, $n = 98$). However, for those who completed both pre-post measures, a McNemar test indicated that this shift was not a significant change in overall beliefs about SSIs; $\chi^2(1) = 2.25$, $p = 0.13$.

School/counseling center providers entered training with slightly higher composite attitude scores than outpatient/telehealth providers (school: pre $M = 3.60$, $SD = 0.50$; outpatient: pre $M = 3.45$, $SD = 0.68$), and both groups showed similar improvements post-training (school: post $M = 3.88$, $SD = 0.47$; outpatient: post $M = 3.68$, $SD = 0.68$). A Mann-Whitney U test on matched attitude change scores indicated no significant change for either group ($Mchange = 0.29 - 0.32$, $p = 0.95$, $r = 0.07$), suggesting that training produced comparable attitudinal shifts regardless of practice setting.

Confidence in the SSC Post-Training

The majority of respondents (79.0%, $n = 77$) reported feeling more confident in delivering the SSC immediately post-training (i.e., immediately following the 90-minute didactic and prior to the one-on-one mock SSC session), while 21.0% ($n = 21$) reported feeling the same. No providers reported feeling less confident. School/counseling center providers showed a somewhat higher rate of increased confidence (85%, $n = 46$ of 54) relative to outpatient/telehealth providers (70%, $n = 21$ of 30), though formal significance testing was not conducted given the limited response categories. Overall, providers attributed changes in confidence primarily to the information and details provided in the training, including how to complete each step of the structured action plan (31.5%; $n = 23$) and how the SSC may be useful in their practice (22.7%; $n = 17$).

Preparedness to Deliver the SSC Post-Training

A paired Wilcoxon signed-rank test on the matched sample indicated there was a significant positive change in overall scores of perceived preparedness from pre- ($M = 66.66$, $SD = 20.63$) to post-training (M

= 72.46, SD = 15.61); $W = 632.0$, $p = 0.01$, $r = .31$.

Overall, pre-training general MH preparedness was $M = 78.9$ ($SD = 19.8$), while post-training SSC-specific preparedness was $M = 76.2$ ($SD = 20.7$). A paired Wilcoxon signed-rank test on the matched sample ($n = 67$) indicated there was no significant change in general mental health preparedness to SSC preparedness from pre- ($M = 79.55$; $SD = 20.03$) to post-training ($M = 76.81$; $SD = 18.51$); $W = 886.5$, $p = 0.13$, $r = .24$. However, a Wilcoxon signed-rank test on the matched sample showed a significant increase in perceptions of available brief contact services for clients from pre- ($M = 49.40$; $SD = 30.52$) to post-training ($M = 65.72$; $SD = 24.02$); $W = 123.5$, $p < .001$, $r = .73$. Further, a significant between-group difference in preparedness change was observed ($W = 636.5$, $p = .016$, $r = 0.36$): school/counseling center providers reported a decrease in perceived SSC preparedness (the SSC-specific preparedness item, distinct from the general mental health preparedness item used at pre-training) from pre to post (pre $M = 79.7$; post $M = 70.9$), while outpatient/telehealth providers reported an increase (pre $M = 79.6$; post $M = 83.8$). It is important to note that the pre and post-items, while conceptually related, assess somewhat different constructs (general MH preparedness vs. SSC-specific preparedness); formal comparisons should therefore be interpreted with caution. Pre-training perceived availability of brief-contact options was $M = 49.40$ ($SD = 30.50$), while post-training, the corresponding mean was $M = 65.72$ ($SD = 23.9$). A paired Wilcoxon signed-rank test on the matched sample indicated there was a significant positive change in overall scores of preparedness from pre- ($M = 49.40$; $SD = 30.52$) to post-training; $W = 123.50$, $p < .001$, $r = 0.60$, suggesting that after training, providers perceived greater availability of options for clients not requiring multi-session care. This improvement did not differ significantly between school/counseling center and outpatient providers ($W = 197.0$, $p = .79$).

SSC Knowledge Quiz (20 questions tailored to SSC content delivered during training).

On the 13 single-answer items, providers demonstrated strong post-training knowledge ($M = 11.4$ correct out of 13, $SD = 2.7$; 87.6% correct). Item-level analysis revealed that the most frequently missed items were regarding whether the SSC model is a theoretical orientation and whether the SSC could be adapted for crisis management. Knowledge post-training did not differ significantly between school/counseling center ($M = 11.4$, $SD = 2.4$, $n = 54$) and outpatient/telehealth providers ($M = 11.6$, $SD = 2.5$, $n = 32$; $W = 783.0$, $p = .45$, $r = 0.72$), suggesting that training produced equivalent knowledge gains across setting types.

Concerns about Delivering the SSC

Post-training, providers were asked whether they had any concerns about delivering the SSC in their setting. Approximately one-third of respondents reported concerns (28.2%, $n = 20$), with an additional 22.5% ($n = 16$) reporting uncertainty, and 49.3% ($n = 35$) reporting no concerns. Concern rates were similar across school/counseling center (Yes: 26.9%, $n = 7$ of 26) and outpatient/telehealth providers (Yes: 25.8%, $n = 8$ of 31).

Among those who endorsed concerns ($n = 20$), qualitative responses identified several recurring themes, including concerns about time constraints ($n = 5$) and administrative burden ($n = 3$; e.g., documentation, billing concerns), questions about appropriate patient selection criteria ($n = 6$; e.g., age, applicability to different presenting problems), and uncertainty about how to integrate SSC delivery into existing workflow structures ($n = 5$). A subset of providers specifically noted concerns about using the SSC with populations experiencing severe or complex presentations ($n = 2$; e.g., serious mental illness, active suicidality). These concerns were more frequently endorsed by outpatient providers, who cited billing and documentation requirements as structural barriers.

Training Supports and Implementation Context

Providers were asked to identify which training components they found most helpful or relevant to their practice. The most commonly endorsed supports were tips on implementation of the SSC ($n = 52$; 74%), followed by case examples of the SSC action plan ($n = 48$; 69%) and walkthrough of the protocol ($n = 47$; 67%). Comparing across setting groups, outpatient providers more frequently selected implementation tips ($n = 21$; 68%), case examples ($n = 22$; 71%), protocol walkthroughs, and scripts to use with clients ($n = 20$; 65%). Similarly, school-based providers endorsed implementation tips ($n = 22$; 85%), case examples ($n = 18$; 69%), and protocol walkthroughs ($n = 18$; 69%).

Providers were also asked to identify appropriate times to deliver the SSC in their workflow. The most commonly endorsed timing was during a “stuck point” when the provider is unsure how to proceed (75%, $n = 52$), followed by during a moment of crisis (68%, $n = 47$), during an intake (54%, $n = 37$), and prior to or in conjunction with referral to other services (51%, $n = 35$). School and outpatient providers agreed, but differed in their endorsed implementation contexts, with school providers more likely to endorse using the SSC with family members of clients (47%, $n = 14$) compared to outpatient providers (38%, $n = 10$).

Comparing groups, school/counseling center providers more frequently endorsed delivery during an intake (65%, $n = 17$ of 26 vs. 37%, $n = 11$ of 30 outpatient) and during a moment of crisis (77%, $n = 20$ of 26 vs. 60%, $n = 18$ of 30 outpatient). Outpatient providers more often endorsed delivery with family members of clients (47%, $n = 14$ of 30 vs. 38%, $n = 10$ of 26 school) and before referral (47%, $n = 14$ of 30 vs. 46%, $n = 12$ of 26 school).

When asked what additional supports would help them feel more prepared to deliver the SSC, providers ($n = 22$) most requested practice sessions ($n = 12$), example completed action plans ($n = 9$), and ongoing consultation or supervision feedback on their SSC delivery ($n = 3$), all of which were provided to all trainees post-didactic training.

Discussion

Scalable implementation of evidence-based treatments in community settings depends on a workforce able to deliver them with fidelity (e.g., Fairburn & Patel, 2014; Kazdin & Rabbitt, 2013). We trained providers in school-based counseling center settings to deliver a solution-focused single-session

intervention (SSC; Sung et al., 2023) and examined a blended pre- and during-implementation training strategy targeting early adoption determinants. Quantitative and qualitative ratings indicated high acceptability and feasibility and increases in provider-reported confidence, knowledge, and preparedness.

Providers across care settings identified features of the training and procedures that bear on scalability. Attitudes toward the SSC and confidence were similar across settings, but preparedness diverged, decreasing from pre to post among school-based providers and increasing among outpatient and telehealth providers. Qualitative accounts indicate that, for school-based clinicians, the training brought into focus structural limitations not addressed by the training, including expectations to prioritize crisis response, concerns about fit with student age and case severity, and documentation and billing requirements in school mental health systems. In contrast, outpatient providers who reported increased confidence described stronger alignment with existing workflows and greater flexibility to integrate the SSC within clinic operations. Past studies suggest training in school-based settings requires further recalibration (Conners et al., 2022; Cook et al., 2019; Lyon et al., 2019), including deploying context-responsive implementation strategies such as ongoing coaching and technical assistance and use of local champions and peer learning structures to support adaptation and uptake.

Both quantitative and qualitative responses indicate that post-training confidence was tied to two elements: the structured protocol and the use of tailored case examples. Participants identified the action plan and early integration of top problem and top hope as features that made a single session seem workable. This emphasis extended to how respondents reasoned about the model, favoring a focused, goal-directed session that builds on client strengths. Qualitative feedback also identified gaps in the training format. Respondents called for less didactic instruction and more applied practice, including role-plays, exposure to a broader range of client presentations, and recorded exemplars drawn from their settings, such as disengaged or mandated adolescents. Several emphasized the need for additional time allocated to observation and supervised practice. This pattern aligns with evidence that skill acquisition requires active, coached practice and ongoing support (Beidas & Kendall, 2010). For SSC training, this implies reallocating time from didactics to observed practice with setting-matched cases and pairing the initial training with structured post-training consultation.

One of the largest pre-post shifts was in session dose expectations, which decreased across nearly all problem areas with moderate to large effects. The largest changes were observed for depression, behavioral problems, and developmental delays, family relationship problems could not be evaluated post-training, as this item was dropped from the post-survey. Respondents often anchored these changes to discrete, targetable problems aligned with a single-session model, though some continued to assume higher dose requirements for child and parent interventions, particularly in school settings. Several qualitative accounts identified this shift in dose expectations as central to increased confidence, pointing to specific elements of the training that made a single session seem viable. This pattern suggests that targeting dose beliefs may be a key lever for early adoption and should be explicitly addressed and reinforced through applied training and follow-up support.

A related limitation concerns measurement timing: all outcomes reported here were collected immediately following the didactic and before the one-on-one mock SSC session and individualized feedback that followed. Many providers specifically requested practice mock sessions as an additional support; thus, it is possible that confidence, preparedness, or knowledge would have shown further gains had they been reassessed after the mock session; the present design cannot speak to the incremental contribution of that component.

Conclusion

These findings point to several priorities for future work. First, studies should assess retention of SSC knowledge and delivery skill beyond initial training, including objective indicators of fidelity. Second, trials should identify which training components drive change, for whom, and under what conditions, with explicit tests of strategy-context fit in school settings where organizational structures differ from outpatient care. Third, evaluation of train-the-trainer approaches is warranted to test whether capacity can be scaled within and across organizations at lower cost (Yarber et al., 2015). Fourth, school-based research should examine how embedding SSC within structured triage pathways and tiered systems shapes uptake and appropriate use, including clear differentiation of SSC as a Tier 2 standalone intervention versus a Tier 3 entry point to ongoing care. Based on these distinctions, implementation may require standardized triage protocols and defined role expectations to prevent misuse and ensure alignment with problem type and severity. Finally, comparative studies should test training intensity, contrasting fully asynchronous formats with coached models, to determine the minimum support needed for competent delivery in resource-constrained contexts.

Declarations

Competing Interests

All trainings described in this manuscript were provided under contracts between the Lab for Scalable Mental Health and the participating organizations for delivery of the Single Session Consultation and implementation of this evidence-based intervention within those organizations. The manuscript and data collection were not part of this contracted work. JLS serves on the Scientific Advisory Board for Walden Wise and the Clinical Advisory Board for Koko (unpaid) and receives book royalties from New Harbinger; Oxford University Press; and Little, Brown Book Group. She is cofounder and chief scientific advisor for Navi. No Navi products were used or are referenced in the present manuscript.

Author Contribution

ES conceptualized the study, contributed to methodology, and led formal analysis. ES, PZ, KC, MH, and JS contributed to investigation. ES and PZ wrote the original draft. ES, PZ, KC, MH, and JS reviewed and edited the manuscript. All authors reviewed the manuscript.

Data Availability

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Tables

Table 1 Demographic and Professional Characteristics of Participants

Variable	M	SD
Age (years)	41.3	(13.7)
Variable	n	%
Sex at birth		
Female	107	84.9%
Male	19	15.1%
Gender identity		
Woman	105	83.3%
Man	18	14.3%
Gender fluid / queer / agender	3	2.4%
Race/ethnicity (select all that apply)		
White or European American	85	67.5%
Black or African American	28	22.2%
Hispanic or Latino	7	5.6%
Asian or Asian American	7	5.6%
Arab, Middle Eastern, or North African	1	0.8%
Multiracial / More than one	5	4.0%
Prefer not to answer	3	2.4%
Career level		
Entry-Level	15	11.9%
Junior	20	15.9%
Mid-Career	53	42.1%
Senior	27	21.4%
Credential / degree (select all that apply)		
LPC / LPCA / LPC-S (Licensed Professional Counselor)	30	23.8%
LCSW / LMSW / LSW / LISW (Social Work licensure)	12	9.5%
Master's degree (MA / MS / MSW / MEd)	36	28.6%
PhD	3	2.4%
PsyD	5	4.0%

EdS / EdD	3	2.4%
Other	2	1.6%
Work setting (select all that apply)		
Outpatient clinic	74	58.7%
School settings	60	47.6%
Telehealth / teletherapy platforms	42	33.3%
Private practice	16	12.7%
Other	18	14.3%
Service location (select all that apply)		
Rural	46	36.5%
Suburban	40	31.7%
Urban	46	36.5%
Client age range served (select all that apply)		
5–11 (elementary school)	17	13.5%
11–14 (middle school)	20	15.9%
14–18 (high school)	31	24.6%
18–24 (college)	22	17.5%
25–34	15	11.9%
35–44	9	7.1%
45–54	5	4.0%
55–64	4	3.2%

Note. Percentages are based on $N = 126$ unless otherwise noted. Race/ethnicity, work setting, service location, client age range, and credential items allowed selection of multiple options; percentages sum to more than 100%. Five participants selected more than one racial/ethnic category.

Table 2 *Minimum Number of Sessions Beliefs: Pre- and Post-Training Means and Standard Deviations (Matched Sample)*

Problem Area	Pre M (SD)	Post M (SD)	n
Anxiety / Excessive Worry	4.75(4.27)	2.00(2.21)	59
Depression / Mood Problems	6.02(6.16)	2.25(2.56)	59
Behavioral Problems	6.38(5.21)	2.10(2.34)	58
Attention / Hyperactivity	5.96(5.33)	2.18(2.33)	57
Autism / Developmental Delay	8.23(6.01)	3.62(3.29)	52
Peer Relationship Problems	3.98(3.79)	1.98(2.43)	56
Trauma / Upsetting Life Events	7.96 (7.18)	3.75(3.88)	56
Combination of Problems	9.07(9.11)	3.68(4.44)	57
Family Relationship Problems	5.07(5.09)	—	64

Note. Means and SDs are from matched pre–post pairs only. Higher scores indicate providers believed more sessions were needed to see any improvement. Family Relationship Problems was not assessed at post-training (—). *n* varies across problem areas due to missing data.

Table 3 *SSC Attitude Scale Item Means and Standard Deviations: Pre- and Post-Training (Full Unmatched Samples)*

	Pre-Training		Post-Training	
Item	M	SD	M	SD
Positive items				
SSC is appealing to me as a practitioner	4.24	0.86	4.29	0.79
SSC seems easy to use	3.75	0.80	4.01	0.89
SSC seems feasible to implement	3.99	0.79	4.19	0.74
SSC seems useful for my future work	4.10	0.80	4.27	0.73
SSC will be useful for my clients	4.09	0.74	4.23	0.69
My clients will be happy to receive SSC	3.62	0.87	3.89	0.74
Most clients will benefit from one session	3.62	0.92	3.85	0.88
One session can bring clinically meaningful improvement	3.66	0.77	3.87	0.88
Reverse-scored items (higher score = more favorable after recoding)				
SSC is NOT applicable to my clients☒	3.65	0.83	3.84	0.89
Clients will be UNSATISFIED with one session☒	3.04	0.78	3.36	0.92
Clients REQUIRE more than one session☒	2.80	0.89	3.32	0.87
SSC can ONLY benefit mild difficulties☒	2.96	1.00	3.22	1.07
SSC is ONLY useful as adjunct to longer therapy☒	3.12	0.98	3.50	0.97
SSC is ONLY helpful short term☒	2.95	0.96	3.39	0.98

Note. Items rated on a 5-point scale (1 = *Completely Disagree*, 5 = *Completely Agree*). Pre-training *N* = up to 126; post-training *N* = up to 101; item-level *n* varies due to missingness. ☒Reverse-scored items are recoded so that higher scores reflect more favorable attitudes toward the SSC across all items. Scale adapted from Sung et al. (2025).