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A mixed methods study examining teacher impressions of a psychoeducational program on common issues during childhood

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A MIXED METHODS STUDY EXAMINING TEACHER IMPRESSIONS OF A PSYCHOEDUCATIONAL PROGRAM ON COMMON ISSUES DURING CHILDHOOD

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ABSTRACT

The rate of youth suffering from untreated emotional and behavioral problems has risen in recent years. Various barriers to treatment utilization of youth and their families have been identified in the literature, including logistical factors (i.e. transportation, lack of child care), financial barriers, and system barriers, such as inadequate education on mental health difficulties within the school system and poor provision of empirically-derived tools for teachers to manage these difficulties. In order to narrow the gap between treatment need and utilization, a psychoeducational program for teachers of school-aged children has been developed. A mixed methods study was conducted as a means to gain teacher impressions of the program's effectiveness in disseminating evidence-based classroom strategies that can be used by teachers to manage common childhood problems. Qualitative data analysis procedures based on grounded theory were undertaken to code collected data from narrative interviews. Major themes that emerged included a demonstrable need for the psychoeducational program, high teacher demands as a barrier to implementation of the program, and preference for integration of the program with existing professional development initiatives. Quantitative data analysis revealed that teachers perceived the program as effective for teachers and school staff at increasing knowledge and skill related to childhood emotional/behavioral (E/B) functioning. Limitations, strengths, and recommendations for future directions are discussed.

Keywords: barriers to treatment, youth, psychoeducation, teachers

Introduction

Childhood mental health issues have gained increased levels of attention within the public sector throughout the past decade, especially given the high prevalence of mental health difficulties for youth across the United States. The 2009 report of the National Research Council and Institute of Medicine found that approximately 14 and 20 percent of youth suffer from mental, emotional, and behavioral disorders each year, impacting nearly 7.4 million children (National Research Council and Institute of Medicine, 2009; US Department of Health and Human, Health Resources, and Service Administration, Maternal and Child Health Bureau [HHS/HRSA/MCHB], 2010). Similarly, a recent report of the Centers for Disease Control and Prevention (2013) found that millions of children between the ages of 3 and 17 in the U.S. suffer from a variety of mental health disorder, including mood disorders, anxiety disorders, attention-deficit/hyperactivity disorder (ADHD), disruptive behavior disorders, and autism spectrum disorders, to name a few. Further, as many as 40 percent of children within this group suffer from a comorbid mental health disorder (HHS/HRSA/MCHB, 2010). Severe mental illness in childhood has been linked to difficulties accomplishing normative developmental tasks, including academic achievement, establishment of healthy interpersonal relationships, and transition into the workforce (National Research Council and Institute of Medicine [NRC/IOM], 2009). The estimated annual cost of youth mental health difficulties, including the cost of treatment, lack of meaningful contribution to society, and the resulting drug and alcohol use, antisocial behaviors, and violence, is a staggering $247 billion (NRC/IOM, 2009).

Many youth who suffer from emotional and behavioral problems do not receive the help they need. According to the National Survey of Children's Health conducted in 2007, only 60% of children (ages 2-17) with an ongoing emotional, developmental, or behavioral issue received

mental health services during the previous year (HHS/HRSA/MCHB, 2010). When unmet need was examined by ethnicity and health insurance status, researchers found that the rate of unmet need is significantly higher among Latino children and uninsured children than white children and insured children (Kataoka, Shang, & Wells, 2002). In addition, the number of youth who had unmet mental health needs appear to be on the rise (Roll, Kennedy, Tran, & Howell, 2013). This growing discrepancy between youth mental health needs and actual service utilization rates has prompted researchers to examine barriers commonly encountered by children on the treatment-seeking pathway as well as factors that facilitate treatment use and engagement in the treatment process. This growing body of research aims to increase treatment utilization and to reduce negative outcomes for youth with mental health concerns.

Barriers to Treatment for Youth

While service barriers impact individuals of all ages within the treatment-seeking process, attention to barriers to youth is particularly salient due to a child's reliance on adults to identify mental health/behavioral difficulties and linkage to treatment. Although the literature on barriers to mental health treatment for children and adolescents is limited, Gould, Beals-Erickson, and Roberts (2012) have made efforts to streamline the examination of service barriers. Through the evaluation of characteristics of an individual/family, the service system, and the community/larger society, Gould and colleagues have identified factors that prevent a child from receiving needed mental health treatment, despite being offered within the community (p. 768). Examination of the individual and family barriers, system barriers, community barriers, and sociocultural barriers will be outlined below to inform strategies to reduce barriers to treatment and increase treatment utilization.

Individual and family barriers. Individual barriers were described as "stressors and

obstacles" (Kazdin, Holland, Crowley, & Breton, 1997, p. 1053) in the Barriers to Treatment Scale. Examples of stressors and obstacles include *logistical* factors that interfere with attendance to therapy, such as difficulties in scheduling due to conflicting time commitments, sickness of child or caregiver during appointment times, and lack of transportation or childcare (Bannon & McKay, 2005; Kazdin, Holland, & Crowley, 1997; Kernan, Griswold, & Wagner, 2003; King et al., 2009; Williams, Horvath, Wei, Van Dorn, & Jonson- Reid, 2007). In addition, Gould and colleagues (2012) also cited *financial* factors that limit treatment enrollment and engagement. For example, the affordability of treatment has been found to be a prominent barrier to treatment attendance (Betz, Baer, Poulsen, Vahanvaty, & Bare, 2004; Leigh, Powers, Vash, & Nettles, 2004; Pajer, Kelleher, Gupta, Rolls, & Gardner, 2007); however, some research studies indicated that there was not a significant relationship between mental health coverage and the treatment participation for children in need of services (Cuffel et al., 2000; Stevens, Kelleher, Ward-Estes, & Hayes, 2006).

Parental factors, including parental psychopathology, limited formal education, and negative expectations towards treatment outcomes, were cited in the literature as additional individual and family service barriers that limit treatment engagement (Gould et al., 2012; Owens, Hoagwood, Horowitz, Leaf, Poduska, Kellam, & Ialongo, 2002). In a study evaluating the impact of parental mental illness on children, parents' mental health needs often obscured the needs of the children (Stallard, Norman, Huline-Dickens, Salter, & Cribb, 2004). Interestingly, these children also demonstrated a need to "protect their parents from additional distress" related to the child's own mental health care needs (p. 50). In addition, Hinojosa, Knapp, and Woodworth (2014) examined differences in levels between family strain impacting mental health care utilization for youth across White and Latino families. The researchers found that higher

levels of parental formal education served as a resource or protective factor that mediated the effects of strain common in families with a child diagnosed with a mental health disorder (Hinojosa, Knapp, & Woodworth, 2014). Lastly, although limited research has been conducted in this area for child mental health, Nock and Kazdin (2001) found that parents of families characterized by ethnic minority status, socioeconomic disadvantage, and single-parent status exhibited lower expectancies for child mental health treatment, which is associated with the belief that therapy is less credible. These families are perceived to be at risk for increased barriers to treatment.

System barriers. Gould and colleagues (2012) conceptualized system barriers as barriers to treatment that are inherently a part of the current mental health service system. The system barriers that exist for children in need of mental health services discussed below include limited access to appropriate services, the child's reliance on the school system/teachers and their parents/guardians, and the lack of communication between the various systems involved in a child's life and care.

Children and families often have limited access to appropriate mental health services within their community based on their individual needs. One major limitation of the services system is limited access to services provided in a client's preferred language due to a lack of language diversity among clinicians (Ton, Koike, Hales, Johnson, & Hilty, 2005). Sentell, Shumway, and Snowden (2007) found that non-English speaking individuals were less likely than their English-speaking counterparts to receive necessary mental health treatment. Other system barriers include the location of service provision, hours that services are offered, eligibility criteria restricting access to care, and failures to educate the community about the services available (Gould et al., 2012). Furthermore, despite the research pertaining to

knowledge of evidenced-based practices (EBPs) shown to be effective in the treatment of children, many service providers are unable to utilize these practices due to "lack of proper training and funding" (p. 769).

Children are subjected to additional systems barriers due to their reliance on the school/teacher and home/parent systems in the treatment-seeking process. While adults are generally solely responsible for identifying a mental health need and accessing treatment, a child's mental health treatment is initiated and maintained by individual adults and services systems. School systems play a significant role as the primary gateway of mental health treatment for youth, providing approximately 70 to 80 percent of child mental health services in the U.S. (Farmer, Burns, Phillips, Angold, & Costello, 2003; Hoagwood, Burns, Kiser, Ringeisen, & Schoenvrald, 2001; Rones & Hoagwood, 2000; Williams et al., 2007). Given the impact of mental health difficulties on academic performance and character development, teachers and school administrators should have a vested interest in the mental health needs of school-aged students (Spirito, Boergers, Donaldson, Bishop, & Lewander, 2002). Despite this correlation, teachers and school officials are often highly impacted by various other academic and administrative responsibilities, resulting in the mental health needs of students being overlooked (Farmer et al., 2003; Williams et al., 2007). Additional barriers within the school system include the lack of systematized teacher training/education on the knowledge required for the identification of children at risk for mental health difficulties and the lack of awareness of community-based mental health resources offered outside of the educational setting (Farmers et al., 2003; Williams et al., 2007). Such barriers impede the school system's ability to make appropriate referrals for children in need and point to a need for a psychoeducational intervention targeting school personnel on common childhood mental health difficulties, strategies to manage

associated behaviors in the classroom setting, and guidelines regarding when to refer a child for further needs assessment or mental health treatment (Farmers et al., 2003).

Although parents are a primary source of referral for children, there are a number of reasons why parents may never seek treatment for their child. Some researchers propose one reason is that many caregivers perceive their child's problems to be immutable and beyond their control (Roberts, Joe, & Hallbert-Rowe, 1992). Conversely, other parents may see periods of improvement in their child as a sign that treatment is not needed (Kournay, Garber, & Tornusciolo, 1990). Limited financial resources and scheduling issues are also factors that prevent parents from bringing their child in for services (Morrissey-Kane & Prinz, 1999). Furthermore, Angold and colleagues (1998) found that parental perception of burden (e.g., stigma, personal well-being, time commitment) is a strong predictor of treatment initiation for children. Moreover, it is important to note that even those parents who seek treatment for their children often do not make it their first scheduled appointment (Morrissey-Kane & Prinz, 1999).

The lack of communication and collaboration between families and the school system often compound the system barriers to treatment for children and adolescents. In a study conducted by Williams and colleagues (2007), teachers often reported feeling a lack of respect and barriers to obtaining consents for school-based mental health services from parents and guardians. Researchers also found that parents who received mental health referrals for their children often had the perception that school staff were responsible for following through with treatment recommendations independent of parent input (p. 102). Additional barriers to youth treatment have identified within the parent/family and provider relationship. Baker-Ericzén and colleagues (2013) found significant differences between therapist and parent experiences during the early stages of treatment. Teachers described highly valuing parent participation and utilizing

family-centered treatments, while parents reported feeling unsupported and blamed by the therapist. Furthermore, child clients reported "dissatisfaction in their mental health treatment", citing increased need for a "directive therapeutic style" (p. 854).

In summary, several barriers exist in three major systems (i.e., school/teacher, home/parent, specialty mental health service clinics) that directly impact youth mental health care, and poor collaboration among these systems leads to further unmet mental health needs.

Community barriers. The attitudes and characteristics that pervade throughout a community inevitably impact the perception of services provided within the area (Gould et al., 2012). Parents identified stigma towards mental health difficulties and treatment as a significant community barrier (Larson et al., 2013). Stigma has been defined as "attribute that is deeply discrediting" (Goffman, 1963, p. 3) and a "mark of shame related to a membership in a deviant or castrated subgroup" (Hinshaw, 2005, p. 715). Individuals suffering from mental illness have been identified as one of the most highly stigmatized persons of society across many cultures (Bos, Pryor, Reeder, & Stutterheim, 2013). Children with mental health illness are often subjected to increased levels of stigma due to perceived dangerousness related to childhood mental health disorders, resulting in being treated in increasingly negative and punitive ways (Pescosolido, Fettes, Martin, McLeod, & Monohan, 2007; Walter, Coleman, Lee, Squire, & Friesen, 2008). Parents of children with mental health difficulties often experience an extension this stigma and have been found to worry about concealing their child's mental health diagnosis from members of the community (Hinshaw, 2005; Mukolo, Hefinger, & Wallston, 2010). Further, many individuals suffering from mental illness experience "self-stigma," (Corrigan & Rao, 2012, p. 464) a phenomenon that occurs when an individual comes to accept the stigma that has been imposed upon them by the community and/or society as truth.

Despite efforts to reduce stigma, negative attitudes towards mental health services have been shown to increase over the last four decades (Mackenzie, Erickson, Deane, & Wright, 2014). Larson and colleagues (2013) found that approximately 15 percent of parents believed that their friends and family would be unsupportive if their child were to receive mental health treatment. "Parents also believed that their child would not want to go to a mental health center," suggesting potential stigma experienced by the child or at least the perception that the child may also experience stigmatizing attitudes (p. 164). Similarly, Bowers, Manion, Papadopoulos, and Gauvreau (2013) found that youth commonly experience stigma regarding school-based mental health services, suggesting that stigma is a concern even for the most common youth services setting. Parental attitudes on help-seeking behavior also influence a family's openness to receiving mental health (Morrissey-Kane & Prinz, 1999). Morrissey-Kane and Prinz (1999) found that children whose parents were confident in their capacity to enact change in their community maintained better treatment engagement and success.

Community barriers also include factors salient to the specific community in which the child/family resides, including prevalence of violence and socioeconomic status/poverty level. Hoberman (1992) found that urban youth exposed to greater levels of violence and poverty underutilized the mental health services available in the community, even when controlling for parental level of education and treatment affordability. In sum, the pervasiveness of stigma towards mental health issues and individual community factors must be considered when evaluating a child/family's treatment-seeking process.

Sociocultural barriers. Culture is a major factor influencing mental health service utilization among youth. The impact of gender, race/ethnicity, discrimination and disparities in the health services system, religion and spirituality, immigrant status, and the compounded

barriers experienced by individuals within minority groups are discussed below as significant sociocultural barriers to children and families.

Primarily, gender and race/ethnicity have been linked to mental health treatment-seeking attitudes, perceptions, and behaviors (Ojeda & Bergstresser, 2008). Studies have shown that males and ethnic-minorities are less likely to access available mental health services as compared to women and non-Hispanic white populations (Kessler, Brown, & Broman, 1981; Wang et al., 2005). An exploration of care-seeking attitudes within the Latino community offers some insight into the substantial unmet treatment need amount Latino children (Ojeda & Bergstresser, 2008). Specifically, it is common among Latinos to view physical symptoms as more concerning than mental health issues; thus, many Latinos turn to physicians for help rather than mental health providers (Kouyoumdjian, Zamboanga, & Hansen, 2003). Another culture-specific aspect of help-seeking relates to social norms within one's ethnic or racial community. Within many "collectivistic societies, individuals go to members of their own cultural group for help before seeking assistance from others" (p. 401).

According to Ojeda and Bergstresser (2008), mistrust or fear of the mental health care system exists within some minority communities, particularly the African American community, who have experienced racial and ethnic discrimination within the health care systems. Research on ethnic disparities in special education found that Black children were more likely to have been found eligible for services through the emotional disturbance (ED) label, the special education label typically provided to children who exhibit disruptive behaviors (Mandell, Davis, Bevans, & Guevara, 2008). Despite the higher rates of eligibility for Black students under the ED category, "they were "less likely to receive necessary services when compared to White children in Special education" (p. 42). Various researchers reported that children classified under the ED

label were more often enrolled in highly restrictive educational settings, compared to children labelled under learning disabilities and other health impairments, despite the research indicating that education in inclusive settings is associated with better academic and socio-emotional outcomes (Fisher & Meyer, 2002; Landrum, Katsiyannis, & Archwamety, 2004; Landrum, Tankersley, & Kauffman, 2003; Vaughn & Linan-Thompson, 2003). In addition to the restricted educational setting often imposed upon Black children labeled as emotionally disturbed, research indicated that teacher who specialized in working with children labeled as ED also reported feeling less prepared to work with their students compared to other special education teachers for other eligibilities, indicative of additional risk factors for these students (Wagner et al., 2006). Preliminary research on special education outcomes found that children labelled as ED exhibited poorer outcomes than children classified for special education under other eligibility labels, likely due to the above factors (Donovan & Cross, 2002). Furthermore, greater stigma has been associated with the ED classification and has been historically associated with services in segregated settings (Hosp & Reschly, 2003; Serwatka, Dove, & Hodge, 1986). Not surprisingly, a parent's history of discrimination coupled with the disproportionate placement of their children within restrictive educational setting can greatly influence the decision to seek treatment for his or her child.

Furthermore, personal experiences with or related accounts of mental health providers lacking in cultural competency may lead ethnically diverse individuals to feel as though treatment will not be useful for someone within their community. In addition to feeling misunderstood by service providers, these individuals may feel confused about the information presented to them due to possible language barriers. Racial bias and discrimination within the health care system not only perpetuates negative help-seeking attitudes, but it also jeopardizes

the quality of services available to ethnic minorities in general (Eiraldi, Mazzuca, Clarke, & Power, 2006).

Various other facets of culture impact the help-seeking process, such as religious affiliation/spirituality and immigrant status. For instance, Villatoro, Morales, and Mays (2014) examined aspects of family culture within the Latino community that impacted mental health help-seeking behavior and utilization. Findings indicated that "Latino families who engaged in high levels of *behavioral familismo,"* or behaviors associated with attitudes valued by the family, were "more likely to seek informal or religious assistance in response to emotional difficulties rather than formal mental health services to reduce the likelihood of bringing shame upon their family" (p. 355). Villatoro, Dixon, and Mays (2016) proposed increased utilization of faith-based organization in the delivery of mental health services as means to reduce disparities in the treatment of Latino families. Additionally, while recent efforts have been made to improve access to mental health services for low-income underserved populations, undocumented immigrants are largely unable to benefit from the Affordable Care Act, excluding approximately one million children from obtaining appropriate health care coverage (Villatoro et al., 2016; Wallace, Torres, Sadegh-Nobari, Pourat, & Brown, 2012).

Minority groups in the U.S. are at risk for compounded sociocultural barriers to mental health services. In addition to the varying help-seeking attitudes across and within races, ethnic groups, and religions, minority groups are subjected to *double stigma,* which Gary (2005) defines as the detrimental outcome related with the discrimination experienced by minority group persons living with a mental health disorder. For these individuals, ethnic stereotypes in it of themselves serve as deterrents to seeking mental health treatment. In addition, various cultures "perceive mental illness as shameful and threatening of a family's status or reputation" within

their ethnic community (p. 987). “Parents/families of children suffering from mental health difficulties often experience guilt” related to difficulties obtaining adequate treatment within their community (p. 988). The stress of having a child suffering from mental health difficulties is often compounded for ethnically diverse families due to the additional stigma and secondary emotions of guilt and shape, which may further discourage them from seeking mental health treatment altogether.

The impact of sociocultural barriers is reflected in the significant racial and ethnic differences in mental health services utilization for high-risk youth (Garland et al., 2005). Garland and colleagues found that non-Hispanic white youths received more mental health services when compared to Asian America, African American, and Latino youth. Further, “youth involved with the police and/or juvenile justice system were significantly less likely to access professional mental health services, and were more reliant on informal services” (e.g., counseling from clergy, services from alternative healers; p. 1342).

In sum, various cultural factors, including race/ethnicity, gender, religion and spirituality, and immigration status, impact the treatment seeking process for children and families in need of mental health services. Moreover, the historical experiences of racism and discrimination may often compound the existing sociocultural barriers that exist for families today. As such, the sociocultural context of each child and family must be considered by providers across the various services systems involved in the treatment seeking process.

Factors that Reduce Barriers to Youth Treatment

Barriers to youth treatment have been widely established, and researchers have turned their attention to reducing such barriers to promote evidence-based services utilization. Much of the attention has been directed to systems barriers faced by youth, as these systems are

instrumental for service initiation and treatment retention.

Three factors associated with overcoming barriers within the school system have been identified in the literature (Langley, Nadeem, Kataoka, Stein, & Jaycox, 2010). The researchers proposed increased organization within the school system as the first step towards the reduction of barriers to treatment. More specifically, Langley and colleagues (2010) advocate for increased coordination and collaboration between individual school administration and district personnel to facilitate greater organization between systems. Subsequently, researchers recommended increased communication and networking between the schools and clinicians within the community providing evidence-based treatments to children and adolescents. Langley and colleagues (2010) suggested that increased collaboration between schools and providers would facilitate the school system's ability to bring evidence-based treatments to school setting. Finally, researchers advocated for increased administrative support for the implementation of evidence-based mental health treatment to reduce the numerous barriers to services utilization for youth.

In addition to the above three factors, communication between the home and school environments is essential to the reduction of barriers to treatment to youth in need. A comprehensive study on parent-teacher agreement on childhood mental health difficulties across 21 societies found significant discrepancies between parent and teacher reports (Rescorla et al., 2014). More specifically, while parents and teachers both were less likely to endorse internalizing problems, such as sadness, anxiety, and somatic complaints, discrepant reporting of externalizing problems (e.g., aggression, rule-breaking) occurred between parents and teachers across all societies included in the study. The findings highlight the importance of obtaining teacher and parent report of child symptomatology/behaviors and facilitating increased communication between the home and school systems when treating youth. Further, due to the

high frequency of disagreement on child mental health needs, Azad, Kim, Marcus, Sheridan, and Mandell (2016) suggested the implementation teacher and parent training programs that teach collaborative problem-solving strategies to reduce barriers to treatment in increase treatment utilization.

Within the parent/home system, research shows that parental involvement throughout their child's treatment is crucial to treatment initiation and treatment effectiveness. As Taylor and Adelman (2001) pointed out, parents who do not feel "a sense of commitment" (p. 219) are less likely to keep their children in treatment or to encourage the child's continued participation throughout the process. Parental involvement in treatment has been correlated with an increase in their child's psychological well-being over time and a lower likelihood of early termination (Liang, 2010). Moreover, increased parental motivation is a predictor of greater treatment adherence and retention, which suggests that efforts to foster parental engagement are important to yielding better treatment outcomes among youth (Chaffin et al., 2009; Nock & Kazdin, 2005; Nock & Photos, 2006). In recent years, interventions have proven effective at increasing treatment attendance and adherence by providing parents with psychoeducation about the treatment process and helping them to identify and preemptively plan for potential barriers that might come up (Nock & Kazdin, 2005). Thus, there is a strong need for increased application of interventions addressing parent/home system barriers to promote positive therapeutic outcomes.

Research regarding strategies to reduce sociocultural barriers youth mental health treatment recommended racial or ethnic matching, or concordance, between providers and families as means to improve treatment utilization and decrease premature treatment dropout (Flicker, Waldron, Turner, Brody, & Hops, 2008; Ward, 2005). Because concordance is not always feasible, cultural competences among providers is strongly emphasized to mitigate the

effects of barriers to treatment. Cardemil and Battle (2003) found that open dialogue about issues of race and ethnicity early in the treatment engagement process promoted trust within the therapeutic relationship and ultimately led to improved treatment progress. Similarly, research indicated that provider knowledge on culture-specific issues of racism and discrimination have also facilitated improved treatment engagement (Chang & Berk, 2009). With regard to child treatments for ethnic minority groups, increased treatment adherence was associated with provider consideration of family values, cultural factors, and strengths in the development of the treatment plan (Stormshak et al., 2011). Consistent attendance and treatment adherence for ethnic minority families was also associated with provider efforts to reduce logistical constraints through considerations regarding parent work schedules, childcare needs, and transportation.

Treatment Engagement

Treatment engagement is a construct that lacks clear operationalization throughout the research (Staudt, 2007). Various terms have been used interchangeably to describe treatment engagement, including but not limited to client attendance, involvement, participation, commitment, buy-in, and retention (Ellis, Lindsey, Barker, Boxmeyer, & Lochman, 2013). Recent efforts have been made to conceptualize treatment engagement to fully encompass the array of terms that have been cited in the literature as markers of engagement.

Researchers have examined the multifaceted construct of treatment engagement and identified two primary components, the behavioral and attitudinal components (Morrissey-Kane & Prinz, 1999). Staudt (2007) defined behavioral engagement as the client's performance on tasks required to provide treatment, such as treatment attendance, completion of homework, and discussion of feelings, which in turn leads to achieved treatment outcomes. "Attitudinal engagement is the resulting emotional investment in treatment from the belief that treatment will

be result in the belief that treatment will beneficial" (p. 185). A family's attitudinal engagement has been found to mediate their behavioral engagement. Thus, research indicates that the multiple factors that impact attitudinal engagement, such as barriers to treatment, familial stressors, perceptions of treatment efficacy, the strength of the therapeutic alliance, and treatment satisfaction, should be addressed to improve to improve overall treatment engagement (Becker et al., 2014).

Recent literature on treatment engagement highlights the importance of conceptualizing engagement as an ongoing dynamic process that continually influences the relationship between the practitioner/therapist, the child client, and family (Becker et al., 2014; Ellis et al., 2013; McGinty, Diamond, Brown, & McCammon, 2003; Staudt, 2007). The process of treatment engagement begins with the recognition of a child's mental health problems by instrumental adults (e.g., parents, teachers) in their lives (first engagement phase; McKay & Bannon, 2004). The subsequent phases involve connecting children in need and their families with appropriate mental health resources (second engagement phase) and ensuring that the child in need is receiving services (third engagement phase). The extant literature primarily focuses on the third phase of the engagement process, once a child has entered treatment. It is during this phase that the above definition of treatment engagement, including the attitudinal and behavioral components, becomes relevant. Substantially less is understood about the first and second phases of the engagement process.

Programs Designed to Decrease Barriers and Increase Engagement

The significant barriers to treatment identified for children and families have prompted researchers and practitioners to develop programs meant to improve the treatment engagement process at all stages, from problem identification/recognition to treatment utilization and

retention. Lukens and McFarlane (2004) found that psychoeducation has been an effective evidence-based practice that significantly bolsters treatment engagement, particularly as these models reduce stigma and isolation associated with mental health concerns. Given the research on the efficacy of psychoeducational interventions, specific criteria for empirically supported psychoeducational programs has been developed, which include a clearly delineated outline of intervention or treatment manual (Chambells & Hollon, 1998; Task Force on Promotion and Dissemination of Psychological Procedures, 1995).

Psychoeducational programs can be conceptualized as universal, selective, or indicated prevention. Specifically, universal prevention applies to programs that aim to improve the mental health of all individuals within a population or society in general (Gordon, 1983; Mrazek & Haggerty, 1994). Selective prevention refers to programs designed for individuals who have a significantly higher chance of developing a mental disorder than most people — those termed at-risk for mental health problems. Finally, indicated prevention targets individuals showing early signs of mental illness and aims to prevent the worsening of conditions after an individual has exhibited distress and impairment (Leavell & Clark, 1965). Much of the existing literature has focused on psychoeducational programs that sustain youth in services once they have initiated treatment for specific psychological disorders. Although fewer programs have focused on the earlier phases of engagement involving the identification of children in need of services and the provision of appropriate referrals (Herman, Reinke, Stormont, Puri, & Agarwal, 2010), several existing programs that are conceptualized at various prevention levels (e.g., universal, selective, indicated) have met with promising findings.

Indicated Psychoeducational Programs. The Multi-Family Psychoeducational Group (MFPG) Therapy Program is one example of an indicated psychoeducational program (Fristad,

Gavazzi, & Soldano, 1998). The MFPG targeted children diagnosed with various mood disorders and their families and focused on alleviating symptoms, improving coping, enhancing familial communication, and expanding social support systems/resources. The program format included eight group family sessions, with smaller break out youth groups. As means to reduce barriers to treatment and improve program feasibility, sessions were offered in the afternoons and evenings to account for varying family schedules. Program evaluation results revealed improved family climate, indicated by improved parent and child attitudes and behavior towards one another (p. 399). These results were found immediately following the conclusion of the program and at a four-month follow-up and were particularly robust for father participants.

The MFPG Therapy Program was later modified for children with the specific diagnoses of bipolar disorder and major depressive disorder/dysthymia (Fristad, Gavazzi, & Mackinaw-Koons, 2003). The modified program was implemented in 16 individual family psychoeducational sessions with parent and child sessions alternating weekly. Additionally, parents joined their children at the beginning and end of each child session. Findings revealed that child participants significantly increased knowledge about symptoms of both disorders, use of support services, and report of parental support.

Another indicated psychoeducation program was developed for parents of youth ages 5-18 diagnosed with ADHD (Ferrin et al., 2013). The program format included 12 group sessions, with the first nine weeks focused on psychoeducation on the disorder and the last three weeks focused on teaching behavioral management strategies for ADHD symptoms and defiant behavior. Program evaluation revealed high parent satisfaction due to the improved attention and concentration and increased pro-social behaviors of their children.

Russell, John, and Lakshmanan (1999) developed an indicated unnamed

psychoeducational program for parents of children below the age of 13 years with intellectual abilities. This program was implemented over the course of ten weekly sessions to the parents only. The program significantly increased parental knowledge about intellectual disability, improved parental attitude toward child rearing, and management of their child's disability.

Selective Prevention Programs. Webster-Stratton (2011) developed a comprehensive selective prevention program called Incredible Years (IY), a training series for children with conduct, attention, and internalizing problems, as well as for their parents and teachers. The IY program targets families at greater risk for mental health difficulties due to the compounded effects of multiple risk factors, including financial disadvantage and involvement with child protective services or foster care system. Webster-Stratton (2011) developed varying curricula for the differing age groups of the children (i.e., baby, toddler preschool-aged, and school-aged). The program format for the parent training series varies in length (9-20 weekly group session) based on the group needs, with extended programs for families at greater risk. The program format for the teacher training program includes monthly workshops across a six-month period with the goal of enhancing classroom management skills of teacher participants. Incredible Years has been primarily utilized as a selective prevention program; however, the program can also be delivered as a universal prevention program. The IY selective prevention training series for children is intended for children identified with a conduct, attentional, or internalizing problem and is conducted in a group format across 18-22 weeks in an outpatient setting. The universal prevention component is delivered within the preschool and early primary grade classroom setting for all students two to three times per week throughout the school year. Although IY has gained mounting support as an evidence-based practice for young and school-aged children, community providers and school systems have cited difficulties with implementation of the

comprehensive program, despite the strategies prescribed by IY creators (Webster Stratton & Herman, 2010).

Efficacy studies of the IY program suggest significantly reduced disruptive behavior and increased prosocial behavior in children whose parents completed the indicated intervention program (Menting, de Castro, & Matthys, 2013). Effects were less robust for children whose parents completed the universal prevention program, in part likely due to the lower levels of change from pre-treatment to post-treatment. Teachers who completed the teacher program reported significantly increased use of positive behavior management strategies, increased perceptions of the usefulness of these strategies, and increased overall confidence in their ability to manage classroom behavior problems (Fergusson, Horwood, & Stanley, 2013). Children who participated in the child training program showed significant improvement in their problem-solving ability and conflict-management skills; however, the most significant and sustained improvements in child behavior were found in studies that combined either child or teacher training with parent training (Webster-Stratton & Herman, 2010).

Universal Prevention Programs. Few universal prevention programs targeting general youth populations have been developed thus far. Rocco, Ciano, and Balestrieri (2001) sought to reduce the prevalence of eating disorders in adolescent girls and developed a universal prevention program focused on promoting healthy body images and normalizing typical developmental transitions. The program format included monthly group session over a nine-month period. The program was delivered to female students in the first, third, and fifth grades. Program participants demonstrated reduced feelings of ineffectiveness, anxiety, and fear related to maturity and decreased bulimic attitudes as compared to students in the control group (i.e., female students in second and fourth grades).

Similarly, Cohen and Irwin (1983) developed Parent-Time, a universal psychoeducational program for parents of adolescents ranging in age from 11 to 14 years. The program was offered as a series of 90-minute sessions held over five consecutive weeks. The program provided support, information, and problem solving techniques that parents of adolescents could use during their child's particularly stressful transition period into adolescence. Rather than focusing on identified problem behaviors or symptoms, the program aim was to support families through their child's transition through this normative developmental stage. Parents who completed the program reported benefiting from learning about normative adolescent behavior, experienced increased feelings of self-confidence in their parenting skills, appreciated the need for listening and limit setting for their adolescents, and honed the ability to share concerns regarding their children.

Parents as Teachers of Safety (PaTs) is another universal psychoeducational program developed for young children (ages 3-5) and their parents (Kenny, 2009). The program aimed to prevent childhood sexual abuse. The program format included biweekly group session over the course of an eight-week period with paralleled parent and child groups. Child participants of PaTs demonstrated increased knowledge of sexual abuse and safety behaviors. Parent participants reported improvements in their child's assertiveness skills and communication about sexual abuse following treatment.

The Family Check-Up (FCU) model is designed to provide parents and children with school-based mental health support at various levels of the continuum, including universal, selected, and indicated (Herman et al., 2010). At the universal level, this prevention program offers all students and their parents resources and services for a wide range of topics including parenting skills and children's mental health. The FCU includes three meetings with a child's

caregivers and involves assessment, feedback, discussion, and goal-setting (Stormshak, Fosco, & Dishion, 2010). The goal of the program is to assist families in examining their functioning and identifying changes needed to improve the family's functioning. Such changes may include seeking further mental health services or resources (e.g., family therapy, individual therapy, self-help books) or making specific behavioral changes within the family (e.g., scheduling regular family activities; Uebelacker, Hechet, & Miller, 2006). According to Herman and colleagues (2010), the FCU "serves as a service entry tool for connecting parents to other evidence-based programs" (p. 663). Findings reveal that participation in the program led to significant improvements in self-regulation skills, reductions in depressive symptoms, and increased school engagement among youth (Stormshak et al., 2010).

What Works in Engagement Programs?

Research evaluating factors that facilitated familial treatment engagement and retention for children in need identified commonalities across programs that successfully reduced barriers to treatment (Ingoldsby, 2010). Of note, all programs evaluated in the study were utilized after a child had already entered treatment and focused on treatment retention. All successful program utilized a family-centered approach and made considerations for the individual needs, concerns, and barriers to treatment of the family participants. In addition, increased treatment engagement was associated with early and consistent attention on the engagement process throughout the program intervention with all family members involved. Moreover, Ingoldsby (2010) found that families responded well to the inclusion of strategies to enhance family support and coping. Lastly, programs that facilitated improved familial engagement utilized motivational interviewing strategies and were rooted in a strong theoretical framework. Researchers promote the inclusion of these general strategies to enhance family engagement and retention in child

mental health programs.

A Universal Psychoeducational Program for Parents and Teachers

The existing literature suggests that psychoeducational programs are effective at reducing barriers to service utilization; however, the majority of programs studied have focused on retaining children in services once they have already initiated treatment with less emphasis on the earlier phases of the engagement process, which includes problem identification and treatment-seeking attitudes and behaviors. Similarly, most of the psychoeducational programs surveyed are at the level of selective or indicated prevention, with relatively fewer programs developed at the level of universal prevention. In addition, many programs do not involve more than one major stakeholder of youth mental health care, and are designed for implementation for either parents or teachers—not both.

The current study aims to develop a universal psychoeducational program geared towards parents and teachers of school-aged children with the purpose of increasing knowledge on common childhood difficulties and behavior management strategies to address these issues. The researchers propose separate paralleled programs for parents and teachers within the public-school system with participant-specific manuals. The psychoeducational program is scientifically driven and grounded in evidence-based techniques for youth with mental health difficulties. The overarching aim is to reduce stigma associated with mental health issues and treatment. In sum, the program strives to aid teachers and parents in the recognition of problem behaviors and possible symptomatology and referral for professional mental health services. It is posited that the psychoeducational program will narrow the gap between youth mental health need and treatment utilization by facilitating the early stages of the help-seeking and engagement process.

The present program utilizes a modular approach consistent with the definition of

modularity proposed by Chorpita, Daleiden, and Weisz (2005), which promotes "breaking complex activities into simpler parts that function independently" (p. 142). The manualized intervention is divided into five stand-alone modules, each focused on a different childhood difficulty to enhance the utility of the program. Psychoeducational content and evidenced-based techniques included in each module will be specifically relevant to the emotional or behavioral issue of focus. While parents and teachers are encouraged to attend the full workshop series, they can also attend only the module that they find relevant for them and their students, thus increasing the feasibility of program attendance for busy adults.

Please contact the researchers, Genevieve Lam and Erika Rajo, to view the psychoeducational manual.

Hypothesis for Investigation

Researchers conducted quantitative and qualitative evaluations of the proposed psychoeducational program and manual to obtain comprehensive feedback on its feasibility and utility to enhance teacher knowledge of common childhood difficulties and strategies to manage associated behaviors. Teachers were selected for examination in this study because they serve as primary gatekeepers to the treatment of children suffering from mental health difficulties. Given the sheer amount of time students spend in schools, policymakers have recommended that teachers be an "active partner in the mental health care of our children" (President's New Freedom Commission on Mental Health, 2003, p. 53; Walker, 2004). While the mental health needs of school-aged children are apparent, 70% of children diagnosed with a mental illness receive inadequate treatment or do not receive treatment at all (Tashman, Waxman, Nabors, & Weist, 1998). Due to the unique position teachers have in the lives of their students, it is imperative that teachers gain training in empirically supported tools to remediate the impact of

childhood difficulties in the classroom (Koller & Bertel, 2006).

Teachers play a key role in understanding mental health needs and are critical to the referral process, as many childhood difficulties manifest through emotional and/or behavioral problems in the school setting (Reinke, Stormont, Herman, Puri, & Goel, 2011). While teachers serve an instrumental role in the lives of school-aged children, parents are ultimately responsible for following up with referrals for service and must both consent to the treatment of their child and participate in the therapeutic process. As such, a parallel study examined the effectiveness of a manualized psychoeducational program for parents, while the present study aimed to evaluate teacher perspectives on the effectiveness of a manualized psychoeducation program for teachers. The objective was to explore teacher responses to the psychoeducational program and to obtain information about how to improve the contents of the manual as well as facilitate administration of the program to teachers in the community; therefore, no specific hypotheses was formulated.

Methods

Description of the Program

The psychoeducational program was designed for teachers of early school-aged children in the public-school setting. The manualized intervention was designed to provide teachers with knowledge of emotional/behavioral (E/B) issues common during childhood, empirically-based strategies for managing such difficulties in the classroom, and information regarding when and how to refer students in need to mental health services. The program includes five distinct modules that can each be implemented as stand-alone sessions or as part of a sequence of psychoeducational sessions: (a) Social Skills, (b) Disruptive Behaviors, (c) Internalizing Behaviors, (d) Attention/Concentration Difficulties, (e) Staying Connected with Your Students. Two parallel manuals were created for each module, a manual designed for use by the facilitators, which includes additional instructions and prompts to lead the group effectively, and a manual designed for use by the teacher participants in which they can make notes and keep for their review. Each module was designed to be conducted within a 60 to75-minute group session and is structured to include a didactic portion, group activities to enhance learning and retention, and semi-structured discussion. Content included in each module was developed through a comprehensive review of the literature on evidence-based psychoeducation and intervention practices of childhood E/B issues (see Appendix A for extended review of the literature). The structure of the manual including subsections (e.g., purpose of session, agenda) and provider instructions were based on the Community Partners In Care (CPIC) Cognitive Behavioral Therapy program manuals, a project for which the dissertation chair was a research investigator (Miranda et al., 2008). The present study aimed to examine potential barriers of teacher attendance to the psychoeducational program and to assess the usefulness and ease of

implementation of specific manual content.

Research Design

In order to evaluate which aspects of a newly developed manualized intervention were effective and which areas needed to be improved upon, the researchers determined that a mixed-methods approach should be utilized for the present study. Through using a mixed-methods design, the researchers benefited from applying both qualitative and quantitative approaches to enrich the study design as well as the data collection, analysis, and interpretation processes (Johnson, Onwuegbuzie, & Turner, 2007). Such a mixed-methods design, which was rooted in grounded theory, was conducive to the researchers' overarching goal of learning more about the psychoeducational program through the collection of data without having an established hypothesis (Cunningham, Weathington, & Pittenger, 2013). This approach was employed from the outset of the present study, as it was determined that both quantitative and qualitative data would provide valuable information relevant to the specific study aims. Thus, both quantitative (i.e., self-report questionnaire) and qualitative data (i.e., focus group interviews) were collected for all participants to explore teachers' perspective of the proposed intervention. A mixed-method analysis was conducted using Microsoft Excel. Once the collected data was coded and prepared for an inductive content analysis, the researchers began to search for the implications of the data as it pertains to the proposed intervention.

Recruitment

After obtaining full Institutional Review Board (IRB) approval, teacher participants were recruited for the study (see Appendix B for IRB notice of approval). The first step in the recruitment process included contacting the principal of a public elementary school within Los Angeles county via letter requesting permission to conduct a teacher focus group examining

perspectives on the psychoeducational program (see Appendix C for recruitment letter). Once permission was granted, the researchers allowed school administration to disseminate information regarding the focus group how they deemed appropriate. The researchers worked collaboratively with the principal to schedule a date for the focus group convenient for the interested teacher participants. In the in-person meeting, research associates provided an overview of the project, emphasized the voluntary nature of participating in the study, and informed participants that they could withdraw participation at any time. The consent form (see Appendix D), accompanied by a script (see Appendix E), was reviewed in its entirety with each participant. The script that was utilized to review the consent form once again emphasized the voluntary nature of participating in this study as well as the option to withdraw at any time. Additionally, confidentiality and their limits were reviewed. Participants were informed that research associates will take all reasonable measures to protect the confidentiality of their records; however, under California law, there are exceptions to confidentiality, including suspicion that a child, elder, or dependent adult is being abused or if an individual discloses an intent to harm him/herself or others. Participants were informed that, in the above cases, the researchers are mandated by law to report these issues to the proper authorities, including but not limited to the police department, child protective services, or elder protective services. Prior to participating in the study, each participant was provided with a copy of the consent form. The participants provided verbal consent to participation as means to minimize unnecessary identifiable information collected through written documentation. Participants were provided with a $15 gift certificate to Starbucks for their participation.

Data Collection and Interviewing

All data collection was gathered through one focus group (4 participants) conducted by

two research interviewers (a Psy.D. doctoral student and her dissertation chairwoman) in February 2016. During the interview, each participant completed a self-report questionnaire and provided narrative answers to verbal questions. The entire interview and questionnaire completion process lasted approximately 60 minutes.

Demographic questionnaire. The first step of the data collection process involved the distribution of a brief questionnaire containing both qualitative and quantitative items to be completed independently by participants. The demographic questionnaire (see Appendix F) asked teacher participants to report the following information: age, gender, race/ethnicity, preferred language, education attained, years taught, grades taught, current grade taught, type of school setting of their current place of employment, current classroom size, number of classroom aides, additional teaching credentials earned, and previous training in childhood mental health.

Group interviews. The second part of the data collection process involved a focus group interview with four teachers conducted by the two researchers described above. Interviews followed a standard protocol containing a semi-structured interview script (see Appendix G for interview protocol). Interviewers read aloud open-ended questions directly from the script and participant responses were recorded using a digital recording device. The questions posed to participants pertained to their perspectives of the presented manualized intervention program, including the feasibility of implementing the program and the usefulness of the manual content. For instance, participants were asked to discuss why they think the psychoeducational program would/would not be useful for other teachers and how to conveniently schedule workshops for teachers to attend during the school year. Participants were also asked to discuss any potential barriers to adopting the program in a school setting as well as possible solutions for addressing these barriers. Additionally, participants were asked about perceived strengths and weaknesses of

the program in general and with regards to the program manual content. Lastly, the interviewer inquired specifically about potential benefits of the program (i.e., practical behavioral management strategies to use in the classroom, more accurate identification of/referrals for children in need of psychological services).

Quantitative self-report data. The final step of the data collection strategy involved the distribution of a brief written quantitative questionnaire, which was completed individually by each participant. The teacher participant questionnaires were developed through a collaborative effort by the research team members to generate questions eliciting feedback on and reactions to the proposed program using a Likert scale (see Appendix H for quantitative questionnaire).

Participants

Teacher participants. Participants were recruited for the study if they currently worked at an elementary school within the Wiseburn Elementary School District (WESD), a lower to middle income public school district in Southern California. The students of the WESD are ethnically diverse (Multiracial 7%, Asian 6%, Caucasian 15%, African-American 14%, and Latino 58%). According to the United States Census Bureau in 2015, the WESD is more ethnically diverse than the population of Los Angeles County, with greater numbers of Latino and African-American students represented in the sample. Persons of all ethnicities, genders, sexual orientations, and religious backgrounds were permitted to participate in the study. Participants were excluded from the study if they do not currently work in an elementary school within the WESD.

Teacher participants included a total sample of four teachers from Juan Cabrillo Elementary School, a local public elementary school in the WESD. Specific information regarding teacher participants was gathered and reported utilizing their responses to the Teacher

Demographic Questionnaire. The participants included three current public elementary school teachers (75%) and one former public elementary school teacher currently working as the school counselor (25%). All participants were female (100%) and identified their language preferences as English (100%). The participants included three White participants (75%) and one Hispanic or Latino participant (25%). Participant age ranged spanned from 27 to 41 (M = 36.0, SD = 6.38). The participants' educational backgrounds were composed of 25% master's degrees and 75% 4-year college degrees. Participant teaching experiences ranged from 2 to 17 years (M = 9.5, SD = 8.10). With regard to their respective years of experiences, two participants taught two different grade levels (50%), one taught three (25%), and another taught six (25%) different grade levels. Current grade levels taught by participants included pre-K, first grade, and second grade. One participant did not respond to this item as she currently works as the school counselor. Current classroom sizes of the 3 teacher participants ranged from 22 to 24 students (M = 23.33, SD = 1.55). One teacher participant currently had 2 classroom aids (25%), whereas the other two teacher participants had one each (50%). All participants (100%) taught in a public school setting throughout their teaching careers. All participants (100%) held at least one valid teaching credential. Two participants held a Multiple Subject Credential, one participant (25%) held a Bilingual, Crosscultural, Language and Academic Development (BCLAD) credential, and another participant (25%) held multiple credentials (i.e., Multiple Subjects Credential and Crosscultural, Language and Academic Development [CLAD]). One participant endorsed having additional training related to childhood mental health (25%; e.g., Master's Degree in School Counseling).

Research team. The research team was composed of three individuals—two doctoral level psychology graduate students, who acted as coders, in addition to an assistant professor of

psychology and the dissertation chair who served as the auditor. Researchers evaluated each of their backgrounds to address any potential biases and desired outcomes to the current study.

The primary researcher on the study is a 27-year old, Asian-American female doctoral student in clinical psychology. She was raised in Southern California in a lower middle-class family, the elder of two siblings of divorced parents. Throughout her primary and secondary school education, she attended small, private Catholic schools with ethnically diverse student bodies. Throughout her upbringing, she was exposed to the various religious backgrounds of her parents (i.e., Buddhism, Catholicism) and was raised Catholic. She currently identifies as agnostic and does not engage in any religious or spiritual practices. Her cultural background, familial experience with childhood mental health issues, and clinical training has shaped her understanding of the many barriers to treatment that impact a family's treatment-seeking process. She firmly believes that every child and family deserves access to cost-effective, culturally competent mental health services.

The second researcher is a 30-year-old, Latina female clinical psychology doctoral student. She was born and raised in New Orleans, Louisiana and has lived in Maryland and California during her graduate school years. She comes from a lower middle-class family, has one younger sibling, and both of her parents immigrated to the U. S. before the age of ten (her mother from Cuba and her father from Honduras). Her parents divorced when she was 16 years old and neither has since remarried. She attended Catholic school from Kindergarten through college. Although she does not currently practice any religious faith, she believes in a higher power. Her parents have always promoted open communication regarding both practical and emotional difficulties. Her family also values the process of therapy; however, she has encountered many families who view psychological treatment as a sign of weakness due to

limited knowledge of mental health. She believes everyone should have access to information about mental health in general as well as psychological services available so that they can make informed decisions.

The auditor is a 37-year-old, Chinese-American female assistant professor of psychology and licensed psychologist who is the dissertation chair for this project. She is board certified in Clinical Child and Adolescent Psychology by the American Board of Professional Psychology. She was born in Taipei, Taiwan, immigrated to the U. S. at the age of eight, and has lived in various cities in New York and California. As a child, she was raised in a working, lower class family until her adolescent years when her parents' hard work resulted in a financially stable environment, they became part of the upper income class. She was educated in the public-school system throughout her upbringing. Her parents have been married for 36 years. She was raised with spiritual beliefs, has pursued Catholicism actively since she was 18 years old, and currently actively participates in her faith community in Los Angeles, CA. She understands the stigma and various barriers in the mental health help seeking pathway and believes that everyone should have access to effective evidence-based care regardless of their socioeconomic status or severity of mental illness.

Transcription

The first and second researchers (Genevieve, the 27-year-old Asian American female, and Erika, the 29-year-old Latina) served as transcribers for the research study. The auditor of the study trained each transcriber on a system adapted from the University of Washington's Thesis manual to ensure verbatim transcription of all audio recordings of the focus group session. More specifically, each transcriber utilized a standardized template, which listed the time stamp in the first column and the verbatim questions and comments of the interviews and

responses provided by the teacher participants in the second column. The first transcriber was responsible for transcribing the audiotape and the second transcriber subsequently reviewed and edited the transcript. Lastly, the auditor reviewed the transcript for a second time against the audiotape to ensure accuracy and finalized the transcript. Please refer to Appendices J and K for transcription template and training protocol, respectively.

Coding

Two doctoral level psychology graduate students (who were the primary researchers for this study) served as the coders for this study. Their dissertation chair and research supervisor served as the auditor. The auditor provided the coders training on essential concepts, terms, and issues relevant to the current study. The coders received additional individual training on techniques of the coding method utilized in this study. The researchers and auditor each coded the transcript separately throughout the coding process.

Human Subjects/Ethical Considerations

Considerations regarding confidentiality and ethical standards for research participants were made throughout the study. For instance, the limits of confidentiality for interviews and for research database inclusion were reviewed at the outset of the focus group with the teacher participants. Researchers provided all participants with informed written consent to participate in the interview (please see Appendix D for informed consent form). No identifying information was collected on the interview documents to preserve confidentiality. Instead, participants were provided a research identification number (RIN) upon enrollment to de-identify them for research purposes (Mertens, 2009). Additionally, all research team members who handled data in the research database completed an IRB certification course (see Appendix K for IRB certificates). Moreover, researchers/coders completed a Health Insurance Portability &

Accountability Act of 1996 (HIPAA) course prior to accessing research database content to endure adequate adherence to ethical standards of participant research and handling of confidential health information. Lastly, researchers took steps to maintain confidentiality by ensuring that research coders did not personally know the teacher participants prior to the study.

Research Bias and Quality of Study

The first researcher also served as a focus group interviewer and was individually trained by the study auditor based on standardized instructions for conducting interviews to ensure the quality of the study. In addition, the researchers and the auditor considered potential biases that might have impacted coding procedures by proactively explored their own biases and expectations of the study by discussing their preconceived notions about participants' potential responses. Furthermore, the researchers and the auditor acknowledged factors from their own personal and clinical experiences that may have influenced expectations of the current study. The purpose of such discussion was to minimize the effect of researcher bias on coding procedures and promote objective coding of data. To enhance the quality of the study further, the researchers continued to practice reflexivity throughout the coding and analysis phases of the study by asking themselves a series of questions and subsequently reflecting on how their answers may impact the data as well as the data analysis (Miller & Brewer, 2003). Engaging in the reflexive process throughout all stages of the study allowed the researchers to maintain awareness of any ethical issues to consider and broader social constructs that may have influenced the findings.

Reliability. Coding was conducted on the audio transcript by three doctoral-level raters and by the auditor of this study using Microsoft Excel. Lombard, Snyder-Duch, and Bracken (2002) suggested that Kappas of .80 or greater are considered acceptable interrater reliability in most situations, while scores of .70 are often deemed acceptable levels for exploratory

qualitative research. The process of calculating intercoder reliability involves examining the degree to which coders agree on a set of units (Kurasaki, 2000). Hruschka and colleagues (2004) found that coding teams produced significantly different codes during the initial coding phase; however, through codebook revisions and recoding, research teams have established strong intercoder reliability. In the present study, two rounds of inter-rater reliability tests were conducted to achieve a Kappa of .80 or greater. In the first round of inter-rater reliability where strands were selected from the transcript for testing amongst the three researchers (two coders and one auditor), Kappa values ranged from less acceptable (<.70) to good reliability (>.80) for various codes. After another discussion amongst the coders and a more thorough review of the codebook definitions for each code, new strands of the data set were selected from the transcript for re-testing amongst the three researchers. All calculated Kappa values after the second round of interrater reliability testing were higher than >.80 between each researcher pair (coder 1 and auditor, coder 2 and auditor, and coder 1 and coder 2).

Procedures for Analyzing Data

The current study utilized qualitative data analysis procedures to code and extract conclusions from the collected data. Researchers coded the transcript using Microsoft Excel. After preparation of the transcript, the coders engaged in inductive content analysis, a process of examining the data for main themes that emerge from the teacher participants (Elo & Kyngas, 2008; Hsieh & Shannon, 2005; Zhang & Wildemuth, 2009). Researchers subsequently coded the raw interview data by establishing a consensus about the units to be coded, coding all the text units, developing categories, and finally drawing conclusions about the coded data by consolidating the codes into overall categories. Three occurrences of a theme were required to qualify as an individual code. In accordance with guidelines for qualitative data analyses,

inductive content analysis was conducted through a three-part process involving open coding, category creation, and abstraction (Elo & Kyngas, 2008).

The three researchers (including the auditor) began the open coding process by reading through each transcription, making notes and writing down thoughts and ideas as many times as necessary until each felt that she captured the essential descriptors to describe aspects that answered the research questions (Elo & Kyngas, 2008).

Subsequently, the two graduate student researchers independently grouped similar codes and generated category labels for each grouping. Guided by the research questions, the researchers coded the data by searching for themes in teacher feedback on the psychoeducational program. The researchers subsequently submitted the concept groups to the auditor for review and feedback to identify idiosyncratic analyses or mislabeled data (Hsieh & Shannon, 2005). The auditor reviewed the categories and codes and examine notes taken during the coding process to ensure reliability of the researchers' process and findings through evaluation of dependability and confirmability (Zhang & Wildemuth, 2009). The auditor separately coded the transcribed data and note her own thought processes. Next, the auditor reviewed the data and identified areas of agreement with the researchers' codes and areas for further thought. After a consensus was established among both researchers and the auditor regarding organizing and coding the data into concept groups, the researchers and auditor each independently coded the transcript and identified concepts that occur throughout the data. Subsequently, sections of the transcript, such as words or phrases, were assigned to represent a concept or a theme.

Following coding, the two graduate student researchers organized these groups hierarchically and identified Parent Themes that described one or several concept groupings (Elo & Kyngäs, 2008). The researchers compared the themes that were identified and agreed upon

ways to collapse the categories into larger themes; that is, the researchers explored the categories initially identified, conducted cross-analysis procedures by organizing similar themes into categories, and searched for relationships between the themes and categories (Zhang & Wildemuth, 2009).

In the process of abstraction, the researcher team (graduate students and auditor) formulated general descriptions of the research topics by generating categories (Elo & Kyngäs, 2008) More specifically, the "researchers moved back and forth between hierarchical concept levels (i.e., codes, concept categories/child codes, and parent themes) to ensure all concepts were tied back to the research question" (p. 113). The two graduate student researchers subsequently submitted the theme hierarchy to the auditor for review and feedback once again to identify idiosyncratic analyses or mislabeled data (Hseih & Shannon, 2005). The auditor then reviewed the abstracted codes, concept sub-categories, and parent themes and provided feedback based on her own experience of coding transcripts, reviewing codes, and examining the data hierarchically. Following this review, the primary researcher adjusted codes/themes within the hierarchy to auditor incorporate feedback. The auditor determined final codes through a second review of the hierarchy. The coding was subsequently rechecked by each graduate student researcher for consistency and by the auditor to ensure accuracy. Basic frequencies of coded responses were determined for each theme and category using Microsoft Excel.

Researchers could not assume that the coding system they agreed upon in the data analysis phase of this study would definitively ensure that the entire body of data was coded consistently (Zhang & Wildemuth, 2009), which further stressed the importance of the checking process during the open coding and abstraction phases. The checking process minimized the impact of coder fatigue on coding, "accounted for how per-existing biases of each researcher

could have influenced how she choose coding themes, and established inter-coder verification" (p. 8).

Quantitative data analysis was conducted using Microsoft Excel. Descriptive analyses were conducted on the demographic data and quantitative self-report data of teacher ratings of the psychoeducational manual.

Results

Qualitative Findings

In the current study, four participating teachers were asked open-ended questions about responses to the psychoeducational program. The four major categories assessed from the interviews were implementation/feasibility, feedback on the program, program need, and applicable content. The most commonly identified responses to the psychoeducational program included references to implementation/feasibility, which accounted for 36% of the data, and feedback on the program, which made up 23% of the data. References to program need accounted for 21% of the data set. Finally, responses referencing applicable content made up 19% of the data set. Refer to Figure 1 for the distribution of codes between each category.

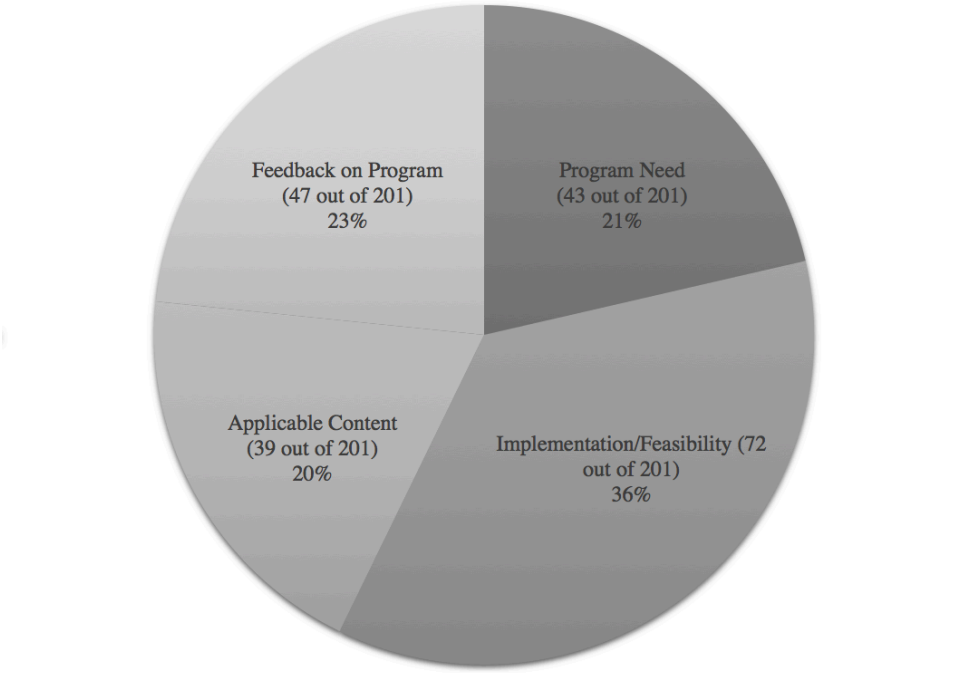

Figure 1. Category distribution chart. Chart providing the number of codes identified within each category. Numbers are provided to indicate how many codes were identified for each category out of a total of 201 codes. Percentages are also included to denote the percentage of the total data accounted for by each category.

Implementation and Feasibility. Feedback regarding implementation and feasibility of the program was the category that comprised the majority of responses to the psychoeducational program, constituting 72 out of 201 codes (72/201 = 36% of all codes). The six themes that emerged in this category of questions included *high teacher demands*, *professional development programs*, *teacher coaching*, *integration with school programs*, *modular implementation*, and *institutional support*.

The most prominent theme within this category was high teacher demands, defined as the high demands on teachers and their schedules as a barrier to implementation (see Appendix L for Table 2 [teacher codebook]). This theme comprised 32% of the codes within this category (23/72 codes = 32%). For instance, one participant stated, "Teachers are highly impacted. There's so much more curriculum and demands in terms of just what's expected of students and teachers academically…sometimes its [additional training on childhood E/B issues] seen as one more thing that I have to do." Another participant said, "They [teachers] could see the benefit of it, but in the pressure of things, I think it [additional training on childhood E/B issues] would really be on the back burner."

Many participant responses within this category related to the theme of integration with professional development programs, defined as desire for psychoeducational program to be integrated into teacher professional development programming. This theme comprised 28% of the codes within this category (20/72 codes = 28%). In response to researcher's requests for feedback regarding feasible implementation, one participant stated, "I would say that [integration into professional development days] to me would be the most feasible because it's the day where it's a pupil free day, so our full attention is on the sessions that we're in." Another participant concurred with that sentiment stating, "The staff development day would be the best."

Additionally, another portion of participant responses related to the theme of teacher coaching, defined as the provision of direct coaching to teachers in the classroom as teachers utilized skills learned through the didactic presentation of the module(s). This theme comprised 19% of codes within this category (14/72 codes = 19%). More specifically, one participant responded, "Giving teachers that time to see the material, but also get coached on it and to be able to have that support… would be a definite good component to add." One participant expressed hesitation towards that idea, questioning whether all teachers "would buy into that [implementation of teacher coaching]," but agreed that it could be an adjunctive option instead.

Another theme identified in this category was integration with school programs, defined as integration of the psychoeducational program into existing school programs targeting needs of children suffering from E/B difficulties. This theme comprised 8% of codes within this category (6/72 codes = 8%). One participant stated, "Maybe you guys start that with things we already have in place." Another participant stated, "Normally, there's some kind of social skills program that is part of the curriculum for each school or for classrooms and this would be a good way to kind of build that, curriculum [additional training on childhood E/B issues] in there."

A less commonly identified theme that emerged in participant responses was modular implementation, defined as the preference for smaller psychoeducational workshops focused on a singular topic at a time. This theme comprised 7% of the codes within this category (5/72 codes = 7%). One participant stated, "It would help to breakdown the information where it's not just one dosage of it." Another less commonly identified theme noted was institutional support, defined as support from the school and district identified as crucial to increasing the feasibility of implementation. This theme comprised 6% of the codes within this category (4/72 codes = 6%). One participant noted that "our district is very supportive of this." In sum, there was a consensus

that focusing on feasibility of implementation was highly important to the teacher participants. Refer to Appendix M for Figure M1 (Theme distribution chart for implementation/feasibility category).

Feedback on Program. Specific feedback on the program comprised a significant portion of participant responses (47/201 = 23% of all codes). Responses in this domain included aspects of the program that teachers found most helpful and yielded the following major themes: r*elevance of content*, *parent-teacher collaboration strategies*, *strength of organization/structure*, *strength of the specificity/clarity of content*, and *intervention timelines*.

The most prominent theme identified within this category was relevance of content, defined as the perspective that content included in the psychoeducational program is relevant to many students in elementary school classrooms. This theme comprised 47% of the codes within this category (22/47 codes = 47%). For example, one participant stated, "It [the psychoeducational program manual] encompassed everything that we would need" and all other participants concurred. Another participant stated that the psychoeducational program "covered what needed to be covered." Another prominent theme that emerged was parent-teacher collaboration strategies, defined as requests for the inclusion of strategies teachers can utilize to enhance the collaboration with students' parents. This theme comprised 30% of the codes within this category (14/47 codes = 30%). For instance, one participant stated that "tools to get the parent on board" would be highly beneficial for elementary school teachers. Another teacher suggested the inclusion of content on the “student-parent-teacher connection.”

Many participant responses within this category related to the theme of organization and structure, defined as teachers’ references to the organization and structure of the manual as a strength of the program. This theme comprised 11% of the codes within this category (5/47

codes = 11%). One teacher noted that “the way that you have it set up is very much appropriate to support the mental health component of the whole school site.” Another participant described the manual as “well organized.” A less commonly identified theme was specificity/clarity of content, defined as the perspective that the specificity and clarity of the content and interventions is a strength of the program. This theme comprised 6% of the codes within this category (3/47 codes = 6%). The manual was described as “very specific” and “clear.”

A less commonly identified theme within this category related to the intervention timelines, defined as requests for the inclusion of suggested timeline that teachers should attempt to utilize the learned interventions before referring a student to mental health services if little progress is made. This theme comprised 6% of the codes within this category (3/47 codes = 6%). For instance, one participant requested "a timeline…. [to] try these interventions." Another participant described that she would benefit from times by being "able to say this [intervention] is working or this is not working." Overall, teacher participants identified the relevance of the content as a major strength of the program and suggested the inclusion of additional content pertaining to strategies to improve collaboration with parents. Refer to Appendix M for Figure M2 (Theme distribution chart for feedback on program category).

Program Need. The need for the proposed psychoeducational program made up a significant portion of the focus group discussion (43/201 = 21% of all codes). Responses in this domain included reasons for which teachers believed the psychoeducational program is necessary and yielded the following major themes: *importance of psychoeducation, need for classroom-based E/B training*, *teacher responsibility*, *E/B impact on academics*, *lack of E/B training*, and *academics over E/B functioning*.

The most prominent theme that emerged in this category related to importance of

psychoeducation, defined as the importance for teachers to be educated on common childhood problems and how to manage them. This theme comprised 42% of the codes within this category (18/43 codes = 42%). One teacher stated, "It [teachers proactively learning about common childhood E/B difficulties] is very important." Another participant agreed with the above sentiment stating, "Absolutely…because everybody, every teacher, all students, all classes, have needs." Another significant theme within this category related to need for classroom-based E/B training, defined as the teachers' expressed need for skill they can utilize to manage childhood E/B problems in the classroom. This theme comprised 21% of the codes within this category (9/43 codes = 21%). For instance, one participant stated, "If you have one more tool to help you or any kinds of tools to help you, that's going to help. Another teacher stated, "Any additional information and strategies and tools that I could gain would benefit my class and classes that come after that." Despite the identified need for classroom management techniques, participant responses identified a related theme, lack of E/B training, defined as the lack of teacher training on how to manage E/B issues in the classroom. This theme comprised 9% of the codes within this category (4/43 codes = 9%). More specifically, one participant stated, "You don't get a lot of that in your teacher credential programs and things like that." Another participant stated, "When we're going through our credential program, the focus is on how to teach and how to instruct and emotional behavioral issues get covered when we can."

Another theme that emerged in this category was teacher responsibility, defined as the potential for teachers to make a significant difference in the E/B functioning of their students. This theme comprised 12% of the codes within this category (5/43 codes = 12 %). One teacher noted that "they [students] are here most of their day and they really need the support here as well." Another participant agreed with that sentiment, stating "We really need to know what's

going on with our students and if we can help them in any way that; we need to be able to help them." Another less commonly noted theme among participant responses was E/B impact on academics, defined as the impact that childhood E/B difficulties have on academic functioning. This theme also comprised 12% of the codes within this category (5/43 codes = 12%). For instance, one teacher stated, "If they're [students] coming with things to school, it affects everything. It affects how they are, how they learn." Despite the identified impact of E/B problems on academics, another related theme that emerged was academics over E/B functioning, defined as there is a tendency for academic performance to be prioritized over the E/B functioning of children. This theme comprised 5% of the codes within this category (2/43 codes = 5%). One participant stated, "Academics are at the forefront." Another teacher noted that "they [students] come to school to learn academically, but they also come to learn social skills." In general, participants noted significant need for a psychoeducational program and classroom-based intervention training. Refer to Appendix M for Figure M3 (Theme distribution chart for program need category).

Applicable Content. Throughout the focus group interview, participants identified applicable content found in the manual to the students in their classrooms (39/201 = 19% of all codes). The common themes to emerge in this category were *child emotional identification*, *referral process*, *attention/concentration*, *social skills training*, *teacher self-car*e, and *bullying prevention/intervention*.

Teachers most commonly identified the theme of child emotional identification, defined as the need for strategies included in the manual that pertained to enhancing a student's ability to label and communicate their emotions. This theme comprised 28% of the codes within this category (11/39 codes = 28%). One teacher stated, "Its [visual emotional charts] good for them,

because… they can, point to a picture" and all other participants agreed with her sentiment. Another commonly identified theme within this category was referral process, defined as the need for guidelines for teachers regarding when to refer a student to mental health intervention services. This theme comprised 21% of the codes within this category (8/39 codes = 20%). For instance, one participant stated, "I think those guidelines for…when to refer is helpful." Another teacher agreed stating, "The component at the end, when to refer for mental health …is a good break down." Teachers also commonly identified the theme related to attention/concentration, defined as the need for strategies they can use in the classroom to manage attention/concentration issues. This theme comprised 18% of the codes within this category (7/39 codes = 18%). One participant noted, "I see the ADHD and I see all of that." When queried about what teachers liked most about the program, another participant stated, "Probably for me the attention [module]."

Less common, but still notable, was the theme of social skills training, defined as the need for classroom strategies to manage social skills issues. This theme comprised 13% of codes within this category (5/39 codes = 13%). One participant stated, "Being a [pre-K] teacher, and a lot of these kids have never been in school. We're all about the social skills." Another participant noted, "We're all about how to say, 'please' and 'thank you.'" Bullying prevention/intervention was another theme that emerged in this category, which is defined as the need for classroom strategies to manage issues of bullying. This theme comprised 8% of the codes within this category (3/39 codes = 8%). One teacher stated, "Exploring the topic on bullying… are really important." Another teacher noted, "I would even say bullying itself could be a whole module. "

Lastly, the theme of teacher self-care emerged within this category, which is defined as the identified need for teachers to learn self-care strategies. This theme comprised 13% of the codes within this category. (5/39 codes = 13%). One participant stated, "Teacher tips for self-

care, I thought that was really good." Another teacher noted the importance of teacher self-care practices in her response, "You have to self-care before you can care for anyone else." In sum, participants identified highly applicable content throughout the manual, especially in the areas of techniques to enhance childhood emotional identification skills and information regarding the referral process for mental health services. Refer to Appendix M for Figure M4 (Theme distribution chart for applicable content category).

Quantitative Findings

Descriptive statistics on the self-report quantitative data regarding responses on the psychoeducational program were analyzed using Microsoft Excel. Most significantly, on average, teachers rated the perceived effectiveness of the psychoeducation program for teachers and school staff at a 4.5 out of 5, which is between *very much* and *extremely* on the Likert scale ($SD = 0.58$). On average, participants rated the need for the psychoeducational program, effectiveness of the information presented regarding the referral process, and usefulness of the classroom behavioral interventions all at a 4.25 out of 5, which is between *very much* and *extremely* on the Likert scale ($SD = 0.50$). Participants rated the perceived interest level of teachers in the presented program at a 3.75 out of 5, which is between *somewhat* and *very much* on the Likert scale ($SD = 0.50$). On average, the teacher perspective regarding the feasibility of implementation into their school was a 3.5 out of 5, which is between *somewhat* and *very much* on the Likert scale ($SD = 0.58$). Lastly, teachers generally rated that their knowledge on childhood E/B issues increased following the focus group interview at 3 out of 5, which is *somewhat* on the Likert scale ($SD = 0.00$). Refer to Table 1 for Descriptive Statistics.

Table 1

Descriptive statistics for quantitative self-report variables

	Total study sample (n = 4)
Quantitative Self-Report Variables	Mean (SD)
Program Need	4.25 (0.5)
Feasibility of School Integration	3.5 (0.58)
Perceived Effectiveness of Program for Teachers/School Staff	4.5 (0.58)
Knowledge Increase Post Program Overview	3.0 (0.0)
Perceived Effectiveness of Referral Information	4.25 (0.5)
Perceived Teacher Interest Level	3.75 (0.5)
Usefulness of Behavioral Interventions	4.25 (0.5)

Discussion

In this study, we sought to obtain feedback on a manualized psychoeducation program for elementary school teachers on common childhood emotional and behavioral difficulties. Findings of this study may help to enhance the program to best meet the needs of elementary school teachers and school personnel as it pertains to development of evidence-based strategies to manage common childhood difficulties. In addition, it is hoped that the implementation of this program will reduce the barriers to professional treatment for youth and families and facilitate prevention of and early intervention for childhood emotional and behavioral problems.

Results suggested that teachers believe there is a substantial need for a psychoeducational program on common childhood difficulties, as this category encompassed 43 out of a total of 201 codes across the present study (21%). This finding is consistent with teacher reports in the literature that approximately 16 to 30% of students in their classrooms exhibit significant social-emotional challenges and behavioral difficulties (Kuperschmidt, Bryant, & Willoughby, 2000; Raver & Knitzer, 2002). Another study found that 75% of teacher participants reported either working directly with students with mental health difficulties through classroom-based intervention or referring them for mental health services (Reinke et al., 2011). Therefore, the current study further indicates that teachers report significant problem behaviors in the classroom and experience a need to develop strategies to manage these problems effectively within the school setting.

Despite expressing a need for the proposed psychoeducational program, teachers appeared to be primarily concerned with the implementation of such a program within the school system, with themes in this category representing 72 of the 201 total codes throughout this study (36%). Their concerns are well documented in the extant literature, as findings shows that

although prevention programs directed at teacher participants are highly efficacious in enhancing the social-emotional functioning of school-aged children, problems with implementation have been found to significant barrier to implementation (Marlow et al., 2015). In our study, teachers identified the high demands on teachers and their schedules as a significant barrier to implementation, which comprised 23 out of the 72 the codes within this category (32%). Additionally, teachers rated the proposed program implementation as only moderately feasible ($M = 3.5$, $SD = 0.58$) despite their positive responses regarding perceived effectiveness ($M = 4.5$, SD = 0.58) and usefulness ($M = 4.25$, $SD = 0.50$) of the program. These findings regarding school implementation are not unexpected, given the high demands on elementary school teachers cited in the literature, including administrative demands, lack of instructional resources, management of children with problem behaviors, and other student related demands (Lambert, McCarthy, O'Donnell, & Wang, 2009).

Results indicated that integration of the psychoeducational program into existing professional development initiatives would reduce predicted problems related to implementation, responses that resulted in 20 out of 72 codes within this category (28%). In addition, findings suggested that inclusion of in-vivo coaching would improve the teacher application of skills learned in the psychoeducational program, with 14 out of 72 codes within this category (19%). This aligns with literature that supports the use of coaching activities as means to improve teacher implementation of proactive classroom management techniques. Reinke and colleagues (2014) measured the effectiveness of weekly coaching on the Incredible Years Teacher Classroom Management, which included “performance feedback, action planning, modeling, reviewing, role playing, and goal setting” (p. 157). Implementation of learned “intervention techniques were better sustained over time by teachers who received more coaching as compared

to teachers who received less coaching" (p. 158). In sum, the literature on implementation challenges as well as strategies to overcome these challenges in the school setting is consistent with our qualitative findings.

Our results also suggested that teachers perceived the program as highly effective at increasing the knowledge of teachers and school personnel on childhood emotional and behavioral problems ($M = 4.5$, $SD = 0.58$). In addition, teachers identified multiple aspects of the manual content that were highly applicable to the problems seen in their respective classrooms, with 39 out of the 201 codes overall (19%). These content areas included social skills, bullying prevention and intervention, teacher self-care, child emotional identification skills, attention and concentration skills, as well as information regarding the referral process to mental health services and what types of observable behaviors in children should trigger a referral to professionals. This suggests that the developed program would effectively fill the gap in teacher knowledge of empirically supported strategies to target common childhood mental health difficulties that emerge in the classroom setting.

The results indicated teacher preferences for the inclusion of techniques to enhance parent-teacher collaboration, with 14 out of 47 codes within this category (30%). Research studies have found that inter-professional and parent collaboration facilitates mental health promotion (Ekornes, 2015; Feinstein, Fielding, Udvari-Solner, & Joshi, 2009). Consistent with the literature, the current study findings suggest the incorporation of content on enhancing parent-teacher collaboration would improve the proposed psychoeducational program. This point is well-taken and suggests that the researchers' efforts to create both parent and teacher versions of this psychoeducational program are worthwhile. In addition, the content of each of these programs should be expanded to allow for specific strategies to strengthen the parent-teacher

relationship, which may in turn help to strengthen joint adult monitoring efforts of a specific child and quicker intervention for any problem behaviors as they arise.

As a result of our study, improvements have already been incorporated into the next iteration of this manual, including the additions of a new module on Bullying and Cyberbullying and more information to the parent-teacher communication section. In addition, future iterations may also include a module on trauma exposure in childhood. Research on childhood abuse and household dysfunction indicates that approximately one in two individuals has experienced at least one adverse childhood experience, while one in four individuals has experienced two or more adverse events (Felitti et al., 1998). Ballard and colleagues (2015) found differences in behavioral health outcomes for children with various experiences with adverse events based on type of trauma exposure and gender. More specifically, female children endorsed the highest rates of personal experiences with sexual assault or knowledge of someone who had been sexually assaulted and were more likely to exhibit negative psychiatric outcomes (e.g., suicidal behavior, substance abuse, depression), while male children endorsed greater exposure to violence and higher rates of antisocial personality disorder and post-traumatic stress (Ballard et al., 2015). The negative outcomes associated with exposure to childhood trauma have been found to persist into adulthood, with individuals citing higher levels of post-traumatic stress disorder, depression, suicide, drug and alcohol use, and physical health consequences (Anda et al., 2006; Dube et al., 2009; Felitti et al., 1998,). Given the deleterious and persistent impact of trauma on individuals and society, future iterations of the psychoeducational manual might focus on increasing teacher knowledge on the different types of trauma (e.g., abuse, domestic violence, grief and loss, community violence, natural disasters, terrorism, and complex/persistent trauma exposure) and various trauma-related responses that often resemble externalizing and

internalizing behaviors (Little & Akin-Little, 2011; Little, Akin-Little, & Gutierrez, 2009).

Future research may explore the effectiveness of the psychoeducation program at increasing the knowledge of elementary school teachers on common childhood emotional difficulties as well as classroom-based interventions used to target such difficulties by implementing it to teachers in school settings. In addition, to assess pre- and post-program change in knowledge and skill utilization in teachers, future research might consider utilizing observations of teachers prior to the program to obtain baseline data regarding teachers' skill level rather than solely relying on self-report data. Moreover, future studies might also consider evaluating which evidence-based interventions are implemented in the classroom setting, both immediately following attendance to the psychoeducational workshop and longitudinally to evaluate the sustained benefits of the psychoeducational program. In a study conducted by Ballard and colleagues (2015), 15% of participants reported childhood adversity experiences prior to the age of 13, including personal experiences with physical assault/injury, witnessing of physical assault/injury or death, rape or sexual assault, or knowledge of a close friend or family member experiencing sexual assault. Given the pervasiveness of trauma exposure in childhood, future research may also examine the additional barriers to treatment that exist for families with trauma histories (Felitti et al, 1998).

Implementation barriers and factors that facilitate implementation may be further understood by administering the program in different formats and with different parameters in various communities (e.g., weekend workshop, as part of existing teacher meetings, incorporation into existing school-based programs) The efficacy of incorporating a teacher coaching component at improving teacher implementation of skills learned in didactic workshops may also be examined. Specifically, different coaching techniques (such as role-play,

in-vivo feedback, and modeling) and different coaching frequency can be evaluated for its effectiveness at enhancing knowledge retention and skill utilization by teachers.

Lastly, results of the current study sheds light on a large gap within the education and training of preschool and school-aged teachers on the mental health care needs of their students. Further research within this area may reinforce the need for specialized and systematized teacher training on common childhood mental health difficulties, as teachers serve an instrumental role in the treatment referral process.

Limitations

The current study has several limitations that should be considered when interpreting findings. Most significantly, the small sample size of the current study must be taken into consideration. The literature has yet to agree upon a method of determining the ideal sample size for qualitative studies (Trotter, 2012). Qualitative sample sizes are generally smaller than quantitative samples because the intent of qualitative research is to gather more extensive information rather than to conduct meaningful statistical analyses (Creswell, 2013). Literature on qualitative research posited that the ideal standards for sample size is achieved once all concepts are repeated and when no additional concepts emerge, or that more participants are continually added to the sample size until no additional concept categories are found in the data (Bernard, 2011; Schensul & LeCompte, 2010). In contrast, the optimal sample size for quantitative research is determined through conducting a power analysis (Murphy, Myors, & Wolach, 2009). Typically, mixed methods designs are conducted by including a small sample of qualitative participants within the larger quantitative sample, as seen through convergent parallel mixed methods research designs (Creswell, 2013). Given the time constraints of the teachers, which was also cited by participants as a potential barrier to implementation of the psychoeducational

program, the researchers were limited in the sample size as only a few teachers were able to participate that day while others had meetings and workshops they were attending at the same time.

Moreover, due to the small sample size, the current study did not analyze patterns within the group or significant differences across groups (e.g., teachers with additional training in childhood mental health versus teachers without training in childhood mental health) endorsed in on the demographic and quantitative questionnaires. Thus, future studies would benefit from conducting such statistical analyses from data collected from a larger sample of teacher participants.

In addition, our findings represent the perspectives of therapists within one urban public elementary school and do not represent the perspectives of teachers within different schools and school districts. Other districts may have differing perspectives towards mental health, schedules for professional development training days, student needs, etc. Given the homogeneous sample with respect to school setting, it would be important for future studies to gather information about teacher perspectives from varying school settings. Lastly, the current study merely presented a brief overview of the psychoeducational program rather than full implementation of the program. However, teachers who choose to attend the pilot implementation of the program will have full access to the content through the participant manual, didactic components, group activities, and semi-structure discussion presented in five 60-75 minute workshops through the school's professional development initiatives. Thus, it is posited that future teacher attendees of the pilot program will be provided with significantly more information on childhood mental health issues and empirically-based classroom interventions, which will likely result in greater knowledge acquisition post-program than found in the current study.

Strengths

The current study had a number of strengths. Specifically, the mixed methods design utilized in this study allowed the researchers to obtain a comprehensive understanding of teacher reactions to the proposed psychoeducational with open-ended interview questions coupled with closed-ended Likert-type questions (Creswell, 2013). The qualitative analysis of teacher responses uncovered central ideas of the strengths and weakness of the psychoeducational program that might have been overlooked through a purely quantitative approach. In addition, this study design afforded researchers the opportunity to compare participant verbal responses during the focus group interview with the qualitative data, with the assumption that "results across the two means of data collection should yield similar results" (p. 281). Moreover, the current study facilitated interprofessional collaboration of teachers and mental health professionals, which has been identified in the research as a significant means of reducing barriers to treatment for children and families, the underlying goal of the proposed psychoeducational program (Ekornes, 2015; Feinstein, Fielding, Udvari-Solner, & Joshi, 2009). Lastly, the feedback provided by the teacher participants of the current study has already been utilized to improve the psychoeducational program to better meet the needs of elementary school teachers. The program is scheduled to be pilot tested in Fall 2016 with the elementary school teachers at Juan Cabrillo Elementary as means to reduce barriers to mental health treatment in their community.

Conclusions

It is evident that the mental health needs of elementary school children in the United States are inadequately assessed and addressed. The literature has identified teachers as instrumental in the mental health referral process for children suffering from emotional and/or

behavioral difficulties (Williams et al., 2007). In order to reduce the barriers to treatment, and in keeping with an ecological systems-based approach (Bronfenbrenner, 1992; Gould et al., 2012), it is imperative that clinicians engage in interprofessional collaboration with teachers and school administration to deliver needed knowledge and skills training to school personnel within their work setting without adding significant burden to adopt these strategies in their classrooms. The current study, while small, has implications for teacher psychoeducation programs as means to reduce stigma around mental health. This program may help to bridge the gaps in treatment utilization by youth and families, facilitate appropriate referral in a timely manner, and serve as an impetus for changes to local policy that promote implementation of this and similar programs across school districts as a universal prevention program to reducing the public health burden of childhood mental illness.

REFERENCES

American Federation of Teachers, (2007). *Building Parent-Teacher Relationships*. Washington, D.C.: American Federation of Teachers. Retrieved from http://ms.aft.org/files/ct-parent-teacherpartnerships_0.pdf

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., & ... Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. *European Archives of Psychiatry and Clinical Neuroscience 256*, 174–186. https://doi.org/10.1007/s00406-005-0624-4

Angold, A., Messer, S., Stangl, D., Farmer, E., Costello, E., & Burns, B. (1998). Perceived parental burden and service use for child and adolescent psychiatric disorders. *American Journal of Public Health, 88,* 75-80. https://doi.org/10.2105/AJPH.88.1.75

Azad, G. F., Kim, M., Marcus, S. C., Sheridan, S. M., & Mandell, D. S. (2016). Parent-teacher communication about children with autism spectrum disorder: An examination of collaborative problem-solving. *Psychology In The Schools, 53*(10), 1071-1084. https://doi.org/10.1002/pits.21976

Baker, J. A. (2006). Contributions of teacher-child relationships to positive school adjustment during elementary school. *Journal of School Psychology, 44*, 211-229. https://doi.org/10.1016/j.jsp.2006.02.002

Baker-Ericzén, M. J., Jenkins, M. M., & Haine-Schlagel, R. (2013). Therapist, parent, and youth perspectives of treatment barriers to family-focused community outpatient mental health services. *Journal Of Child And Family Studies*, *22*(6), 854-868. https://doi.org/10.1007/s10826-012-9644-7

Ballard, E. D., Van Eck, K., Musci, R. J., Hart, S. R., Storr, C. L., Breslau, N., & Wilcox, H. C. (2015). Latent classes of childhood trauma exposure predict the development of behavioral health outcomes in adolescence and young adulthood. *Psychological Medicine, 45*(15), 3305-3316. https://doi.org/10.1017/S0033291715001300

Bannon, W. M., & McKay, M. M. (2005). Are barriers to service and parental preference match for service related to urban child mental health service use? *Families in Society: The Journal of Contemporary Social Services, 86*, 30–34. https://doi.org/10.1606/1044-3894.1874

Battistich, V., Schaps, E., & Wilson, N. (2004). Effects of an elementary school intervention on students' "connectedness" to school and social adjustment during middle school. *The Journal of Primary Prevention, 24*(3), 243-262. https://doi.org/10.1023/B:JOPP.0000018048.38517.cd

Becker, K. D., Kiser, L. J., Herr, S. R., Stapleton, L. M., Barksdale, C. L., & Buckingham, S. (2014). Changes in treatment engagement of youths and families with complex needs. *Children and Youth Services Review, 46*, 276-284. https://doi.org/10.1016/j.childyouth.2014.09.005

Bernard, H. R. (2011). *Research methods in anthropology: Qualitative and quantitative approaches* (5th Edition). New York, NY: Rowman Altamira.

Betz, C. L., Baer, M. T., Poulsen, M., Vahanvaty, U., & Bare, M. (2004). Secondary analyses of primary and preventative services accessed and perceived service barriers by children with developmental disabilities and their families. *Issues in Comprehensive Pediatric Nursing, 27*, 83–106. https://doi.org/10.1080/01460860490451813

Bierman, K. L., Coie, J., Dodge, K., Greenberg, M., Lochman, J., McMohan, R., & Pinderhughes, E. (2013*). School outcomes of aggressive-disruptive children: Prediction from kindergarten risk factors and impact of the Fast Track prevention program. Aggressive Behavior, 39*(2), 114-130. https://doi.org/10.1002/ab.21467

Bos, A. R., Pryor, J. B., Reeder, G. D., & Stutterheim, S. E. (2013). Stigma: Advances in theory and research. *Basic and Applied Social Psychology, 35*(1), 1–9. https://doi.org/10.1080/01973533.2012.746147

Bowers, H., Manion, I., Papadopoulos, D., & Gauvreau, E. (2013). Stigma in school-based mental health: Perceptions of young people and service providers. *Child And Adolescent Mental Health, 18*(3), 165-170. https://doi.org/10.1111/j.1475-3588.2012.00673.x

Briggs-Gowan, M. J., Carter, A. S., Skuban, E. M., & Horwitz, S. M. (2001). Prevalence of social–emotional and behavioral problems in a community sample of 1- and 2-year-old children. *Journal of the American Academy of Child and Adolescent Psychiatry, 40,* 811–819. https://doi.org/10.1097/00004583-200107000-00016

Bronfenbrenner, U. (1992). *Ecological systems theory*. In R. Vasta (Ed.) Six theories of child development: Revised formulations and current issues (pp. 187-249). London, England: Jessica Kingsley Publishers.

Campbell, S. B. (2002). *Behavior problems in preschool children: Clinical and developmental issues*. New York, NY: Guilford Press.

Centers for Disease Control and Prevention. (2013). Mental health surveillance among children – United States, 2005-2011. Morbility and Mortality Weekly Report, *62*(2), 1-35. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm?s_cid =su6202a1_w

Center for Mental Health in Schools at UCLA. (2008). Conduct and behavior problems related to school aged youth. Los Angeles, CA: Author. Retrieved from http://smhp.psych.ucla.edu/pdfdocs/conduct/conduct.pdf

Chaffin, M., Valle, L., Funderburk, B., Gurwitch, R., Silovsky, J., Bard, D., & … Kees, M. (2009). A motivational intervention can improve retention in PCIT for low-motivation child welfare clients. *Child Maltreatment, 14*(4), 356- 368. https://doi.org/10.1177/1077559509332263

Chambless, D. L. & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66,* 7–18. https://doi.org/10.1037/0022-006X.66.1.7

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology, 56*, 521– 536. https://doi.org/10.1037/a0016905

Chorpita, B., Becker, K., Phillips, L., Ebesutani, C., Cromley, T., & Daleiden, E. (2012). Practitioner Guides. Satellite Beach, FL: PracticeWise.

Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2005). Modularity in the design and application of therapeutic interventions. *Applied and Preventive Psychology, 11*(3), 141-156. https://doi.org/10.1016/j.appsy.2005.05.002

Christophersen, E. R., VanScoyoc, S. M. M., (2013). Treatments that work with children: Empirically supported strategies for managing childhood problems (2nd ed.). Washington, DC, US: American Psychological Association.

Cohen, M. & Irwin, C. E. (1983). Parent-Time: Psychoeducational groups for parents of adolescents. *Health & Social Work*, *8*(3), 196-202. https://doi.org/10.1093/hsw/8.3.196

Corrigan, P. W., & Rao, D. (2012). On the self-stigma of mental illness: Stages, disclosure, and strategies for change. *Canadian Journal of Psychiatry, 57*(8), 464–469. doi:10.1177/070674371205700804.

Creswell, J.W. (2013). *Research design: Qualitative, quantitative, and mixed methods* approaches (4th edition). Los Angeles, CA: Sage Publications.

Cuffel, B., McCulloch, J., Wade, R., Tam, L., Brown-Mitchell, R., & Goldman, W. (2000). Patients and providers' perceptions of outpatient treatment termination in a managed behavioral health organization. *Psychiatric Services, 51*(4), 469–473. https://doi.org/10.1176/appi.ps.51.4.469

Cunningham, C. J. L., Weathington, B. L., & Pittenger, D. J. (2013). *Understanding and conducting research in the health sciences*. Hoboken, NJ: John Wiley & Sons. Retrieved from http://onlinelibrary.wiley.com/doi/10.1002/9781118643624.ch1/summary

Davis, M., Eshelman, E. R., & McKay, M. (2000). *The relaxation & stress reduction workbook* (5th Ed.). Oakland, CA: New Harbinger Publications.

Department of Education. (2014). *What is bullying (ED, Bullying Summit)*. Retrieved from http://www.stopbullying.gov/videos/2010/09/what-is-bullying.html

Donovan, M., & Cross, C. (Eds.). (2002). *Minority students in special and gifted education*. Washington, DC: National Academy Press. Retrieved from https://www.nap.edu/read/10128/chapter/1

Dube, S. R., Fairweather, D., Pearson, W. S., Felitti, V. J., Anda, R. F., & Croft, J. B. (2009). Cumulative childhood stress and autoimmune diseases in adults. *Psychosomatic Medicine, 71*, 243–250. https://doi.org/10.1097/PSY.0b013e3181907888

DuPaul, G. J., Gormley, M. J., & Laracy, S. D. (2014). School-based interventions for elementary school students with ADHD. *Child and Adolescent Psychiatric Clinics Of North America*, *23*(4), 687-697. https://doi.org/10.1016/j.chc.2014.05.003

Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal Of Community Psychology, 41*(3-4), 327-350. http://doi.org/10.1007/s10464-008-9165-0

Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. B. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. *Child Development, 82*, 405–432. https://doi.org/10.1111/j.1467-8624.2010.01564.x

Eiraldi, R. B., Mazzuca, L. B., Clarke, A. T., & Power, T. J. (2006). Service utilization among ethnic minority children with ADHD: A model of help-seeking behavior. *Administration and Policy in Mental Health and Mental Health Services Research, 33*(5), 607-622. https://doi.org/10.1007/s10488-006-0063-1

Ekornes, S. (2015). Teacher perspectives on their role and the challenges of inter-professional collaboration in mental health promotion. *School Mental Health*, *7*(3), 193-211. https://doi.org/10.1007/s12310-015-9147-y

Ellis, M. L., Lindsey, M. A., Barker, E. D., Boxmeyer, C. L., & Lochman, J. E. (2013). Predictors of engagement in a school-based family preventive intervention for youth experiencing behavioral difficulties. *Prevention Science, 14*(5), 457-467. https://doi.org/10.1007/s11121-012-0319-9

Elo, S. & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing, 62*(1), 107-115. https://doi.org/10.1111/j.1365-2648.2007.04569.x

Evans, S. W., Owens, J. S., & Bunford, N. (2014). Evidence-based psychosocial treatments for children and adolescents with attention-deficit/hyperactivity disorder. *Journal of Clinical Child And Adolescent Psychology, 43*(4), 527-551. https://doi.org/10.1080/15374416.2013.850700

Farmer, E. M., Burns, B. J., Phillips, S. D., Angold, A., & Costello, E. J. (2003). Pathways into and through mental health services for children and adolescents. *Psychiatric Services, 54*(1), 60–66. https://doi.org/10.1176/appi.ps.54.1.60

Feinstein, N. R., Fielding, K., Udvari-Solner, A., & Joshi, S. V. (2009). The supporting alliance in child and adolescent treatment: Enhancing collaboration among therapists, parents, and teachers. *American Journal Of Psychotherapy*, *63*(4), 319-344. Retrieved from https://www.researchgate.net/publication/41406618_The_supporting_alliance_in_child_and_adolescent_treatment_enhancing_collaboration_among_therapists_parents_and_teachers

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & ... Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal Of Preventive Medicine, 14*(4), 245-258. https://doi.org/10.1016/S0749-3797(98)00017-8

Fergusson, D. M., Horwood, L. J., & Stanley, L. (2013). A preliminary evaluation of the Incredible Years Teacher Programme. *New Zealand Journal Of Psychology, 42*(2), 51-56. Retrieved from http://www.incredibleyears.com/wp-content/uploads/A-preliminary-evaluation-of-the-IY-teacher-programme-2013.pdf

Ferrin, M., Moreno-Granados, J. M., Salcedo-Marin, M. D., Ruiz-Veguilla, M., Perez-Ayala, M., & Taylor, E. (2013). Evaluation of a psychoeducation programme for parents of children and adolescents with ADHD: Immediate and long-term effects using a blind randomized controlled trial. *European Child &Adolescent Psychiatry, 23*(8), 637-647. https://doi.org/10.1007/s00787-013-0494-7

Fisher, M., & Meyer, L. (2002). Development and social competence after two years for students enrolled in inclusive and self-contained educational programs. *Research and Practice for Persons with Severe Disabilities*, *27*(3), 165–174. https://doi.org/10.2511/rpsd.27.3.165

Flicker, S. M., Waldron, H. B., Turner, C. W., Brody, J. L., & Hops, H. (2008). Ethnic matching and treatment outcome with Hispanic and Anglo substance-abusing adolescents in family therapy. *Journal of Family Psychology, 22*, 439–447. https://doi.org/10.1037/0893-3200.22.3.439

Flores, G., Olson, L., & Tomany-Korman, S. C. (2005). Racial and ethnic disparities in early childhood health and health care. *Pediatrics, 115*, e183–e193. https://doi.org/10.1542/peds.2004-1474

Frey, K. S., Hirshstein, M. K., & Guzzo, B. A. (2000). Second Step: Preventing aggression by promoting social competence. *Journal of Emotional and Behavioral Disorders, 8*, 102–112. https://doi.org/10.1177/106342660000800206

Fristad, M. A., Gavazzi, S. M., & Mackinaw-Koons, B. (2003). Family psychoeducation: An adjunctive intervention for children with bipolar disorder. *Biological Psychiatry, 53*, 1000–1008. https://doi.org/10.1016/S0006-3223(03)00186-0

Fristad, M. A., Gavazzi, S. M., & Soldano, K. W. (1998). Multi-family psychoeducation groups for childhood mood disorders: A program description and preliminary efficacy data. *Contemporary Family Therapy, 20,* 385–403. https://doi.org/10.1023/A:1022477215195

Fristad, M. A., Goldberg-Arnold, J. S., & Gavazzi, S. M. (2002). Multifamily psychoeducation groups (MFPG) for families of children with bipolar disorder. *Bipolar Disorders, 4,* 254-262. https://doi.org/10.1034/j.1399-5618.2002.09073.x

Garland, A. F., Lau, A. S., Yeh, M., McCabe, K. M., Hough, R. L., & Landsverk, J. A. (2005). Racial and Ethnic Differences in Utilization of Mental Health Services Among High-Risk Youths. *The American Journal Of Psychiatry*, *162*(7), 1336-1343. https://doi.org/10.1176/appi.ajp.162.7.1336

Gary, F. A. (2005). Stigma: Barrier to mental health care among ethnic minorities. *Issues in Mental Health Nursing, 26*, 979-999. https://doi.org/10.1080/01612840500280638

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New York, NY: Simon and Schuster.

Gordon, R. S. (1983). An operational classification of disease prevention. *Public Health Reports, 98*(2), 107-109. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1424415/pdf/pubhealthrep00112-0005.pdf

Gould, S. R., Beals-Erickson, S. E., & Roberts, M. C. (2012). Gaps and barriers in services for children in state mental health plans. *Journal of Child Family Studies, 21*, 767-774. https://doi.org/10.1007/s10826-011-9529-1

Gueldner, B., & Merrell, K. (2012). Interventions for students with internalizing behavioral deficits. *Oxford Handbooks Online*. Retrieved from http://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780195369809.001.0001/oxfordhb-9780195369809-e-019.

Hemmeter, M. L., Ostrosky, M., & Fox, L. (2006). Social and emotional foundations for early learning: A conceptual model for intervention. *School Psychology Review, 35*(4), 583-601. Retrieved from https://www.researchgate.net/profile/Michaelene_Ostrosky/publication/228349912_Social_and_emotional_foundations_for_early_learning_A_conceptual_model_for_intervention/links/55005fca0cf2de950a6d6244.pdf

Herman, K. C., Reinke, W. M., Stormont, M., Puri, R., & Agarwal, G. (2010). Using prevention science to promote children's mental health: The founding of the Missouri Prevention Center. *The Counseling Psychologist, 38*(5), 652-690. https://doi.org/10.1177/0011000009354125

Hinojosa, M., Knapp, C., & Woodworth, L. (2014). Family strain among White and Latino parents of children with mental and behavioral health disorders. *Journal Of Child And Family Studies*, *24,* 1575-1581. https://doi.org/10.1007/s10826-014-9961-0

Hinshaw, S. P. (2005). The stigmatization of mental illness in children and parents: Developmental issues, family concerns, and research needs. *Journal Of Child Psychology And Psychiatry, 46*(7), 714-734. https://doi.org/10.1111/j.1469-7610.2005.01456.x

Hoagwood, K., Burns, B. J., Kiser, L, Ringeisen, H., & Schoenvrald., S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services, 52,* 1179-1189. https://doi.org/10.1176/appi.ps.52.9.1179

Hoberman, H. M. (1992). Ethnic minority status and adolescent mental health services utilization. *Journal of Mental Health Administration, 19*(3), 246–267. https://doi.org/10.1007/BF02518990

Hosp, J., & Reschly, D. (2003). Referral rates for intervention or assessment: A meta-analysis of racial differences. *The Journal of Special Education*, *37*(2), 67–80. https://doi.org/10.1177/00224669030370020201

Hruschka, D. J., Schwartz, D., St. John, D. C., Picone-Decaro, E., Jenkins, R. A., & Carey, J. W. (2004). Reliability in coding open-ended data: Lessons learned from HIV behavioral research. *Field Methods, 16*(3), 307-331. https://doi.org/10.1177/1525822X04266540

Hsieh, H. F. & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277-1288. https://doi.org/10.1177/1049732305276687

Hutton, J. L. (1985). What reasons are given by teachers who refer problem behavior students? *Psychology in the Schools, 22,* 79–82. https://doi.org/10.1002/1520-6807(198501)22:1<79::AID-PITS2310220116>3.0.CO;2-F

Ingoldsby, E. M. (2010). Review of interventions to improve family engagement and retention in parent and child mental health programs. *Journal Of Child And Family Studies, 19*(5), 629-645. https://doi.org/10.1007/s10826-009-9350-2

Jennings, P. A., & Greenberg, M. T. (2009). The prosocial classroom: Teacher social and emotional competence in relation to student and classroom outcomes. *Review of Educational Research,79*(1), 491-525. https://doi.org/10.3102/0034654308325693

Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a definition of mixed methods research. *Journal of Mixed Methods Research, 1*(2), 112-133. https://doi.org/10.1177/1558689806298224

Johnson, S., Cooper, C., Cartwright, S., Donald, I., Taylor, P., & Millet, C. (2005). The experience of work-related stress across occupations. *Journal of Managerial Psychology, 20,* 178-187. https://doi.org/10.1108/02683940510579803

Karver, M. S., Handelsman, J. B., Fields, S., & Bickman, L. (2005). A theoretical model of common process factors in youth and family therapy. *Mental Health Services Research, 7*, 35–51. https://doi.org/10.1007/s11020-005-1964-4

Kataoka, S. H., Zhang, L., & Wells, K. B. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *The American Journal of Psychiatry, 159*(9), 1548-1555. https://doi.org/10.1176/appi.ajp.159.9.1548

Katz, L. G., & McClellan, D. E. (1997). *Fostering children's social competence: The teacher's role*. Washington, DC, US: National Association for the Education of Young Children.

Kazdin, A. E., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment and premature termination from child therapy. *Journal Of Consulting And Clinical Psychology, 65*(3), 453-463. https://doi.org/10.1037/0022-006X.65.3.453

Kazdin, A. E., Holland, L., Crowley, M., & Breton, S. (1997). Barriers to treatment participation scale: Evaluation and validation in the context of child outpatient treatment. *Journal Child Psychology and Psychiatry, 38*(8), 1051-1062. https://doi.org/10.1111/j.1469-7610.1997.tb01621.x

Kenny, M. C. (2009). Child sexual abuse prevention: Psychoeducational groups for preschoolers and their parents. *The Journal for Specialists in Group Work, 34*(1), 24-42. https://doi.org/10.1080/01933920802600824

Kernan, J. B., Griswold, K. S., & Wagner, C. M. (2003). Seriously emotionally disturbed youth: A needs assessment. *Community Mental Health Journal, 39*, 475–486. https://doi.org/10.1023/B:COMH.0000003009.21130.da

Kessler, R. C., Brown, R. L., & Broman, C. L. (1981). Sex differences in psychiatric help-seeking: Evidence from four large-scale surveys. *Journal Of Health And Social Behavior*, *22*(1), 49-64. https://doi.org/10.2307/2136367

King, S., Kropf, N. P., Perkins, M., Sessley, L., Burt, C., & Lepore, M. (2009). Kinship in rural Georgia communities: Responding to needs and challenges of grandparent caregivers. *Journal of Intergenerational Relationships, 7*, 225–242. https://doi.org/10.1080/15350770902852369

Koller, J. R. & Bertell, J. M. (2006). Responding to today's mental health needs of children, families, and schools: Revisiting the preservice training and preparation of school-based personnel. *Education and Treatment of Children, 29*(2), 197-217.

Kourany, R. F., Garber, J., & Tornusciolo, G. (1990). Improving first appointment attendance rates in child psychiatry outpatient clinics. *Journal of the American Academy of Child and Adolescent Psychiatry, 29,* 657-660. https://doi.org/10.1097/00004583-199007000-00022

Kouyoumdjian, H., Zamboanga, B. L., & Hansen, D. J. (2003). Barriers to community mental health services for Latinos: Treatment considerations. *Clinical Psychology: Science and Practice, 10*(4), 394-422. https://doi.org/10.1093/clipsy.bpg041

Kuperschmidt, J. B., Bryant, D., & Willoughby, M. (2000). Prevalence of aggressive behaviors among preschoolers in Head Start and community child care programs. *Behavioral Disorders, 26,* 42–52. Retrieved from http://www.jstor.org/stable/23889058

Kurasaki, K. S. (2000). Inercoder reliability for validity conclusions drawn from open-ended interview data. *Field Methods, 12*(3), 179-194. https://doi.org/10.1177/1525822X0001200301

Ladd, G. W., Herald, S. L., & Kochel, K. P. (2006). School readiness: Are there social prerequisites? *Early Education and Development, 17*, 115–150. https://doi.org/10.1207/s15566935eed1701_6

Lambert, R. G., McCarthy, C., O'Donnell, M., & Wang, C. (2009). Measuring elementary teacher stress and coping in the classroom: Validity evidence for classroom appraisal of resources and demands. *Psychology in The Schools, 46*(10). 973-988. https://doi.org/10.1002/pits.20438

Landrum, T., Katsiyannis, A., & Archwamety, T. (2004). An analysis of placement and exit patterns of students with emotional or behav- ioral disorders. *Behavioral Disorders*, *29*(2), 140–153. Retrieved from http://www.jstor.org/stable/23889447

Landrum, T., Tankersley, M., & Kauffman, J. (2003). What is special about special education for students with emotional or behavioral disorders? *The Journal of Special Education*, *37*(3), 148–156. https://doi.org/10.1177/00224669030370030401

Langley, A. K., Nadeem, E., Kataoka, S. H., Stein, B. D., & Jaycox, L. H. (2010). Evidence-based mental health programs in schools: Barriers and facilitators of successful implementation. *School Mental Health, 2*(3), 105-113. https://doi.org/10.1007/s12310-010-9038-1

Larson, J., dosReis, S., Stewart, M., Kushner, R., Frosch, E., & Solomon, B. S. (2013). Barriers to mental health care for urban, lower income families referred from pediatric primary care. *Administration and Policy in Mental Health and Mental Health Services Research, 40*(3), 159-167. https://doi.org/10.1007/s10488-011-0389-1

Lawhon, T., & Lawhon, D. C. (2000). Promoting social skills in young children. Early *Childhood Education Journal, 28*(2), 105-110. https://doi.org/10.1023/A:1009551404906

Leavell, H. R. & Clark, E. G. (1965). *Preventive medicine for the doctor in his community: An epidemiologic approach* (3rd ed.). New York, NY: McGraw-Hill.

Lee, T. (2012). School-based interventions for disruptive behavior. *Child and Adolescent Psychiatric Clinics of North America, 21*(1), 161-174. https://doi.org/10.1016/j.chc.2011.09.002

Leigh, I. W., Powers, L., Vash, C., & Nettles, R. (2004). Survey of psychological services to clients with disabilities: The need for awareness. *Rehabilitation Psychology, 49*, 48–54. https://doi.org/10.1037/0090-5550.49.1.48

Liang, J. (2010). *Parental involvement in mental health services for diverse youth* (Doctoral dissertation). Retrieved from UC San Diego Electronic Theses and Dissertations. (b6889242)

Little, S. G., & Akin-Little, A. (2011). Responses to childhood trauma: An international perspective. *School Psychology International*, *32*(5), 441-447. https://doi.org/10.1177/0143034311402915

Little, S. G., Akin-Little, A., & Gutierrez, G. (2009). Children and traumatic events: Therapeutic techniques for psychologists working in the schools. *Psychology in the Schools, 46,* 199–205. https://doi.org/10.1002/pits.20364

Lombard, M., Snyder-Duch, J., & Bracken, C. C. (2002). Content analysis in mass communication: Assessment and reporting of intercoder reliability. *Human Communication Research, 28*(4), 587-604. https://doi.org/10.1111/j.1468-2958.2002.tb00826.x

Lukens, E. P. & McFarlane, W. R. (2004). Psychoeducation as evidence-based practice: Considerations for practice, research, and policy. *Brief Treatment and Crisis Intervention, 4*(3), 205-225. https://doi.org/10.1093/brief-treatment/mhh019

Mackenzie, C. S., Erickson, J., Deane, F. P., & Wright, M. (2014). Changes in attitudes toward seeking mental health services: A 40-year cross-temporal meta-analysis. *Clinical Psychology Review, 34*(2), 99-106. https://doi.org/10.1016/j.cpr.2013.12.001

Mandell, D. S., Davis, J. K., Bevans, K., & Guevara, J. P. (2008). Ethnic disparities in special education labeling among children with attention deficit/hyperactivity disorder. *Journal Of Emotional And Behavioral Disorders, 16*(1), 42-51. https://doi.org/10.1177/1063426607310848

Marlow, R., Hansford, L., Edwards, V., Ukoumunne, O. C., Norman, S., Ingarfield, S., & ... Ford, T. (2015). Teaching classroom management—A potential public health intervention?. *Health Education, 115*(3-4), 230-248. https://doi.org/10.1108/HE-03-2014-0030

Mazer, J. P. (2013). Associations among teacher communication behaviors, student interest, and engagement: A validity test. *Communication Education, 62*(1), 86-96. https://doi.org/10.1080/03634523.2012.731513

McGinty, K. L., Diamond, J. M., Brown, M. B., & McCammon, S. L. (2003). Training child and adolescent psychiatrists and child mental health professionals for systems of care. In A. J. Pumariega & N. C. Winters (Eds.), *The handbook of child and adolescent systems of care: The new community psychiatry* (pp. 487–507). San Francisco, CA: Jossey-Bass.

McKay, M. M. & Bannon, W. M. J. (2004). Engaging families in child mental health services. *Child and Adolescent Psychiatric Clinics of North America, 13*(4), 905-921. https://doi.org/10.1016/j.chc.2004.04.001

Menting, A. A., de Castro, B. O., & Matthys, W. (2013). Effectiveness of the Incredible Years parent training to modify disruptive and prosocial child behavior: A meta-analytic review. *Clinical Psychology Review, 33*(8), 901-913. https://doi.org/10.1016/j.cpr.2013.07.006

Merrell, K. W., & Gimpel, G. A. (1998). *Social skills of children and adolescents: Conceptualization, assessment, treatment*. Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Mertens, D. M. (2009). *Research methods in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods* (3rd Ed.). Thousand Oaks, CA: Sage.

Meyer, O. L. & Zane, N. (2013). The influence of race and ethnicity in clients' experiences of mental health treatment. *Journal of Community Psychology, 41*(7), 884-901. https://doi.org/10.1002/jcop.21580

Miller, R. L. & Brewer, J. (Eds). (2003). *The A-Z of social research: A dictionary of key Social science research concepts*. London, England: Sage Publications Ltd. https://doi.org/10.4135/9780857020024

Miranda, J., Woo, S., Lagomasino, I., Hepner, K. A., Wiseman, S., & Munoz, R. (2008). *Client's guidebook: Thoughts and your mood*. Unpublished work.

Morrissey-Kane, E. & Prinz, R. J. (1999). Engagement in child and adolescent treatment: The role of parental cognitions and attributions. *Clinical Child And Family Psychology Review, 2*(3), 183-198. https://doi.org/10.1023/A:1021807106455

Mrazek, P. B. & Haggerty, R. J. (1994). *Reducing risks for mental disorders frontiers for preventive intervention research*. Washington, DC: National Academy Press. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK236326/

Mukolo, A., Heflinger, C. A., & Wallston, K. A. (2010). The stigma of childhood mental disorders: A conceptual framework. *Journal of the American Academy of Child and Adolescent Psychiatry, 49*(2), 92–103. http://doi.org/10.1016/j.jaac.2009.12.003.

Murphy, K. R., Myors, B., & Wolach, A. H. (2009). *Statistical power analysis: A simple and general model for traditional and modern hypotheses tests* (3rd ed.). New York, NY: Taylor and Francis Group.

Murray, C., & Murray, K. M. (2004). Child level correlates of teacher-student relationships: An examination of demographic characteristics, academic orientations, and behavioral orientations. *Psychology in the Schools, 41*(7), 751-762. https://doi.org/10.1002/pits.20015

National Research Council and Institute of Medicine. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. Washington, DC: The National Academic Press. Retrieved from https://www.nap.edu/read/12480/chapter/1

Newman-Carlson, D. & Horne, A. M. (2004). Bully Busters: A psychoeducational intervention for reducing bullying behavior in middle school students. *Journal of Counseling & Development, 82*(3), 259-267. https://doi.org/10.1002/j.1556-6678.2004.tb00309.x

Nock, M. K., & Kazdin, A. E. (2001). Parent expectancies for child therapy: Assessment and relation to participation in treatment. *Journal of Child and Family Studies, 10*(2), 155-180. https://doi.org/10.1023/A:1016699424731

Nock, M. K. & Kazdin, A. E. (2005). Randomized controlled trial of a brief intervention for increasing participation in parent management training. *Journal of Consulting and Clinical Psychology, 73*(5), 872-879. https://doi.org/10.1037/0022-006X.73.5.872

Nock, M. K. & Photos, V. (2006). Parent motivation to participate in treatment: Assessment and prediction of subsequent participation. *Journal of Child & Family Studies, 15*(3), 333-346. https://doi.org/10.1007/s10826-006-9022-4

Ojeda, V. & Bergstresser, S. (2008). Gender, race-ethnicity, and psychosocial barriers to mental health care: An examination of perceptions and attitudes among adults reporting unmet need. *Journal of Health and Social Behavior, 49*(3), 317-334. https://doi.org/10.1177/002214650804900306

Owens, P. L., Hoagwood, K., Horwitz, S. M., Leaf, P. J., Poduska, J. M., Kellam, S. G., & Ialongo, N. S. (2002). Barriers to children's mental health services. *Journal of The American Academy of Child & Adolescent Psychiatry, 41*(6), 731-738. https://doi.org/10.1097/00004583-200206000-00013

Pajer, K. A., Kelleher, K., Gupta, R., Rolls, J., & Gardner, W. (2007). Psychiatric and medical health care policies in juvenile detention facilities. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46, 1660–1667. https://doi.org/10.1097/chi.0b013e318157d2da

Pas, E., Bradshaw, C. P., & Hershfeldt, P. A. (2012). Teacher- and school-level predictors of teacher efficacy and burnout: Identifying potential areas of support. *Journal of School Psychology, 50*(1), 129–145. https://doi.org/10.1016/j.jsp.2011.07.003

Pescosolido, B. A., Fettes, D. L., Martin, J. K., McLeod, J. D., & Monahan, J. (2007). Perceived dangerousness of children with mental health problems and support for coerced treatment. *Psychiatric Services, 58*(5), 619–625. https://doi.org/10.1176/ps.2007.58.5.619

President's New Freedom Commission on Mental Health (2003). *Achieving the promise: Transforming mental health care in America. Final report for the President's New Freedom Commission on Mental Health (SMA Publication No. 03-3832).* Rockville, MD: Author. Retrieved from http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf

Program for Early Parent Support. (2015). Self-care for parents. Retrieved from http://www.peps.org/ParentResources/by-topic/self-care/self-care-for-parents

Raver, C. C. (2002). Emotions matter: Making the case for the role of young children's emotional development for early school readiness. *Social Policy Report, 16*(3), 3–18. Retrieved from https://www.cde.state.co.us/cpp/emotionsmatter

Reinke, W. M., Stormont, M., Herman, K. C., & Newcomer, L. (2014). Using coaching to support teacher implementation of classroom-based interventions. *Journal of Behavioral Education, 23*(1), 150-167. https://doi.org/10.1007/s10864-013-9186-0

Reinke, W. M., Stormont, M., Herman, K. C., Puri, R., & Goel, N. (2011). Supporting children's mental health in schools: Teacher perceptions of needs, roles, and barriers. *School Psychology Quarterly, 26*(1), 1-13. https://doi.org/10.1037/a0022714

Rescorla, L. A., Bochicchio, L., Achenbach, T. M., Ivanova, M. Y., Almqvist, F., Begovac, I., & ... Verhulst, F. C. (2014). Parent–teacher agreement on children's problems in 21 societies. *Journal Of Clinical Child And Adolescent Psychology, 43*(4), 627-642. https://doi.org/10.1080/15374416.2014.900719

Roberts, M., Joe, V., & Hallbert-Rowe, A. (1992). Oppositional child behavior and parental locus of control. *Journal of Clinical Child Psychology, 21,* 170-177. https://doi.org/10.1207/s15374424jccp2102_9

Rocco, P. L., Ciano, R. P., & Balestrieri, M. (2001). Psychoeducation in the prevention of eating disorders: An experimental approach in adolescent schoolgirls. *British Journal of Medical Psychology, 74*(3), 351–358. https://doi.org/10.1348/000711201161028

Roll, J. M., Kennedy, J., Tran, M., & Howell, D. (2013). Disparities in unmet need for mental health services in the United States, 1997-2010. *Psychiatric Services, 64*(1), 80-82. https://doi.org/10.1176/appi.ps.201200071

Rones, M. & Hoagwood, K. (2000). School-based mental health services: A research review. *Clinical Child and Family Psychology Review, 3*(4), 223-241. https://doi.org/10.1023/A:1026425104386

Rubin, K. H., Coplan, R. J., & Bowker, J. C. (2009). Social withdrawal in childhood. *Annual Review Of Psychology, 60*, 141-171. https://doi.org/10.1146/annurev.psych.60.110707.163642

Russell, P. S., al John, J. K., & Lakshmanan, J. L. (1999). Family intervention for intellectually disabled children. Randomised controlled trial. *British Journal of Psychiatry, 174,* 254–258. https://doi.org/10.1192/bjp.174.3.254

Schensul, J. J. & LeCompte, M. D. (2010). *Designing and conducting ethnographic research: An Introduction*. Walnut Creek, CA: Altamira Press.

Sentell, T., Shumway, M., & Snowden, L. (2007). Access to mental health treatment by English language proficiency and race/ethnicity. *Journal Of General Internal Medicine, 22*(2), 289-293. https://doi.org/10.1007/s11606-007-0345-7

Serwatka, T. S., Dove, T., & Hodge, W. (1986). Black students in special education: Issues and implications for community involvement. *Negro Education Review, 37,* 17–26.

Spence, S. H. (2003). Social skills training with children and young people: Theory, evidence and practice. *Child and Adolescent Mental Health, 8*(2), 84-96. https://doi.org/10.1111/1475-3588.00051

Spirito, A., Boergers, J., Donaldson, D., Bishop, D., & Lewander, W. (2002). An intervention trial to improve adherence to community treatment by adolescents after a suicide attempt. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*, 435–442. https://doi.org/10.1097/00004583-200204000-00016

Stallard, P., Norman, P., Huline-Dickens, S., Salter, E., & Cribb, J. (2004). The effects of parental mental illness upon children: A descriptive study of the views of parents and children. *Clinical Child Psychology And Psychiatry*, *9*(1), 39-52. https://doi.org/10.1177/1359104504039767

Staudt, M. (2007). Treatment engagement with caregivers of at-risk children: Gaps in research and conceptualization. *Journal of Child And Family Studies, 16*(2), 183-196. https://doi.org/10.1007/s10826-006-9077-2

Steinhausen, H. (2009). The heterogeneity of causes and courses of attention-deficit/hyperactivity disorder. A*cta Psychiatrica Scandinavica, 120*(5), 392-399. https://doi.org/10.1111/j.1600-0447.2009.01446.x

Stevens, J., Kelleher, K. J., Ward-Estes, J., & Hayes, J. (2006). Perceived barriers to treatment and psychotherapy attendance in child community mental health centers. *Community Mental Health Journal, 42*(5), 449-458. https://doi.org/10.1007/s10597-006-9048-5

Stormshak, E. A., Connell, A. M., Véronneau, M., Myers, M. W., Dishion, T. J., Kavanagh, K., & Caruthers, A. S. (2011). An ecological approach to promoting early adolescent mental health and social adaptation: Family-centered intervention in public middle schools. *Child Development*, *82*(1), 209-225. https://doi.org/10.1111/j.1467-8624.2010.01551.x

Stormshak, E. A., Fosco, G. M., & Dishion, T. J. (2010). Implementing interventions with families in schools to increase youth school engagement: The family check-up model. *School Mental Health: A Multidisciplinary Research and Practice Journal, 2*(2), 82-92. https://doi.org/10.1007/s12310-009-9025-6

Tashman, N. A., Waxman, R. P., Nabors, L. A., & Weist, M. D. (1998). The Prepare approach to training clinicians in school mental health programs. *Journal of School Health, 68*, 162-172. https://doi.org/10.1111/j.1746-1561.1998.tb06337.x

Task Force on Promotion and Dissemination of Psychological Procedures. (1995). Training in and dissemination of empirically validated psychological treatments: Report and recommendations. *Clinical Psychologist, 48,* 3–23. Retrieved from http://www.div12.org/sites/default/files/InitialReportOfTheChamblessTaskForce.pdf

Taylor, L. & Adelman, H. S. (2001). *Enlisting appropriate parental cooperation and involvement in children's mental health treatment*. In E. R. Welfel & R. E. Ingersoll (Eds.), The Mental Health Desk Reference (pp. 219-224). New York, NY: Wiley. Retrieved from http://web.b.ebscohost.com.lib.pepperdine.edu/ehost/ebookviewer/ebook/bmxlYmtfXzYzNDU2X19BTg2?sid=49f04313bcf14c32833469f82db11203@sessionmgr103&vid=0&format=EB&rid=1

Ton, H., Koike, A., Hales, R. E., Johnson, J., & Hilty, D. M. (2005). A qualitative needs assessment for development of a cultural consultation service. *Transcultural Psychiatry, 42*, 491–504. https://doi.org/10.1177/1363461505055629

Trotter, R. I. (2012). Qualitative research sample design and sample size: Resolving and unresolved issues and inferential imperatives. *Preventive Medicine: An International Journal Devoted to Practice And Theory, 55*(5), 398-400. https://doi.org/10.1016/j.ypmed.2012.07.003

Tseng, W., Kawabata, Y., Gau, S. S., & Crick, N. R. (2014). Symptoms of attention-deficit/hyperactivity disorder and peer functioning: A transactional model of development. *Journal of Abnormal Child Psychology, 42*(8), 1353-1365. https://doi.org/10.1007/s10802-014-9883-8

Uebelacker, L. A., Hecht, J., & Miller, I. W. (2006). The family check-up: A pilot study of a brief intervention to improve family functioning in adults. *Family Process, 45*, 223-236. https://doi.org/10.1111/j.1545-5300.2006.00092.x

United Stats Census Bureau (2015). *QuickFacts Los Angeles County, California*. Retrieved from http://www.census.gov/quickfacts/table/PST045216/06037,06

U.S. Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs, (2006). *Teaching Children with Attention Deficit Hyperactivity Disorder: Instructional Strategies and Practices*. Washington, DC, 2006. U.S. Retrieved from https://www2.ed.gov/rschstat/research/pubs/adhd/adhd-teaching-2006.pdf

US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2010). *The mental and emotional well-being of children: A portrait of states and the nation 2007*. Rockville, MD: US Department of Health and Human Services. Retrieved from http://www.mchb.hrsa.gov/nsch/07emohealth/moreinfo/pdf/nsch07.pdf

Vaughn, S., & Linan-Thompson, S. (2003). What is special about special education for students with learning disabilities? *The Journal of Special Education*, *37*(3), 140–147. https://doi.org/10.1177/00224669030370030301

Villatoro, A. P., Dixon, E., & Mays, V. M. (2016). Faith-based organizations and the Affordable Care Act: Reducing Latino mental health care disparities. *Psychological Services, 13*(1), 92-104. https://doi.org/10.1037/a0038515

Villatoro, A. P., Morales, E. S., & Mays, V. M. (2014). Family culture in mental health help-seeking and utilization in a nationally representative sample of Latinos in the United States: The NLAAS. *American Journal Of Orthopsychiatry, 84*(4), 353-363. https://doi.org/10.1037/h0099844

Wagner, M., Friend, M., Bursuck, W. D., Kutash, K., Duchnowski, A. J., Sumi, W. C., & Epstein, M. H. (2006). Educating Students With Emotional Disturbances: A National Perspective on School Programs and Services. *Journal Of Emotional And Behavioral Disorders, 14*(1), 12-30. https://doi.org/10.1177/10634266060140010201

Walker, H. M. (2004). Commentary: Use of evidence-based interventions in schools: Where we've been, where we are, where we need to go. *School Psychology Review, 33*, 398-407. Retrieved from https://www.researchgate.net/publication/279558529_Commentary_Use_of_evidence-based_interventions_in_schools_Where_we%27ve_been_where_we_are_and_where_we_need_to_go

Walker, J. S., Coleman, D., Lee, J., Squire, P. N., & Friesen, B. J. (2008). Children's stigmatization of childhood depression and ADHD: Magnitude and demographic variation in a national sample. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*(8), 912–920. https://doi.org/10.1097/CHI.0b013e318179961a

Wallace, S. P., Torres, J., Sadegh-Nobari, T., Pourat, N., & Brown, E. R. (2012). *Undocumented immigrants and health care reform*. Los Angeles, CA: UCLA Center for Health Policy Research. Retrieved from http://healthpolicy.ucla.edu/publications/Documents/PDF/undocumentedreport-aug2013.pdf

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. *Archives Of General Psychiatry*, *62*(6), 629-640. https://doi.org/10.1001/archpsyc.62.6.629

Ward, E. C. (2005). Keeping it real: A grounded theory study of African American clients engaging in counseling at a community mental health agency. *Journal of Counseling Psychology, 52*, 471–481. Retrieved from http://psycnet.apa.org/index.cfm?fa=buy.optionToBuy&id=2005-13343-002

Webster-Stratton, C. (2011). *The Incredible Years: Parent, teacher, and children's training series*. Seattle, WA: Incredible Years, Inc. Retrieved from http://www.incredibleyears.com/books/iy-training-series-book/

Webster-Stratton, C. (n.d.) *Helping children learn to regulate their emotions*. Retrieved from http://incredibleyears.com/parents-teachers/articles-for-parents/

Webster-Stratton, C. & Herman, K. C. (2010). Disseminating incredible years series early-intervention programs: Integrating and sustaining services between school and home. *Psychology In The Schools, 47*(1), 36-54. https://doi.org/10.1002/pits.20450

Weisz, J., & Kazdin, A. (2010). *Evidence-based Psychotherapies for children and adolescents* (2nd Ed.). New York, NY: Guilford.

Whelley, P., Cash, R. E., & Bryson, D. (2004). *Helping children at home and school II: Handouts for families and educators*. Retrieved from http://www.nasponline.org/resources/

Williams, J. H., Horvath, V. E., Wei, H., Van Dorn, R. A., & Jonson-Reid, M. (2007). Teachers' perspectives of children's mental health service needs in urban elementary schools. *Children and Schools, 29*, 95–107. https://doi.org/10.1093/cs/29.2.95

Zhang, Y. & Wildemuth, B. M. (2009). Qualitative analysis of content. In B. Wildemuth (Ed.), Applications of Social Research Methods to Questions in Information and Library. Retrieved from https://www.ischool.utexas.edu/~yanz/Content_analysis.pdf

APPENDIX A

Extended Review of the Literature

Author(s) and Year	Title	Summary of Pertinent Information
American Federation of Teachers, (2007)	Building Parent-Teacher Relationships	Proposed strategies teachers can utilize to facilitate improved communication with families of students
Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., & … Giles, W. H. (2006)	The enduring effects of abuse and related adverse experiences in childhood	Results of the ongoing studies of Adverse Childhood Experiences (ACE) Study revealed ongoing changes in brain structure and neurobiological symptoms that impact health and well-being of individuals in adulthood
Angold, A., Messer, S., Stangl, D., Farmer, E., Costello, E., & Burns, B. (1998)	Perceived parental burden and service use for child and adolescent psychiatric disorders	Parental perception of burden (e.g., stigma, personal well-being, time commitment) is a strong predictor of treatment initiation for children; significant predictors of perceived burden included levels of child symptomatology and impairment, as well as parental mental health problems
Azad, G. F., Kim, M., Marcus, S. C., Sheridan, S. M., & Mandell, D. S. (2016).	Parent-teacher communication about children with autism spectrum disorder: An examination of collaborative problem-solving	Researchers examined the communication between parents and teachers regarding difficulties with their child/student with autism and found that parents and teachers struggle to engage in problem-solving strategies together.
Baker, J. A. (2006).	Contributions of teacher-child relationships to positive school adjustment during elementary school	Results revealed that improved teacher-student relationships were associated with lower levels of externalizing behaviors and serves as a protective factor against internalizing problems of children
Baker-Ericzén, M. J., Jenkins, M. M., & Haine-Schlagel, R. (2013)	Therapist, parent, and youth perspectives of treatment barriers to family-focused community outpatient mental health services	Disparities occur between the therapist and parent/youth perspectives regarding treatment engagement; Therapists reported valuing parent participation and utilization of family focused therapy; Parents reported feeling

		blamed, unsupported, and unheard by their child's therapists; Youth clients reported dissatisfaction in mental health services they received, expressed wish that their therapists would take a more active role in therapy
Ballard, E. D., Van Eck, K., Musci, R. J., Hart, S. R., Storr, C. L., Breslau, N., & Wilcox, H. C. (2015)	Latent classes of childhood trauma exposure predict the development of behavioral health outcomes in adolescence and young adulthood	Ongoing evaluation of the ACE study revealed differences across gender and type of trauma. Results indicate that childhood trauma exposure is associated with higher levels of PTSD, depression, substance use, and physical health problems
Bannon, W. M., & McKay, M. M. (2005)	Are barriers to service and parental preference match for service related to urban child mental health service use?	Barriers to service in urban communities primarily included concrete barriers, most significantly transportation problems, stressful barriers, including feeling too tired to come, and doubt barriers, specifically not being sure therapy will work
Battistich, V., Schaps, E., & Wilson, N. (2004)	Effects of an elementary school intervention on students' "connectedness" to school and social adjustment during middle school	Researchers evaluated effects of comprehensive intervention program on reducing childhood risk and improving resilience of youth. Findings were consistent with hypothesis, with increased commitment to school and fewer behavior problems in student participants
Becker, K. D., Kiser, L. J., Herr, S. R., Stapleton, L. M., Barksdale, C. L., & Buckingham, S. (2014)	Changes in treatment engagement of youths and families with complex needs	Three domains of treatment engagement were identified: therapeutic alliance, satisfaction with services, and treatment participation; families in intensive therapy settings had significantly lower initial engagement
Bernard, H.R. (2011)	Research Methods in Anthropology: Qualitative and Quantitative Approaches, Fifth edition	Ideal sample size for qualitative research is posited to be achieved once all concepts have been repeated and when no additional concepts emerge from the data
Betz, C. L., Baer, M. T., Poulsen, M.,	Secondary analyses of primary and preventative	Examination of service accessed and service obstacles to treatment

Vahanvaty, U., & Bare, M. (2004)	services accessed and perceived service barriers by children with developmental disabilities and their families	of children with developmental disabilities revealed treatment affordability as a significant treatment barrier
Bierman, K. L., Coie, J., Dodge, K., Greenberg, M., Lochman, J., McMohan, R., & Pinderhughes, E. (2013)	School outcomes of aggressive-disruptive children: Prediction from kindergarten risk factors and impact of the Fast Track prevention program	Study examined the impact of multi-component intervention program at reducing aggressive and disruptive behaviors in children. Results indicated that behavior problems and skills at school entry predicted future school difficulties. Long-term sustained effects of program were not evidenced.
Bos, A. R., Pryor, J. B., Reeder, G. D., & Stutterheim, S. E. (2013).	Stigma: Advances in theory and research.	Researchers provided a theoretical overview of the concept of stigma, including differentiations between self-stigma, public stigma, structural stigma, and stigma by association
Bowers, H., Manion, I., Papadopoulos, D., & Gauvreau, E. (2013)	Stigma in school-based mental health: Perceptions of young people and service providers	Stigma is perceived as a significant barrier to youth accessing school-based mental health services and substance abuse programs; limited mental health literacy in school; engaging youth in planning and developing mental health and substance abuse treatment programs is one means of decreasing barrier to treatment
Briggs-Gowan, M. J., Carter, A. S., Skuban, E. M., & Horwitz, S. M. (2001)	Prevalence of social-emotional and behavioral problems in a community sample of 1- and 2-year-old children	Approximately 10% of preschoolers exhibit noticeable social and behavioral problems, with between 4% and 6% of these children exhibiting serious problems; results suggest that there is a significant need for early identification of emotional/ behavioral problems in young children due to the risk of delayed competence and disruptions in family life
Bronfenbrenner, U. (1992)	Six theories of child development: Revised formulations and current issues	Ecological systems theory suggests that development is a function of force from multiple settings and from the relations between these settings; these settings include

		one's microsystem (one's immediate environment), mesosystems (connections between the various microsystems), exosystems (indirect environment), and macrosystem (social and cultural
Campbell, S. B. (2002)	Behavior problems in preschool children: Clinical and developmental issues	Advanced social skills in early childhood has been associated with low levels of anxiety, symptoms of impulsivity, disruptiveness, and defiance
Centers for Disease Control and Prevention. (2013)	Mental health surveillance among children – United States, 2005-2011	Data on prevalence of mental disorders revealed that millions of children (ages 3-17) in the U.S. who suffer from anxiety disorders, attention deficit-hyperactivity disorder (ADHD), autism spectrum disorders, mood disorders (e.g. depression), disruptive behavioral disorders, and many other mental health issues; children with mental health issues were noted often experiencing difficulties in multiple areas of their lives including at home, in school, and with peers
Center for Mental Health in Schools at UCLA. (2008).	Conduct and Behavior Problems Related to School Aged Youth	Identified common difficulties children with aggressive and disruptive behaviors encounter and strategies parents and teachers can utilize in response to facilitate improved behavioral regulation
Chaffin, M., Valle, L., Funderburk, B., Gurwitch, R., Silovsky, J., Bard, D., & ... Kees, M. (2009)	A motivational intervention can improve retention in PCIT for low-motivation child welfare clients	Motivational orientation intervention was found to improve retention only when combined with PCIT; benefits of the intervention were robust across demographic characteristics and participation barriers
Chambless, D. L., & Hollon, S. D. (1998)	Defining empirically supported therapies	Empirically supported treatments include the various factors: randomized clinical trials, description of the clinical sample, outcome assessment, and treatment manuals and standardized implementation

Chang, D. F., & Berk, A. (2009)	Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy	Based upon the study, recommendations were made regarding clinical practice, including early discussion of culture and diversity issues in treatment, acknowledgement of the potential biases and limitations within the therapist-client's cultural relationships
Chorpita, B., Becker, K., Phillips, L., Ebesutani, C., Cromley, T., & Daleiden, E. (2012).	Practitioner Guides. Satellite Beach, FL: PracticeWise.	Compilation of evidence-based practices distilled by elements found to be more efficacious to facilitate practitioner use of relevant elements given client's needs and demographics
Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2005)	Modularity in the design and application of therapeutic interventions	Modular designs of psychotherapy provides a promising framework for testing the underlying assumptions of traditional therapy protocols; modularity offers numerous potential advantages, including reusability of modules, ease of updating/reorganizing protocols, enhanced adaptability for applied content, and increased therapist satisfaction
Christophersen, E. R., VanScoyoc, S. M. M., (2013)	Treatments that work with children: Empirically supported strategies for managing childhood problems (2nd ed.).	Compilation of empirically supported strategies for childhood difficulties
Cohen, M., & Irwin, C. E. (1983)	Parent-Time: Psychoeducational groups for parents of adolescents.	Parent-Time is a universal psychoeducational program for parents of adolescents ranging in age from 11 to 14 years; offered as a series of 90-minute sessions held over five consecutive weeks; provided support, information, and problem solving techniques that parents of adolescents can use during the particularly stressful time during of their child's transition into adolescence; parents who completed the program reported benefiting from learning about normative for adolescent

		behavior, experienced increased feelings of self-confidence in their parenting skills, appreciated the need for listening and limit setting for their adolescents, and honed the ability to share concerns regarding their children
Corrigan, P. W., & Rao, D. (2012)	On the self-stigma of mental illness: Stages, disclosure, and strategies for change..	Discussion of self-stigma and it's relation to mental health treatment across various cultural facets.
Creswell, J.W. (2013)	Research Design: Qualitative, Quantitative, and Mixed Methods Approaches, 4th edition	Core assumption of mixed method research is that the use of a combination of qualitative and quantitative approaches will provide a more complete understanding of a research question than either approach on its own; qualitative sample sizes are generally smaller than quantitative samples because the intent of qualitative research is to gather more extensive information rather than to conduct meaningful statistical analyses; mixed methods designs are conducted by including a small sample of qualitative participants within the larger quantitative sample, as seen through convergent parallel mixed methods research designs;
Cuffel, B., McCulloch, J., Wade, R., Tam, L., Brown-Mitchell, R., & Goldman, W. (2000)	Patients' and providers' perceptions of outpatient treatment termination in a managed behavioral health organization	Evaluation of patients' and providers' perspectives revealed that treatment ended because patient and provider agreed that treatment goals had been sufficiently met; only a small percent of providers reported that managed care denied ongoing treatment
Cunningham, C. J. L., Weathington, B. L., & Pittenger, D. J. (2013)	Understanding and conducting research in the health sciences	Mixed-methods research designs are rooted in grounded research, which provides researchers with the opportunity to collecting data without having an established hypothesis
Davis, M., Eshelman,	The relaxation & stress	Strategies outlined by researchers

E. R., & McKay, M. (2000)	reduction workbook (5th ed.).	that have been found to be efficacious at reducing stress for chidlren and families
Department of Education. (2014).	What is bullying (ED, Bullying Summit).	Parent friendly definition and information provided regarding bullying and the prevalence of bullying in school-aged children
Donovan, M., & Cross, C. (Eds.). (2002)	Minority students in special and gifted education.	Research shows that minority students are often times overrepresented in special education classrooms, indicating problematic identification practices in school settings
Dube, S. R., Fairweather, D., Pearson, W. S., Felitti, V. J., Anda, R. F., & Croft, J. B. (2009)	Cumulative childhood stress and autoimmune diseases in adults	Ongoing study of results of the ACE study indicate that children who endured childhood traumatic stress were more susceptible to physical health problems, including autoimmune disease in adulthood
DuPaul, G. J., Gormley, M. J., & Laracy, S. D. (2014)	School-based interventions for elementary school students with ADHD	Prevalence of ADHD as reported by parents indicated that ADHD has increased by approximately 42% since the last 8 years, with the median age of diagnosis occurring at age 6
Durlak, J. A., & DuPre, E. P. (2008)	Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation	Meta-analysis of quantitative studies revealed that level of implementation impacts the outcomes obtained from promotion and prevention programs; implementation is impacted by numerous variables including communities, providers and innovations, aspects of the delivery system and the prevention support system
Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. B. (2011)	The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions.	Preventative interventions were found to be highly efficacious in enhancing the social-emotional functioning of school-aged children, problems with implementation have been found to significant impact the outcome of the intervention
Eiraldi, R. B., Mazzuca, L. B.,	Service utilization among ethnic minority children with	Results indicate that racial bias and discrimination within the health

Clarke, A. T., & Power, T. J. (2006)	ADHD: A model of help-seeking behavior.	care system perpetuate negative help-seeking attitudes and jeopardizes the quality of services available to ethnic minorities in general; matching provider and families based on race/ethnicity is associated with increased treatment utilization and lower treatment dropout
Ekornes, S. (2015)	Teacher perspectives on their role and the challenges of inter-professional collaboration in mental health promotion.	Teacher perceive their gatekeeping role as significant to the referral process; teachers also highlight the importance of and challenges to inter-professional collaboration including communication and confidentiality, time constraints, contextual presence and understanding, cross-system contact, school leadership, and teacher competence in mental health
Ellis, M. L., Lindsey, M. A., Barker, E. D., Boxmeyer, C. L., & Lochman, J. E. (2013)	Predictors of engagement in a school-based family preventive intervention for youth experiencing behavioral difficulties	Engagement has been defined as attendance, involvement, participation, commitment, buy-in, and retention; levels of engagement have been shown to fluctuate throughout the course of treatment intervention; child levels of engagement early in treatment influenced parent mid-intervention relationship
Elo, S., & Kyngäs, H. (2008)	The qualitative content analysis process.	Qualitative data analysis can be organized hierarchically into theme titles that describe one or several concept groupings and parent themes
Evans, S. W., Owens, J. S., & Bunford, N. (2014)	Evidence-based psychosocial treatments for children and adolescents with attention-deficit/hyperactivity disorder.	Behavioral techniques for chidlren with attention and concentration problems include classroom accommodations and changes in instructional procedures, including daily report cards
Farmer, E. M., Burns, B. J., Phillips, S. D., Angold, A., & Costello, E. J. (2003)	Pathways into and through mental health services for children and adolescents	The education system was the most common point of entry and provision of mental health services across all child age groups;

		interagency collaboration between the three primary sectors within a child's life, including education, specialty mental health service, and general medicine, is critical in the treatment of children
Feinstein, N. R., Fielding, K., Udvari-Solner, A., & Joshi, S. V. (2009)	The supporting alliance in child and adolescent treatment: Enhancing collaboration among therapists, parents, and teachers	The therapeutic alliance between therapist and patients in pediatric, as well as inter-professional collaboration facilitate mental health promotion
Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & ... Marks, J. S. (1998)	Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults.	Researchers found that children who experienced adverse childhood events were more likely to engage in behaviors that increased their risk of death, including substance and alcohol use, and were at greater risk for depression and suicide
Fergusson, D. M., Horwood, L. J., & Stanley, L. (2013)	A Preliminary Evaluation of the Incredible Years Teacher Programme	Evaluation of IY revealed teacher reports of increased frequency of use and usefulness of positive behavior management strategies and higher levels of teacher satisfaction of the program, including overall program, strategies, techniques, and workshop leaders
Ferrin, M., Moreno-Granados, J. M., Salcedo-Marin, M. D., Ruiz-Veguilla, M., Perez-Ayala, M., & Taylor, E. (2013).	Evaluation of a psychoeducation programme for parents of children and adolescents with ADHD: immediate and long-term effects using a blind randomized controlled trial.	Authors developed and evaluated a 12-week manualized psychoeducational program for parents of children and adolescents ranging in age from 5-18 years with Attention-Deficit/Hyperactivity Disorder (ADHD); first 9 weeks educated parents on the disorder while the last three weeks introduced parents to behavioral strategies for managing symptoms of ADHD and reducing defiant behavior; parents who completed the program reported that their children exhibited reduced ADHD symptoms and improved pro-social behavior.
Fisher, M., & Meyer,	Development and social	Researchers evaluated that social

L. (2002)	competence after two years for students enrolled in inclusive and self-contained educational programs.	and developmental competence of children enrolled in the least restrictive setting and found better outcomes as compared to students who were in more restrictive learning environments
Flicker, S. M., Waldron, H. B., Turner, C. W., Brody, J. L., & Hops, H. (2008)	Ethnic matching and treatment outcome with Hispanic and Anglo substance-abusing adolescents in family therapy.	Evaluations of factors that facilitated improved treatment engagement and outcomes revealed improved outcomes for therapy dyads that were ethnically matched
Flores, G., Olson, L., & Tomany-Korman, S. C. (2005).	Racial and ethnic disparities in early childhood health and health care	Minority parents reported that providers rarely if ever understood their child-rearing practices and were more often asked about violence, smoking, and drug use; findings suggest that minority children experience multiple disparities in health status, insurance coverage, topics addressed in visit, parents' feeling understood, parental satisfaction, and referral to specialists
Frey, K. S., Hirshstein, M. K., & Guzzo, B. A. (2000).	Second Step: Preventing aggression by promoting social competence	Second step is a violence-prevention program created to reduce the development of social, emotional and behavioral problems; teacher instruction on emotional identification and communication in early childhood was correlated with enhanced social skills and lower levels of problem behaviors
Fristad, M. A., Gavazzi, S. M., & Mackinaw- Koons, B. (2003)	Family psychoeducation: An adjunctive intervention for children with bipolar disorder.	Multi-Family Psychoeducation Group (MFPG) Therapy Program was modified for children with specific diagnoses of bipolar disorder and major depressive disorder or dysthymia; child participants significantly increased knowledge about symptoms of both disorders, use of support services, and report of parental support
Fristad, M. A., Gavazzi, S. M., & Soldano, K. W. (1998)	Multi-family psychoeducation groups for childhood mood disorders: A program description and	Multi-Family Psychoeducation Group (PFPG) Therapy Program for children diagnosed with mood disorders; family participants

	preliminary efficacy data	reported improved family climate, increase in positive behavior and decrease in negative behavior of child; improvements were sustained four months following intervention
Fristad, M. A., Goldberg-Arnold, J. S., & Gavazzi, S. M. (2002)	Multifamily psychoeducation groups (MFPG) for families of children with bipolar disorder	Multi-family psychoeducation groups (MFPG) was evaluated for children with bipolar disorder and mood disorders; participating families gained knowledge, skills support and positive attitudes during treatment
Garland, A. F., Lau, A. S., Yeh, M., McCabe, K. M., Hough, R. L., & Landsverk, J. A. (2005)	Racial and Ethnic Differences in Utilization of Mental Health Services Among High-Risk Youths.	Researchers examined the difference of treatment utilization by ethnic and racial groups and found lower rates of utilization by minority groups
Gary, F. A. (2005)	Stigma: Barrier to mental health care among ethnic minorities	Double stigma is a concept that describes the negative outcomes associated with discrimination based on minority group status and the burden of having to live with a mental disorder; mental illness is perceived as shameful in many cultures and can threaten a family's reputation or status in the community as well as their relationships with others
Goffman, E. (1963).	Stigma: Notes on the management of spoiled identity	Researcher reviewed the literature on stigma and provided another definition of the concept to integrate the viewpoints on stigma towards mental health treatment
Gordon, R. S. (1983)	An operational classification of disease prevention	Preventative measures are those which should be applied to persons not currently suffering; universal prevention programs are the most generally applicable to most populations
Gould, S. R., Beals-Erickson, S. E., & Roberts, M. C. (2012).	Gaps and barriers in services for children in state mental health plans	Significant gaps and barriers exist in the mental health care of children; most frequently recognized gap was identified as lack of providers; most frequent barrier was identified as lack of

		funding
Gueldner, B., & Merrell, K. (2012)	Interventions for Students with Internalizing Behavioral Deficits	Researchers compiled research on evidence-based strategies to treat children with internalizing problems
Hemmeter, M. L., Ostrosky, M., & Fox, L. (2006)	Social and Emotional Foundations for Early Learning: A Conceptual Model for Intervention.	Researchers recommended various strategies to facilitate improved social and emotional development within the school setting, advocating for improved communication between teachers and students
Herman, K. C., Reinke, W. M., Stormont, M., Puri, R., & Agarwal, G. (2010)	Using prevention science to promote children's mental health: The Founding of the Missouri Prevention Center	Research shows that emotional and behavioral problems in children can be prevented; preventative science has been shown to improve the mental health of children
Hinojosa, M., Knapp, C., & Woodworth, L. (2014)	Family strain among White and Latino parents of children with mental and behavioral health disorders	Family strain differs among White and Latino families; Latino family strain was predicted by age of parent, perception of treatment quality; child's current symptom burden; White family strain was predicted by child health status, symptom burden, and parent level of education
Hinshaw, S. P. (2005)	The stigmatization of mental illness in children and parents: Developmental issues, family concerns, and research needs	Stigmatization exists regarding mental illness in children and parents; stigmatization of childhood conditions is related to low status of children and the devaluation of mental disorders; stigma has great impact on parenting, which impacts the development of their children
Hoagwood, K., Burns, B.J., Kiser, L., Ringeisen, H.. & Schoenvrald. S. K. (2001)	Evidence-based practice in child and adolescent mental health services	Children undergo more rapid psychological, neuronal, and physiological changes over a shorter amount of time; creation of treatment for a child is rarely undertaken without consideration of the family context; improving implementation of evidence-based practice includes adopting new models of treatment development and augmentation
Hoberman, H. M.	Ethnic minority status and	Urban youth have been found to be

(1992)	adolescent mental health services utilization.	less likely to utilize the mental health services available within their own communities, despite the greater number of risk factors for mental health problems among urban minority youth, even when controlling for affordability and parental level of education
Hosp, J., & Reschly, D. (2003)	Referral rates for intervention or assessment: A meta-analysis of racial differences.	Evaluation of referrals within special education revealed that African American children were more likely classified under the emotional disturbance category and were more often segregated within the educational setting
Hruschka, D. J., Schwartz, D., St. John, D. C., Picone-Decaro, E., Jenkins, R. A., & Carey, J. W. (2004)	Reliability in coding open-ended data: Lessons learned from HIV behavioral research	Evaluation of the interrater reliability process revealed that initial coder teams produce significantly differing codes; intercoder reliability improved following codebook revision and recoding
Hsieh, H. F., & Shannon, S. E. (2005)	Three approaches to qualitative content analysis	Content analysis is widely utilized in qualitative research and has three approaches, including conventional, directed, or summative; in content analysis, code categories are derived directly from data; in directed analysis, analysis starts with a theory or relevant research findings as guidance for initial codes; content analysis involves counting and comparisons of the content
Hutton, J. L. (1985)	What reasons are given by teachers who refer problem behavior students?	Elementary school teachers serve a critical role as the individuals who initiate referrals on behalf of their student; most frequently stated reasons for referral included poor peer relationships, frustration, below academic achievement, shy/withdrawn behavior, fighting, refusal to work, short attention span
Ingoldsby, E. M. (2010).	Review of interventions to improve family engagement and retention in parent and	Four out of seven general approaches to treatment engagement were found to be

	child mental health programs	successful: brief early treatment engagement discussions, family systems approaches, enhancing family support and coping, and motivational interviewing
Jennings, P. A., & Greenberg, M. T. (2009)	The prosocial classroom: Teacher social and emotional competence in relation to student and classroom outcomes.	Researchers found that improved parent-teacher communication was associated with improved prosocial classroom behavior for students
Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007)	Toward a definition of mixed methods research	Mixed method designs provides researchers the benefit of qualitative and quantitative approaches throughout the data collection, data analysis, and interpretation processes
Johnson, S., Cooper, C., Cartwright, S., Donald, I., Taylor, P., & Millet, C. (2005)	The experience of work-related stress across occupations	An evaluation of professions revealed that teaching is one of the most stressful professions worldwide, with teachers reporting lower scores on measures of physical health, psychological well-being, and job satisfaction
Karver, M. S., Handelsman, J. B., Fields, S., & Bickman, L. (2005)	A theoretical model of common process factors in youth and family therapy	Evaluation of universal aspects of the therapy process that impact therapy outcomes found treatment engagement can be measured through treatment attendance/retention, homework completion, participation in the discussion of feelings, etc.
Kataoka, S. H., Zhang, L., & Wells, K. B. (2002)	Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status	The majority of children in need of mental health evaluations do not receive the services; 2-3% of 3-5 year old children and 6-9% of 6-17 year old children were identified as needing mental health services; 80% did not receive care; Latino participants and uninsured participants had higher rates of unmet need relative to children of other backgrounds;
Katz, L. G., & McClellan, D. E. (1997)	Fostering children's social competence: The teacher's role.	A system for fostering social competence is presented in this study, with emphases on skill acquisition, fluency training, and

		maintenance and generalization of skills
Kazdin, A. E., Holland, L., & Crowley, M. (1997)	Family experience of barriers to treatment and premature termination from child therapy	Barriers to participation in treatment significantly contributed to therapy dropout rates; among family participants at high risk of dropout, the perception of few barriers to treatment was associated to a reduced risk to drop out; parent perceptions of barriers to treatment, such as logistical factors (scheduling difficulties, sickness of child or caregiver) influenced drop out
Kazdin, A., E., Holland, L., Crowley, M., & Breton, S. (1997).	Barriers to treatment participation scale: Evaluation and validation in the context of child outpatient treatment	Evaluation of the Barriers to Treatment Scale found four themes: stressors and obstacles that compete with treatment, treatment demands and issues, perceived relevance of treatment, relationship with therapist; the experience of barriers to treatment participation per parent or therapist report predicted higher rates of treatment dropout, fewer weeks in treatment, higher rates of cancellations/no shows
Kenny, M. C. (2009)	Child sexual abuse prevention: Psychoeducational groups for preschoolers and their parents.	Parents as Teachers of Safety (PaTs) is a universal psychoeducational program for children ages 3 to 5 and their parents with the aim of preventing child sexual abuse; the prevention program significantly increased children's knowledge about sexual abuse and safety; parent ratings revealed perceptions that their children were more assertive in overall behavior and better able to communicate thoughts and feelings regarding sexual abuse post treatment
Kernan, J. B., Griswold, K. S., & Wagner, C. M. (2003)	Seriously emotionally disturbed youth: A needs assessment.	Evaluation of the needs of seriously emotionally disturbed youth revealed a need for improved case management, service coordination, child and family specific services,

		and expanded community-based services; one significant barrier to treatment attendance was found to be lack of childcare
Kessler, R. C., Brown, R. L., & Broman, C. L. (1981)	Sex differences in psychiatric help-seeking: Evidence from four large-scale surveys	Study examined differences across sexes with regard to help-seeking behavior and found that men were less likely to seek treatment and access mental health services as compared to women
King, S., Kropf, N. P., Perkins, M., Sessley, L., Burt, C., & Lepore, M. (2009)	Kinship in rural Georgia communities: Responding to needs and challenges of grandparent caregivers	Study of grandparents raising grandchildren revealed that grandparents encountered numerous challenges related to child rearing, including limited services for children with disabilities, lack of assistance with legal issues related to adoption, lack of intensive services providers, feelings of isolation in the community; grandparents barriers to support group participation included lack of transportation and childcare
Koller, J. R., & Bertel, J. M. (2006)	Responding to Today's Mental Health Needs of Children, Families and Schools: Revisiting the Preservice Training and Preparation of School-Based Personnel	Teachers identified as pivotal in the treatment of childhood mental health needs; teachers must gain training in empirically supported tools to manage the impact of childhood difficulties in the classroom
Kourany, R. F., Garber, J., & Tornusciolo, G. (1990)	Improving first appointment attendance rates in child psychiatry outpatient clinics	Study regarding child psychiatry outpatient appointment attendance revealed that many parents view periods of improvement in their child's functioning as a sign that treatment is not needed
Kouyoumdjian, H., Zamboanga, B. L., & Hansen, D. J. (2003)	Barriers to community mental health services for Latinos: Treatment considerations	Underutilization of mental health services by Latinos continues to be a growing concern; physiological symptoms are generally viewed as more concerning than mental health issues in Latino culture; the collectivistic tradition of Latino culture promotes individuals to go to members of their own cultural groups for help prior to seeking

		assistance from other individuals or agencies
Kuperschmidt, J. B., Bryant, D., & Willoughby, M. (2000)	Prevalence of aggressive behaviors among preschoolers in Head Start and community child care programs	Evaluation of preschoolers per teacher report revealed that approximately 16 to 30% of students in Head Start classrooms exhibit significant social-emotional difficulties and behavioral problems; the multidimensional nature of aggression was evaluated, and results indicate that aggressive behaviors may constitute two types of aggression, antisocial and relational
Kurasaki, K. S. (2000)	Intercoder reliability for validating conclusions drawn from open-ended interview data	Interrater reliability calculations are conducted through examination of the degree to which coders agreed upon a set number of transcription units
Ladd, G. W., Herald, S. L., & Kochel, K. P. (2006)	School readiness: Are there social prerequisites?	Researchers evaluated the various perspectives of school readiness skills, including interpersonal challenges that occur for young children as they enter kindergarten
Lambert, R. G., McCarthy, C., O'Donnell, M., & Wang, C. (2009)	Measuring elementary teacher stress and coping in the classroom: Validity evidence for the classroom appraisal of resources and demands	Classroom Appraisal of Resources and Demands (CARD) revealed that teacher demands include the stressors of managing children with problem behaviors, lack of instructional resource, administrative demands, and other student related demands
Landrum, T., Katsiyannis, A., & Archwamety, T. (2004).	An analysis of placement and exit patterns of students with emotional or behavioral disorders	Researchers examined the outcomes of students with emotional and behavioral problems and found that little improvement was found despite ongoing school intervention
Landrum, T., Tankersley, M., & Kauffman, J. (2003)	What is special about special education for students with emotional or behavioral disorders?	Researchers advocate for use of researched and evidence-based practices within school settings to facilitate improved social and emotional functioning for these students
Langley, A. K., Nadeem, E., Kataoka,	Evidence-based mental health programs in schools: Barriers	Evaluation of factors associated with implementation of Cognitive

S. H., Stein, B. D., & Jaycox, L. H. (2010)	and facilitators of successful implementation	Behavioral Intervention for Trauma in Schools (CBITS) revealed three factors that improved implementation of the school service: that greater organizational structure, administrative support, and clinicians' social network of other clinicians implementing the program
Larson, J., dosReis, S., Stewart, M., Kushner, R., Frosch, E., & Solomon, B. S. (2013)	Barriers to mental health care for urban, lower income families referred from pediatric primary care	Evaluation of parent-reported barriers on the likelihood of treatment attendance to mental health services revealed intangible barriers
Lawhon, T., & Lawhon, D. C. (2000)	Promoting social skills in young children	Researchers identified parent and teacher friendly strategies that can be utilized to promote prosocial behaviors in children
Leavell, H.R., & Clark, E.G. (1965)	Preventive medicine for the doctor in his community: An epidemiologic approach (3rd ed.)	Describes a clinical approach to community health utilizing indicative prevention, where a disease problem is defined, special characteristics of the disease are identified, and the characteristics are made the basis for the development of prevention programs
Lee, T. (2012)	School-based interventions for disruptive behavior	Researcher compiled evidence-based strategies used within the school setting for chidlren with disruptive behaviors
Leigh, I. W., Powers, L., Vash, C., & Nettles, R. (2004)	Survey of psychological services to clients with disabilities: The need for awareness	Barriers to treatment with disabilities were found to include accessibility, funding, lack of provider knowledge, lack of sensitivity, and limited training in disability issues and services
Liang, J. (2010)	Parental involvement in mental health services for diverse youth	Preferred and actual parental involvement was found to reduce functional impairment in youth; while racial/ethnic minority parents endorsed higher levels of preferred involvement than non-Hispanic white participants, Hispanic parents reported having less actual involvement; Hispanic parents

		reported that they child's functional impairment improved overtime as compared to other racial/ethnic groups
Little, S. G., & Akin-Little, A. (2011)	Responses to childhood trauma: An international perspective	Researchers conducted an evaluation of childhood responses to traumatic events across various nations and promoted school-based awareness regarding the impact of trauma
Little, S. G., Akin-Little, A., & Gutierrez, G. (2009)	Children and traumatic events: Therapeutic techniques for psychologists working in the schools.	Researchers compiled the strategies used within school settings to address trauma reactions, including Trauma-Focused CBT
Lombard, M., Snyder-Duch, J., & Bracken, C.C. (2002)	Content analysis in mass communication: Assessment and reporting of intercoder reliability	In most research situations, intercoder reliability is generally deemed acceptable with a Kappas of .80 or greater, with .90 viewed as excellent; interrater reliability for exploratory qualitative research is deemed acceptable at a Kappa of .70
Lukens, E. P., & McFarlane, W. R. (2004)	Psychoeducation as evidence-based practice: Considerations for practice, research, and policy.	Psychoeducation recently gained backing as an evidence-based practice to significantly enhancing treatment engagement for youth and their families
Mackenzie, C. S., Erickson, J., Deane, F. P., & Wright, M. (2014)	Changes in attitudes toward seeking mental health services: A 40-year cross-temporal meta-analysis	Evaluation of help-seeking attitudes revealed that negative attitudes towards mental health have persisted throughout the last four decades, and have become increasingly negative over time
Mandell, D. S., Davis, J. K., Bevans, K., & Guevara, J. P. (2008)	Ethnic disparities in special education labeling among children with attention deficit/hyperactivity disorder.	Researchers evaluated the ethnic disparities between services provided to children in special education by race. Black students were more likely to be labeled with emotional disturbance but less likely to receive the necessary services
Marlow, R., Hansford, L., Edwards, V., Ukoumunne, O. C., Norman, S.,	Teaching classroom management—A potential public health intervention?	Researchers studied the effect of a teacher classroom management program and found that teachers reported an increase in self-efficacy

Ingarfield, S., & ... Ford, T. (2015).		and improvememnts within the classroom following participation in the program, but cited implementation barriers to such an intervention.
Mazer, J. P. (2013).	Associations Among Teacher Communication Behaviors, Student Interest, and Engagement: A Validity Test.	Evaluation of teacher classroom behavior was conducted to identify strategies to improve student engagement and interest in the classroom setting.
McGinty, K. L., Diamond, J. M., Brown, M. B., & McCammon, S. L. (2003)	Training child and adolescent psychiatrists and child mental health professionals for systems of care	Six important aspects needed to work in systems of care include partnering with families, service planning, attending to caregiver stress, interdisciplinary collaboration, supervision, and outcomes and accountability
McKay, M. M., & Bannon, W. M. J. (2004)	Engaging families in child mental health services	Initial treatment engagement for youth with mental health needs is initiated by instrumental adults, including teachers, parents, or other adults within his/her context;
Menting, A. A., de Castro, B. O., & Matthys, W. (2013)	Effectiveness of the Incredible Years parent training to modify disruptive and prosocial child behavior: A meta-analytic review	Evaluation of the effectiveness of the Incredible Years (IY) program revealed that teacher participants endorsed significant increases in use of positive behavioral management techniques, increased perception of the utility of the techniques, and increased overall confidence in teachers' ability to manage problematic behaviors in the classroom
Merrell, K. W., & Gimpel, G. A. (1998)	Social skills of children and adolescents: Conceptualization, assessment, treatment	Researchers identified four distinct components of social competence for children and adolescents, including self-related behaviors, task-related behaviors, interpersonal behaviors, and environmental behaviors
Mertens, D.M. (2009)	Research methods in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods. (3rd Ed.)	Ethical research practices emphasize the importance of maintaining participant confidentiality by de-identifying research materials by providing research identification numbers to

		all participants upon enrollment into the study
Meyer, O. L. & Zane, N. (2013)	The influence of race and ethnicity in clients' experiences of mental health treatment	Clinician knowledge of race, ethnicity, and issues of discrimination and prejudice was necessary in the treatment of ethnic minority clients when compared to White clients
Miller, R.L. & Brewer, J. (Eds). (2003)	The A-Z of social research: A dictionary of key social science research concepts.	Qualitative researchers must engage in reflexivity throughout the data collection and analysis stages in order to enhance the quality of the study and to minimize research biases
Miranda, J., Woo, S., Lagomasino, I, Hepner, K. A., Wiseman, S., & Munoz, R. (2008)	Client's guidebook: Thoughts and your mood	Individual client treatment manual for depression utilizing cognitive behavioral therapy adapted from a group format manualized treatment
Morrissey-Kane, E., & Prinz, R. J. (1999)	Engagement in child and adolescent treatment: The role of parental cognitions and attributions	Parental involvement in treatment is highly influenced by parents' beliefs regarding the cause of their child's problems, parents' perceptions regarding their ability to manage those problems, parents' expectations about the ability for treatment to help the problem behavior; attrition significantly impacts the effectiveness and cost of services; parent barriers also include limited financial resources and scheduling problems
Mrazek, P. B., & Haggerty, R. J. (1994)	Reducing risks for mental disorders frontiers for preventive intervention research	Universal prevention programs as those which are applied to all individuals in order to improve mental health of all persons within that population
Mukolo, A., Heflinger, C. A., & Wallston, K. A. (2010).	The stigma of childhood mental disorders: A conceptual framework	Researchers outlined a framework to understand the complexities of the stigma associated with childhood mental illness and best practices regarding how to work with children and families suffering from the effects of stigma
Murphy, K. R., Myors, B., & Wolach,	Statistical Power Analysis: A Simple and	Power analysis has been identified as the gold standard for determining

A. H., (2009)	General Model for Traditional and Modern Hypothesis Tests, 3rd edition	sample size for probabilistic research
National Research Council and Institute of Medicine. (2009)	Preventing mental, emotional, and behavioral disorders among young people: progress and possibilities	It is estimated that approximately 14-20% of youth suffer from mental health disorders including drug and alcohol use, violence, antisocial and/or aggressive behavior; cost of such disorders for youth is estimated to be approximately $247 billion
Newman-Carlson, D. & Horne, A. M. (2004).	Bully Busters: A Psychoeducational Intervention for Reducing Bullying Behavior in Middle School Students.	Researchers developed a psychoeducational program for school-aged students for the purpose of reducing bullying behavior through increasing feelings of empathy for the experience of peers
Nock, M. K., & Kazdin, A. E. (2001)	Parent expectancies for child therapy: Assessment and relation to participation in treatment	Evaluation of parent expectations regarding child mental health treatment revealed that families of ethnic minority status, single-parent households, and socioeconomic disadvantage had lower expectations of mental health treatment
Nock, M. K., & Kazdin, A. E. (2005)	Randomized controlled trial of a brief intervention for increasing participation in parent management training	Providing parents with psychoeducation regarding the treatment process and aiding parents in identifying and planning for anticipated barriers has been found effective at improving treatment attendance and adherence
Nock, M. K., & Photos, V. (2006)	Parent Motivation to Participate in Treatment: Assessment and Prediction of Subsequent Participation	The Parent Motivation Inventory (PMI) was developed to measure parental motivation on treatment participation; increased parental motivation predicted perception of fewer treatment barriers, which was associated with increased treatment attendance
Ojeda, V., & Bergstresser, S. (2008)	Gender, race-ethnicity, and psychosocial barriers to mental health care: An examination of perceptions	The main cultural factors influencing mental health treatment utilization in youth and their families has been identified as race

	and attitudes among adults reporting unmet need	and ethnicity, which are strongly linked to treatment seeking attitudes and behaviors; minority communities, particularly within the African American community, often experience mistrust or far of the mental health care system, potentially a result of the discrimination they have faced
Owens, P. L., Hoagwood, K., Horwitz, S. M., Leaf, P. J., Poduska, J. M., Kellam, S. G., & Ialongo, N. S. (2002).	Barriers to children's mental health services	Researchers examined the barriers to mental health treatment for children include parental factors, such as limited formal education, low expectations of treatment outcomes, and parental pyschopathology
Pajer, K. A., Kelleher, K., Gupta, R., Rolls, J., & Gardner, W. (2007)	Psychiatric and medical health care policies in juvenile detention facilities	Implications of the study highlight the cost/affordability of treatment as a significant barrier to implementation of health care policy initiatives
Pas, E., Bradshaw, C. P., & Hershfeldt, P. A. (2012)	Teacher- and school-level predictors of teacher efficacy and burnout: Identifying potential areas of support	Evaluation of classroom risks and resources revealed that teachers' emotional exhaustion, a sign of burnout, appears to increase after two academic years
Pescosolido, B. A., Fettes, D. L., Martin, J. K., McLeod, J. D., & Monahan, J. (2007)	Perceived dangerousness of children with mental health problems and support for coerced treatment.	Study results revealed that children in need of mental health treatment are subjected to additional stigma related to increased perceptions of dangerousness, translating into more punitive punishment and treatment in school settings
President's New Freedom Commission on Mental Health (2003).	Achieving the Promise: Transforming Mental Health Care in America. Final Report for the President's New Freedom Commission on Mental Health (SMA Publication No. 03-3832	Policymakers and legislature have increasingly pushed for greater attention on the mental health care needs of students, citing teachers as a significant aspect of the process
Program for Early Parent Support. (2015).	Self-care for parents.	Given the high level of stress on parents, program outlined strategies to promote self-care for parents.

Raver, C. C. (2002)	Emotions matter: Making the case for the role of young children's emotional development for early school readiness	Preschool teachers reported that approximately 10% of students exhibit high levels of aggressive and/or antisocial behavior; 20% of teachers reported that at least half of the students in their classroom exhibit problems with social skills
Reinke, W. M., Stormont, M., Herman, K. C., & Newcomer, L. (2014)	Using coaching to support teacher implementation of classroom-based interventions	The teacher coaching component of the IY Teacher Classroom Management resulted in improved implementation of behavioral management techniques; coaching techniques included action planning, performance feedback, modeling, role playing, and setting of goals
Reinke, W. M., Stormont, M., Herman, K. C., Puri, R., & Goel, N. (2011)	Supporting children's mental health in schools: Teacher perceptions of needs, roles, and barriers	Teachers have been identified as pivotal in the mental health care of children; 75% of teachers work directly with students with emotional-behavioral difficulties or have referred them for mental health treatment
Rescorla, L. A., Bochicchio, L., Achenbach, T. M., Ivanova, M. Y., Almqvist, F., Begovac, I., & ... Verhulst, F. C. (2014).	Parent–teacher agreement on children's problems in 21 societies	Parent and teacher report on social-emotional behavior of their children/students are variable when analyzed item by item.
Roberts, M., Joe, V., & Hallbert-Rowe, A. (1992)	Oppositional child behavior and parental locus of control	Evaluation of the Parent Locus of Control Scale (PLOC) revealed that many parents endorse having an external locus of control, meaning that they believe their child's problems will endure and are beyond their control
Rocco, P. L., Ciano, R. P., & Balestrieri, M. (2001)	Psychoeducation in the prevention of eating disorders: An experimental approach in adolescent schoolgirls	Evaluation of a universal prevention psychoeducational program in intended for adolescent girls sought to educate adolescents and their parents on normative developmental transitions to promote healthy body images; results indicate reduced bulimic attitudes, anxiety, feelings of

		ineffectiveness, and fear regarding maturity
Roll, J. M., Kennedy, J., Tran, M., & Howell, D. (2013)	Disparities in unmet need for mental health services in the United States, 1997-2010	Rates of unmet need have increased from 4.3 million in 1997 to 7.2 million by 2010; rates of unmet need were five times higher for uninsured participants than privately ensured individuals
Rones, M., & Hoagwood, K. (2000)	School-based mental health services: A research review	While only 16% of children receive mental health treatment, the majority of services are provided in the school setting (70-80%); school-based mental health programs proved effective at reducing emotional/behavioral problems; features of implementation that increased the sustainability of such programs include consistent program implementation, use of multiple modalities, inclusion of parents, teachers, and child components, and the development of appropriate program components
Rubin, K. H., Coplan, R. J., & Bowker, J. C. (2009)	Social withdrawal in childhood.	Differentiations between childhood internalizing problems, particularly with regard to symptoms of social withdrawal, and provided information to facilitate differential diagnosis between anxiety and depression
Russell, P. S., al John, J. K., & Lakshmanan, J. L. (1999)	Family intervention for intellectually disabled children. Randomised controlled trial	Evaluation of an indicated psychoeducational program for children under the age of 13 with intellectual disabilities and their parents revealed increased parental knowledge on intellectual disability, enhance management of the child's disability, and improved parental attitudes on child rearing
Schensul, J.J., & LeCompte, M.D. (2010)	Designing and Conducting Ethnographic Research: An Introduction	Adequate sample size of qualitative research studies is achieved through interview saturation identified, which is the point in the data collection process where all research questions have been

		thoroughly explored without new concepts emerging
Sentell, T., Shumway, M., & Snowden, L. (2007)	Access to mental health treatment by English language proficiency and race/ethnicity	Evaluation of language barriers to mental health revealed that non-English speaking respondents reported lower rates of receiving necessary services than English speakers when controlled for other factors; most significant disparities occurred with Asian/Pacific Islanders and Latinos
Serwatka, T. S., Dove, T., & Hodge, W. (1986)	Black students in special education: Issues and implications for community involvement.	Researchers evaluated issues regarding overrepresentation of Black children within special education under the emotional disturbance classification and historical context related to these ongoing disparities
Spence, S. H. (2003).	Social skills training with children and young people: Theory, evidence and practice	Researcher compiled evidence-based strategies to improve the social skills of children with difficulties with social functioning within the school setting
Spirito, A., Boergers, J., Donaldson, D., Bishop, D., & Lewander, W. (2002)	An intervention trial to improve adherence to community treatment by adolescents after a suicide attempt	Evaluation of interventions to increase treatment adherence for recently suicidal adolescents revealed that individual, family and services barriers must be addressed for optimal service utilization; mental health difficulties has been shown to directly impact academic outcomes; good mental health was found to be a precursor to becoming a responsible citizen in adulthood
Stallard, P., Norman, P., Huline-Dickens, S., Salter, E., & Cribb, J. (2004)	The Effects of Parental Mental Illness Upon Children: A Descriptive Study of the Views of Parents and Children	Evaluation of parental mental illness indicated that children reported concern regarding parent's well-being; children were noted to attempt to protect other family members from further stress, posing an additional barrier to the identification of mental health difficulties in those children
Staudt, M. (2007)	Treatment engagement with caregivers of at-risk children: Gaps in research and	Two components of treatment engagement have been identified: behavioral, denied as the client

	conceptualization.	performance on tasks necessary to implement treatment and achieve treatment gains, and attitudinal, referring to the emotional investment in treatment that occurs following the belief that treatment is beneficial
Steinhausen, H. (2009).	The heterogeneity of causes and courses of attention-deficit/hyperactivity disorder.	Evaluation of impact of ADHD revealed difficulties with emotional impairment, academic functioning, behavior problems, interpersonal relations, and future poor outcomes in adulthood
Stevens, J., Kelleher, K. J., Ward-Estes, J., & Hayes, J. (2006)	Perceived barriers to treatment and psychotherapy attendance in child community mental health centers	Evaluation of barriers to treatment revealed a non-significant correlation between mental health coverage and financial barriers; parent reports of low perceived relevance of treatment associated with relationship problems between families and clinicians
Stormshak, E. A., Connell, A. M., Véronneau, M., Myers, M. W., Dishion, T. J., Kavanagh, K., & Caruthers, A. S. (2011)	An ecological approach to promoting early adolescent mental health and social adaptation: Family-centered intervention in public middle schools	Evaluation of a parent-focused intervention revealed that considerations of family values and cultural factors, content that has been adapted for ethnically diverse families, and promotion of family strengths has been linked to increased treatment adherence
Stormshak, E. A., Fosco, G. M., & Dishion, T. J. (2010)	Implementing interventions with families in schools to increase youth school engagement: The family check-up model	Evaluation of implementation of Family Check-Up (FCU) revealed high participation; participants endorsed improved self-regulatory skills three years following the study, defined as effortful control of emotions and behaviors; self-regulation was predictive of decreased levels of depression and increased school engagement
Tashman, N. A., Waxman, R. P., Nabors,, L. A., & Weist, M. D. (1998)	The Prepare approach to training clinicians in school mental health programs	The high rate (70%) of inadequate treatment provided to children with mental health difficulties is suggestive of the need for training approaches for clinicians working within the school setting
Task Force on	Training in and dissemination	Increased support of

Promotion and Dissemination of Psychological Procedures. (1995)	of empirically validated psychological treatments: Report and recommendations	psychoeducational interventions as means to improve treatment utilization has led to the development of specific criteria for empirically supported psychoeducation programs, which highlights the importance of clearly outlined treatment intervention in the form of a manual
Taylor, L., & Adelman, H. S. (2001)	Enlisting appropriate parental cooperation and involvement in children's mental health treatment	Evaluations of parental involvement revealed that parents who endorsed feeling a sense of commitment to treatment was associated with child enrollment and parental involvement throughout treatment
Ton, H., Koike, A., Hales, R. E., Johnson, J., & Hilty, D. M. (2005)	A qualitative needs assessment for development of a cultural consultation service	Needs assessment of the development of cultural consultation service revealed a significant limitation of the mental health service system, the limited access to providers in the client's preferred language as a result of a lack of language diversity in mental health professionals
Trotter, R. I. (2012).	Qualitative research sample design and sample size: Resolving and unresolved issues and inferential imperatives	Researcher examined the strengths of mixed methods research designs by evaluating the benefits of qualitative and quantitative research models.
Tseng, W., Kawabata, Y., Gau, S. S., & Crick, N. R. (2014)	Symptoms of attention-deficit/hyperactivity disorder and peer functioning: A transactional model of development.	Researchers provided parents with examples of ADHD symptoms in everyday life.
Uebelacker, L. A., Hecht, J., & Miller, I. W. (2006)	The family check-up: A pilot study of a brief intervention to improve family functioning in adults	Pilot study of Family Check-Up, an intervention intended on assisting families in evaluating their functioning, revealed significant improvement in participant self-regulatory capacities, reduction in depressive symptomatology, and increased levels of school engagement
United Stats Census Bureau (2015).	QuickFacts Los Angeles County, California	Demographics of information in the Los Angeles, California population

US Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs, (2006).	Teaching Children with Attention Deficit Hyperactivity Disorder: Instructional Strategies and Practices	Researchers compiled literature on ADHD and provided recommendations for best practices for teaching children with attention and concentration difficulteis
US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2010)	The mental and emotional well-being of children: a portrait of states and the nation 2007	National Survey of Children's Health revealed that mental health conditions impact approximately 11.3% of children within the United States (approximately 7.4 million children); 40% of children met mental health disorder criteria for two or more disorders
Vaughn, S., & Linan-Thompson, S. (2003).	What is special about special education for students with learning disabilities?	Researchers evaluated services provided to children with learning disabilities and found disparities in the provision of adequate services to Black students
Villatoro, A. P., Dixon, E., & Mays, V. M. (2016)	Faith-based organizations and the Affordable Care Act: Reducing Latino mental health care disparities.	Researchers examined strategies to reduce barriers to treatment for Latino families and found that faith-based organizations may be an optimal means to deliver mental health treatent
Villatoro, A. P., Morales, E. S., & Mays, V. M. (2014)	Family culture in mental health help-seeking and utilization in a nationally representative sample of Latinos in the United States: The NLAAS.	Researchers evaluated aspects that facilitate help-seeking behavior in Latino families and identified behaviors that were associated with improved treatment engagement
Wagner, M., Friend, M., Bursuck, W. D., Kutash, K., Duchnowski, A. J., Sumi, W. C., & Epstein, M. H. (2006)	Educating students with emotional disturbances: A national perspective on programs and services.	Researchers examined teacher competence and comfort in teaching children with special needs and found that teachers were least comfortable and prepared to work with children under the emotional disturbance eligibility
Walker, H. M. (2004)	Commentary: Use of evidence-based interventions in schools: Where we've been, where we are, where we need to go	Schools have been identified by both policymakers and legislators as the solution to the mental health difficulties that plague school-aged children; problems exist that impede implementation of scientifically based strategies,

		including lack of access to interventions and treatment
Walker, J. S., Coleman, D., Lee, J., Squire, P. N., & Friesen, B. J. (2008).	Children's stigmatization of childhood depression and ADHD: Magnitude and demographic variation in a national sample.	Researchers evaluated that stigma related to childhood depression and ADHD and found that stigma regarding childhood mental illness greatly impacts treatment engagement and utilization
Wallace, S. P., Torres, J., Sadegh-Nobari, T., Pourat, N., & Brown, E. R. (2012).	Undocumented immigrants and health care reform.	Researchers evaluated the impact of undocumented status on the treatment of children with mental health difficulties
Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005).	Twelve-Month Use of Mental Health Services in the United States: Results From the National Comorbidity Survey Replication.	Researchers examined the utilization of mental health treatment and found that males and ethnic minorities were less likely to access services
Ward, E. C. (2005).	Keeping it real: A grounded theory study of African American clients engaging in counseling at a community mental health agency.	Researchers examined the literature and found compounded barriers to treatment of African American individuals.
Webster-Stratton, C. (2011)	The Incredible Years: Parent, Teacher, and Children's Training Series	Incredible Years (IY) training series for parents, teachers and children is a selective prevention of high risk families revealed
Webster-Stratton, C. (n.d.)	Helping children learn to regulate their emotions	Researcher outlined strategies to support child's emotional regulation through the support of parents and teachers
Webster-Stratton, C., & Herman, K. C. (2010)	Disseminating Incredible Years series early-intervention programs: Integrating and sustaining services between school and home	Evaluation of implementation of Incredible Years (IY) suggests that strong support for IY as an evidence-based practice; despite the support, problems with implementation persist; most treatment gains were sustained through combined child or teacher training components with parent training component
Weisz, J., & Kazdin, A. (2010).	Evidence-based Psychotherapies for children and adolescents, 2nd edition	Researchers compiled evidence-based practices in the mental health treatment of children and adolescence
Whelley, P., Cash, R. E., & Bryson, D.	Helping children at home and school II: Handouts for	Researchers outlined strategies to facilitate improved behavior in

(2004).	families and educators	children in the home and school settings
Williams, J. H., Horvath, V. E., Wei, H., Van Dorn, R. A., & Jonson- Reid, M. (2007)	Teachers' perspectives of children's mental health service needs in urban elementary schools	Teachers and school systems are a primary gateway for mental health services for their students; a significant barrier to treatment was cited as lack of transportation of families; teachers and school personnel are highly impacted, limiting their availability to focus on childhood mental health treatment; teachers lack knowledge needed to identify need for services; common parent perspectives include that school personnel are solely responsible for following through with treatment recommendations
Zhang, Y., & Wildemuth, B. M. (2009)	Qualitative analysis of content	Qualitative data analysis procedures generally suggest the use of inductive content analysis, specifically that researchers evaluate transcriptions for specific themes; intercoder reliability must be evaluated to ensure dependability and confirmability of coding; cross analysis procedures allow researchers to organize themes into categories

REFERENCES

American Federation of Teachers, (2007). *Building Parent-Teacher Relationships*. Washington, D.C.: American Federation of Teachers. Retrieved from http://ms.aft.org/files/ct-parent-teacherpartnerships_0.pdf

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., & ... Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. *European Archives of Psychiatry and Clinical Neuroscience 256*, 174–186. https://doi.org/10.1007/s00406-005-0624-4

Angold, A., Messer, S., Stangl, D., Farmer, E., Costello, E., & Burns, B. (1998). Perceived parental burden and service use for child and adolescent psychiatric disorders. *American Journal of Public Health, 88,* 75-80. https://doi.org/10.2105/AJPH.88.1.75

Azad, G. F., Kim, M., Marcus, S. C., Sheridan, S. M., & Mandell, D. S. (2016). Parent-teacher communication about children with autism spectrum disorder: An examination of collaborative problem-solving. *Psychology In The Schools, 53*(10), 1071-1084. https://doi.org/10.1002/pits.21976

Baker, J. A. (2006). Contributions of teacher-child relationships to positive school adjustment during elementary school. *Journal of School Psychology, 44*, 211-229. https://doi.org/10.1016/j.jsp.2006.02.002

Baker-Ericzén, M. J., Jenkins, M. M., & Haine-Schlagel, R. (2013). Therapist, parent, and youth perspectives of treatment barriers to family-focused community outpatient mental health services. *Journal Of Child And Family Studies*, *22*(6), 854-868. https://doi.org/10.1007/s10826-012-9644-7

Ballard, E. D., Van Eck, K., Musci, R. J., Hart, S. R., Storr, C. L., Breslau, N., & Wilcox, H. C. (2015). Latent classes of childhood trauma exposure predict the development of behavioral health outcomes in adolescence and young adulthood. *Psychological Medicine, 45*(15), 3305-3316. https://doi.org/10.1017/S0033291715001300

Bannon, W. M., & McKay, M. M. (2005). Are barriers to service and parental preference match for service related to urban child mental health service use? *Families in Society: The Journal of Contemporary Social Services, 86*, 30–34. https://doi.org/10.1606/1044-3894.1874

Battistich, V., Schaps, E., & Wilson, N. (2004). Effects of an elementary school intervention on students' "connectedness" to school and social adjustment during middle school. *The Journal of Primary Prevention, 24*(3), 243-262. https://doi.org/10.1023/B:JOPP.0000018048.38517.cd

Becker, K. D., Kiser, L. J., Herr, S. R., Stapleton, L. M., Barksdale, C. L., & Buckingham, S. (2014). Changes in treatment engagement of youths and families with complex needs. *Children and Youth Services Review, 46*, 276-284. https://doi.org/10.1016/j.childyouth.2014.09.005

Bernard, H. R. (2011). *Research methods in anthropology: Qualitative and quantitative approaches* (5th Edition). New York, NY: Rowman Altamira.

Betz, C. L., Baer, M. T., Poulsen, M., Vahanvaty, U., & Bare, M. (2004). Secondary analyses of primary and preventative services accessed and perceived service barriers by children with developmental disabilities and their families. *Issues in Comprehensive Pediatric Nursing, 27*, 83–106. https://doi.org/10.1080/01460860490451813

Bierman, K. L., Coie, J., Dodge, K., Greenberg, M., Lochman, J., McMohan, R., & Pinderhughes, E. (2013*). School outcomes of aggressive-disruptive children: Prediction from kindergarten risk factors and impact of the Fast Track prevention program. Aggressive Behavior, 39*(2), 114-130. https://doi.org/10.1002/ab.21467

Bos, A. R., Pryor, J. B., Reeder, G. D., & Stutterheim, S. E. (2013). Stigma: Advances in theory and research. *Basic and Applied Social Psychology, 35*(1), 1–9. https://doi.org/10.1080/01973533.2012.746147

Bowers, H., Manion, I., Papadopoulos, D., & Gauvreau, E. (2013). Stigma in school-based mental health: Perceptions of young people and service providers. *Child And Adolescent Mental Health, 18*(3), 165-170. https://doi.org/10.1111/j.1475-3588.2012.00673.x

Briggs-Gowan, M. J., Carter, A. S., Skuban, E. M., & Horwitz, S. M. (2001). Prevalence of social–emotional and behavioral problems in a community sample of 1- and 2-year-old children. *Journal of the American Academy of Child and Adolescent Psychiatry, 40,* 811–819. https://doi.org/10.1097/00004583-200107000-00016

Bronfenbrenner, U. (1992). *Ecological systems theory*. In R. Vasta (Ed.) Six theories of child development: Revised formulations and current issues (pp. 187-249). London, England: Jessica Kingsley Publishers.

Campbell, S. B. (2002). *Behavior problems in preschool children: Clinical and developmental issues*. New York, NY: Guilford Press.

Centers for Disease Control and Prevention. (2013). Mental health surveillance among children – United States, 2005-2011. Morbility and Mortality Weekly Report, *62*(2), 1-35. Retrieved from http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm?s_cid =su6202a1_w

Center for Mental Health in Schools at UCLA. (2008). Conduct and behavior problems related to school aged youth. Los Angeles, CA: Author. Retrieved from http://smhp.psych.ucla.edu/pdfdocs/conduct/conduct.pdf

Chaffin, M., Valle, L., Funderburk, B., Gurwitch, R., Silovsky, J., Bard, D., & … Kees, M. (2009). A motivational intervention can improve retention in PCIT for low-motivation child welfare clients. *Child Maltreatment, 14*(4), 356- 368. https://doi.org/10.1177/1077559509332263

Chambless, D. L. & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology, 66,* 7–18. https://doi.org/10.1037/0022-006X.66.1.7

Chang, D. F., & Berk, A. (2009). Making cross-racial therapy work: A phenomenological study of clients' experiences of cross-racial therapy. *Journal of Counseling Psychology, 56*, 521– 536. https://doi.org/10.1037/a0016905

Chorpita, B., Becker, K., Phillips, L., Ebesutani, C., Cromley, T., & Daleiden, E. (2012). Practitioner Guides. Satellite Beach, FL: PracticeWise.

Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2005). Modularity in the design and application of therapeutic interventions. *Applied and Preventive Psychology, 11*(3), 141-156. https://doi.org/10.1016/j.appsy.2005.05.002

Christophersen, E. R., VanScoyoc, S. M. M., (2013). Treatments that work with children: Empirically supported strategies for managing childhood problems (2nd ed.). Washington, DC, US: American Psychological Association.

Cohen, M. & Irwin, C. E. (1983). Parent-Time: Psychoeducational groups for parents of adolescents. *Health & Social Work*, *8*(3), 196-202. https://doi.org/10.1093/hsw/8.3.196

Corrigan, P. W., & Rao, D. (2012). On the self-stigma of mental illness: Stages, disclosure, and strategies for change. *Canadian Journal of Psychiatry, 57*(8), 464–469. doi:10.1177/070674371205700804.

Creswell, J.W. (2013). *Research design: Qualitative, quantitative, and mixed methods* approaches (4th edition). Los Angeles, CA: Sage Publications.

Cuffel, B., McCulloch, J., Wade, R., Tam, L., Brown-Mitchell, R., & Goldman, W. (2000). Patients and providers' perceptions of outpatient treatment termination in a managed behavioral health organization. *Psychiatric Services, 51*(4), 469–473. https://doi.org/10.1176/appi.ps.51.4.469

Cunningham, C. J. L., Weathington, B. L., & Pittenger, D. J. (2013). *Understanding and conducting research in the health sciences*. Hoboken, NJ: John Wiley & Sons. Retrieved from http://onlinelibrary.wiley.com/doi/10.1002/9781118643624.ch1/summary

Davis, M., Eshelman, E. R., & McKay, M. (2000). *The relaxation & stress reduction workbook* (5th Ed.). Oakland, CA: New Harbinger Publications.

Department of Education. (2014). *What is bullying (ED, Bullying Summit)*. Retrieved from http://www.stopbullying.gov/videos/2010/09/what-is-bullying.html

Donovan, M., & Cross, C. (Eds.). (2002). *Minority students in special and gifted education*. Washington, DC: National Academy Press. Retrieved from https://www.nap.edu/read/10128/chapter/1

Dube, S. R., Fairweather, D., Pearson, W. S., Felitti, V. J., Anda, R. F., & Croft, J. B. (2009). Cumulative childhood stress and autoimmune diseases in adults. *Psychosomatic Medicine, 71*, 243–250. https://doi.org/10.1097/PSY.0b013e3181907888

DuPaul, G. J., Gormley, M. J., & Laracy, S. D. (2014). School-based interventions for elementary school students with ADHD. *Child and Adolescent Psychiatric Clinics Of North America*, *23*(4), 687-697. https://doi.org/10.1016/j.chc.2014.05.003

Durlak, J. A., & DuPre, E. P. (2008). Implementation matters: A review of research on the influence of implementation on program outcomes and the factors affecting implementation. *American Journal Of Community Psychology, 41*(3-4), 327-350. http://doi.org/10.1007/s10464-008-9165-0

Durlak, J. A., Weissberg, R. P., Dymnicki, A. B., Taylor, R. D., & Schellinger, K. B. (2011). The impact of enhancing students' social and emotional learning: A meta-analysis of school-based universal interventions. *Child Development, 82*, 405–432. https://doi.org/10.1111/j.1467-8624.2010.01564.x

Eiraldi, R. B., Mazzuca, L. B., Clarke, A. T., & Power, T. J. (2006). Service utilization among ethnic minority children with ADHD: A model of help-seeking behavior. *Administration and Policy in Mental Health and Mental Health Services Research, 33*(5), 607-622. https://doi.org/10.1007/s10488-006-0063-1

Ekornes, S. (2015). Teacher perspectives on their role and the challenges of inter-professional collaboration in mental health promotion. *School Mental Health*, *7*(3), 193-211. https://doi.org/10.1007/s12310-015-9147-y

Ellis, M. L., Lindsey, M. A., Barker, E. D., Boxmeyer, C. L., & Lochman, J. E. (2013). Predictors of engagement in a school-based family preventive intervention for youth experiencing behavioral difficulties. *Prevention Science, 14*(5), 457-467. https://doi.org/10.1007/s11121-012-0319-9

Elo, S. & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing, 62*(1), 107-115. https://doi.org/10.1111/j.1365-2648.2007.04569.x

Evans, S. W., Owens, J. S., & Bunford, N. (2014). Evidence-based psychosocial treatments for children and adolescents with attention-deficit/hyperactivity disorder. *Journal of Clinical Child And Adolescent Psychology, 43*(4), 527-551. https://doi.org/10.1080/15374416.2013.850700

Farmer, E. M., Burns, B. J., Phillips, S. D., Angold, A., & Costello, E. J. (2003). Pathways into and through mental health services for children and adolescents. *Psychiatric Services, 54*(1), 60–66. https://doi.org/10.1176/appi.ps.54.1.60

Feinstein, N. R., Fielding, K., Udvari-Solner, A., & Joshi, S. V. (2009). The supporting alliance in child and adolescent treatment: Enhancing collaboration among therapists, parents, and teachers. *American Journal Of Psychotherapy*, *63*(4), 319-344. https://www.researchgate.net/publication/41406618_The_supporting_alliance_in_child_and_adolescent_treatment_enhancing_collaboration_among_therapists_parents_and_teachers

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & ... Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal Of Preventive Medicine, 14*(4), 245-258. https://doi.org/10.1016/S0749-3797(98)00017-8

Fergusson, D. M., Horwood, L. J., & Stanley, L. (2013). A preliminary evaluation of the Incredible Years Teacher Programme. *New Zealand Journal Of Psychology, 42*(2), 51-56. Retrieved from http://www.incredibleyears.com/wp-content/uploads/A-preliminary-evaluation-of-the-IY-teacher-programme-2013.pdf

Ferrin, M., Moreno-Granados, J. M., Salcedo-Marin, M. D., Ruiz-Veguilla, M., Perez-Ayala, M., & Taylor, E. (2013). Evaluation of a psychoeducation programme for parents of children and adolescents with ADHD: Immediate and long-term effects using a blind randomized controlled trial. *European Child &Adolescent Psychiatry, 23*(8), 637-647. https://doi.org/10.1007/s00787-013-0494-7

Fisher, M., & Meyer, L. (2002). Development and social competence after two years for students enrolled in inclusive and self-contained educational programs. *Research and Practice for Persons with Severe Disabilities*, *27*(3), 165–174. https://doi.org/10.2511/rpsd.27.3.165

Flicker, S. M., Waldron, H. B., Turner, C. W., Brody, J. L., & Hops, H. (2008). Ethnic matching and treatment outcome with Hispanic and Anglo substance-abusing adolescents in family therapy. *Journal of Family Psychology, 22*, 439–447. https://doi.org/10.1037/0893-3200.22.3.439

Flores, G., Olson, L., & Tomany-Korman, S. C. (2005). Racial and ethnic disparities in early childhood health and health care. *Pediatrics, 115*, e183–e193. https://doi.org/10.1542/peds.2004-1474

Frey, K. S., Hirshstein, M. K., & Guzzo, B. A. (2000). Second Step: Preventing aggression by promoting social competence. *Journal of Emotional and Behavioral Disorders, 8*, 102–112. https://doi.org/10.1177/106342660000800206

Fristad, M. A., Gavazzi, S. M., & Mackinaw-Koons, B. (2003). Family psychoeducation: An adjunctive intervention for children with bipolar disorder. *Biological Psychiatry, 53*, 1000–1008. https://doi.org/10.1016/S0006-3223(03)00186-0

Fristad, M. A., Gavazzi, S. M., & Soldano, K. W. (1998). Multi-family psychoeducation groups for childhood mood disorders: A program description and preliminary efficacy data. *Contemporary Family Therapy, 20,* 385–403. https://doi.org/10.1023/A:1022477215195

Fristad, M. A., Goldberg-Arnold, J. S., & Gavazzi, S. M. (2002). Multifamily psychoeducation groups (MFPG) for families of children with bipolar disorder. *Bipolar Disorders, 4,* 254-262. https://doi.org/10.1034/j.1399-5618.2002.09073.x

Garland, A. F., Lau, A. S., Yeh, M., McCabe, K. M., Hough, R. L., & Landsverk, J. A. (2005). Racial and Ethnic Differences in Utilization of Mental Health Services Among High-Risk Youths. *The American Journal Of Psychiatry*, *162*(7), 1336-1343. https://doi.org/10.1176/appi.ajp.162.7.1336

Gary, F. A. (2005). Stigma: Barrier to mental health care among ethnic minorities. *Issues in Mental Health Nursing, 26*, 979-999. https://doi.org/10.1080/01612840500280638

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. New York, NY: Simon and Schuster.

Gordon, R. S. (1983). An operational classification of disease prevention. *Public Health Reports, 98*(2), 107-109. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1424415/pdf/pubhealthrep00112-0005.pdf

Gould, S. R., Beals-Erickson, S. E., & Roberts, M. C. (2012). Gaps and barriers in services for children in state mental health plans. *Journal of Child Family Studies, 21*, 767-774. https://doi.org/10.1007/s10826-011-9529-1

Gueldner, B., & Merrell, K. (2012). Interventions for students with internalizing behavioral deficits. *Oxford Handbooks Online*. Retrieved from http://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780195369809.001.0001/oxfordhb-9780195369809-e-019.

Hemmeter, M. L., Ostrosky, M., & Fox, L. (2006). Social and emotional foundations for early learning: A conceptual model for intervention. *School Psychology Review, 35*(4), 583-601. Retrieved from https://www.researchgate.net/profile/Michaelene_Ostrosky/publication/228349912_Social_and_emotional_foundations_for_early_learning_A_conceptual_model_for_intervention/links/55005fca0cf2de950a6d6244.pdf

Herman, K. C., Reinke, W. M., Stormont, M., Puri, R., & Agarwal, G. (2010). Using prevention science to promote children's mental health: The founding of the Missouri Prevention Center. *The Counseling Psychologist, 38*(5), 652-690. https://doi.org/10.1177/0011000009354125

Hinojosa, M., Knapp, C., & Woodworth, L. (2014). Family strain among White and Latino parents of children with mental and behavioral health disorders. *Journal Of Child And Family Studies*, *24,* 1575-1581. https://doi.org/10.1007/s10826-014-9961-0

Hinshaw, S. P. (2005). The stigmatization of mental illness in children and parents: Developmental issues, family concerns, and research needs. *Journal Of Child Psychology And Psychiatry, 46*(7), 714-734. https://doi.org/10.1111/j.1469-7610.2005.01456.x

Hoagwood, K., Burns, B. J., Kiser, L, Ringeisen, H., & Schoenvrald., S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services, 52,* 1179-1189. https://doi.org/10.1176/appi.ps.52.9.1179

Hoberman, H. M. (1992). Ethnic minority status and adolescent mental health services utilization. *Journal of Mental Health Administration, 19*(3), 246–267. https://doi.org/10.1007/BF02518990

Hosp, J., & Reschly, D. (2003). Referral rates for intervention or assessment: A meta-analysis of racial differences. *The Journal of Special Education*, *37*(2), 67–80. https://doi.org/10.1177/00224669030370020201

Hruschka, D. J., Schwartz, D., St. John, D. C., Picone-Decaro, E., Jenkins, R. A., & Carey, J. W. (2004). Reliability in coding open-ended data: Lessons learned from HIV behavioral research. *Field Methods, 16*(3), 307-331. https://doi.org/10.1177/1525822X04266540

Hsieh, H. F. & Shannon, S. E. (2005). Three approaches to qualitative content analysis. *Qualitative Health Research, 15*(9), 1277-1288. https://doi.org/10.1177/1049732305276687

Hutton, J. L. (1985). What reasons are given by teachers who refer problem behavior students? *Psychology in the Schools, 22,* 79–82. https://doi.org/10.1002/1520-6807(198501)22:1<79::AID-PITS2310220116>3.0.CO;2-F

Ingoldsby, E. M. (2010). Review of interventions to improve family engagement and retention in parent and child mental health programs. *Journal Of Child And Family Studies, 19*(5), 629-645. https://doi.org/10.1007/s10826-009-9350-2

Jennings, P. A., & Greenberg, M. T. (2009). The prosocial classroom: Teacher social and emotional competence in relation to student and classroom outcomes. *Review of Educational Research,79*(1), 491-525. https://doi.org/10.3102/0034654308325693

Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a definition of mixed methods research. *Journal of Mixed Methods Research, 1*(2), 112-133. https://doi.org/10.1177/1558689806298224

Johnson, S., Cooper, C., Cartwright, S., Donald, I., Taylor, P., & Millet, C. (2005). The experience of work-related stress across occupations. *Journal of Managerial Psychology, 20,* 178-187. https://doi.org/10.1108/02683940510579803

Karver, M. S., Handelsman, J. B., Fields, S., & Bickman, L. (2005). A theoretical model of common process factors in youth and family therapy. *Mental Health Services Research, 7*, 35–51. https://doi.org/10.1007/s11020-005-1964-4

Kataoka, S. H., Zhang, L., & Wells, K. B. (2002). Unmet need for mental health care among U.S. children: Variation by ethnicity and insurance status. *The American Journal of Psychiatry, 159*(9), 1548-1555. https://doi.org/10.1176/appi.ajp.159.9.1548

Katz, L. G., & McClellan, D. E. (1997). *Fostering children's social competence: The teacher's role*. Washington, DC, US: National Association for the Education of Young Children.

Kazdin, A. E., Holland, L., & Crowley, M. (1997). Family experience of barriers to treatment and premature termination from child therapy. *Journal Of Consulting And Clinical Psychology, 65*(3), 453-463. https://doi.org/10.1037/0022-006X.65.3.453

Kazdin, A. E., Holland, L., Crowley, M., & Breton, S. (1997). Barriers to treatment participation scale: Evaluation and validation in the context of child outpatient treatment. *Journal Child Psychology and Psychiatry, 38*(8), 1051-1062. https://doi.org/10.1111/j.1469-7610.1997.tb01621.x

Kenny, M. C. (2009). Child sexual abuse prevention: Psychoeducational groups for preschoolers and their parents. *The Journal for Specialists in Group Work, 34*(1), 24-42. https://doi.org/10.1080/01933920802600824

Kernan, J. B., Griswold, K. S., & Wagner, C. M. (2003). Seriously emotionally disturbed youth: A needs assessment. *Community Mental Health Journal, 39*, 475–486. https://doi.org/10.1023/B:COMH.0000003009.21130.da

Kessler, R. C., Brown, R. L., & Broman, C. L. (1981). Sex differences in psychiatric help-seeking: Evidence from four large-scale surveys. *Journal Of Health And Social Behavior*, *22*(1), 49-64. https://doi.org/10.2307/2136367

King, S., Kropf, N. P., Perkins, M., Sessley, L., Burt, C., & Lepore, M. (2009). Kinship in rural Georgia communities: Responding to needs and challenges of grandparent caregivers. *Journal of Intergenerational Relationships, 7*, 225–242. https://doi.org/10.1080/15350770902852369

Koller, J. R. & Bertell, J. M. (2006). Responding to today's mental health needs of children, families, and schools: Revisiting the preservice training and preparation of school-based personnel. *Education and Treatment of Children, 29*(2), 197-217.

Kourany, R. F., Garber, J., & Tornusciolo, G. (1990). Improving first appointment attendance rates in child psychiatry outpatient clinics. *Journal of the American Academy of Child and Adolescent Psychiatry, 29,* 657-660. https://doi.org/10.1097/00004583-199007000-00022

Kouyoumdjian, H., Zamboanga, B. L., & Hansen, D. J. (2003). Barriers to community mental health services for Latinos: Treatment considerations. *Clinical Psychology: Science and Practice, 10*(4), 394-422. https://doi.org/10.1093/clipsy.bpg041

Kuperschmidt, J. B., Bryant, D., & Willoughby, M. (2000). Prevalence of aggressive behaviors among preschoolers in Head Start and community child care programs. *Behavioral Disorders, 26,* 42–52. Retrieved from http://www.jstor.org/stable/23889058

Kurasaki, K. S. (2000). Inercoder reliability for validity conclusions drawn from open-ended interview data. *Field Methods, 12*(3), 179-194. https://doi.org/10.1177/1525822X0001200301

Ladd, G. W., Herald, S. L., & Kochel, K. P. (2006). School readiness: Are there social prerequisites? *Early Education and Development, 17*, 115–150. https://doi.org/10.1207/s15566935eed1701_6

Lambert, R. G., McCarthy, C., O'Donnell, M., & Wang, C. (2009). Measuring elementary teacher stress and coping in the classroom: Validity evidence for classroom appraisal of resources and demands. *Psychology in The Schools, 46*(10). 973-988. https://doi.org/10.1002/pits.20438

Landrum, T., Katsiyannis, A., & Archwamety, T. (2004). An analysis of placement and exit patterns of students with emotional or behav- ioral disorders. *Behavioral Disorders*, *29*(2), 140–153. Retrieved from http://www.jstor.org/stable/23889447

Landrum, T., Tankersley, M., & Kauffman, J. (2003). What is special about special education for students with emotional or behavioral disorders? *The Journal of Special Education*, *37*(3), 148–156. https://doi.org/10.1177/00224669030370030401

Langley, A. K., Nadeem, E., Kataoka, S. H., Stein, B. D., & Jaycox, L. H. (2010). Evidence-based mental health programs in schools: Barriers and facilitators of successful implementation. *School Mental Health, 2*(3), 105-113. https://doi.org/10.1007/s12310-010-9038-1

Larson, J., dosReis, S., Stewart, M., Kushner, R., Frosch, E., & Solomon, B. S. (2013). Barriers to mental health care for urban, lower income families referred from pediatric primary care. *Administration and Policy in Mental Health and Mental Health Services Research, 40*(3), 159-167. https://doi.org/10.1007/s10488-011-0389-1

Lawhon, T., & Lawhon, D. C. (2000). Promoting social skills in young children. Early *Childhood Education Journal, 28*(2), 105-110. https://doi.org/10.1023/A:1009551404906

Leavell, H. R. & Clark, E. G. (1965). *Preventive medicine for the doctor in his community: An epidemiologic approach* (3rd ed.). New York, NY: McGraw-Hill.

Lee, T. (2012). School-based interventions for disruptive behavior. *Child and Adolescent Psychiatric Clinics of North America, 21*(1), 161-174. https://doi.org/10.1016/j.chc.2011.09.002

Leigh, I. W., Powers, L., Vash, C., & Nettles, R. (2004). Survey of psychological services to clients with disabilities: The need for awareness. *Rehabilitation Psychology, 49*, 48–54. https://doi.org/10.1037/0090-5550.49.1.48

Liang, J. (2010). *Parental involvement in mental health services for diverse youth* (Doctoral dissertation). Retrieved from UC San Diego Electronic Theses and Dissertations. (b6889242)

Little, S. G., & Akin-Little, A. (2011). Responses to childhood trauma: An international perspective. *School Psychology International*, *32*(5), 441-447. https://doi.org/10.1177/0143034311402915

Little, S. G., Akin-Little, A., & Gutierrez, G. (2009). Children and traumatic events: Therapeutic techniques for psychologists working in the schools. *Psychology in the Schools, 46,* 199–205. https://doi.org/10.1002/pits.20364

Lombard, M., Snyder-Duch, J., & Bracken, C. C. (2002). Content analysis in mass communication: Assessment and reporting of intercoder reliability. *Human Communication Research, 28*(4), 587-604. https://doi.org/10.1111/j.1468-2958.2002.tb00826.x

Lukens, E. P. & McFarlane, W. R. (2004). Psychoeducation as evidence-based practice: Considerations for practice, research, and policy. *Brief Treatment and Crisis Intervention, 4*(3), 205-225. https://doi.org/10.1093/brief-treatment/mhh019

Mackenzie, C. S., Erickson, J., Deane, F. P., & Wright, M. (2014). Changes in attitudes toward seeking mental health services: A 40-year cross-temporal meta-analysis. *Clinical Psychology Review, 34*(2), 99-106. https://doi.org/10.1016/j.cpr.2013.12.001

Mandell, D. S., Davis, J. K., Bevans, K., & Guevara, J. P. (2008). Ethnic disparities in special education labeling among children with attention deficit/hyperactivity disorder. *Journal Of Emotional And Behavioral Disorders, 16*(1), 42-51. https://doi.org/10.1177/1063426607310848

Marlow, R., Hansford, L., Edwards, V., Ukoumunne, O. C., Norman, S., Ingarfield, S., & ... Ford, T. (2015). Teaching classroom management—A potential public health intervention?. *Health Education, 115*(3-4), 230-248. https://doi.org/10.1108/HE-03-2014-0030

Mazer, J. P. (2013). Associations among teacher communication behaviors, student interest, and engagement: A validity test. *Communication Education, 62*(1), 86-96. https://doi.org/10.1080/03634523.2012.731513

McGinty, K. L., Diamond, J. M., Brown, M. B., & McCammon, S. L. (2003). Training child and adolescent psychiatrists and child mental health professionals for systems of care. In A. J. Pumariega & N. C. Winters (Eds.), *The handbook of child and adolescent systems of care: The new community psychiatry* (pp. 487–507). San Francisco, CA: Jossey-Bass.

McKay, M. M. & Bannon, W. M. J. (2004). Engaging families in child mental health services. *Child and Adolescent Psychiatric Clinics of North America, 13*(4), 905-921. https://doi.org/10.1016/j.chc.2004.04.001

Menting, A. A., de Castro, B. O., & Matthys, W. (2013). Effectiveness of the Incredible Years parent training to modify disruptive and prosocial child behavior: A meta-analytic review. *Clinical Psychology Review, 33*(8), 901-913. https://doi.org/10.1016/j.cpr.2013.07.006

Merrell, K. W., & Gimpel, G. A. (1998). *Social skills of children and adolescents: Conceptualization, assessment, treatment*. Mahwah, NJ: Lawrence Erlbaum Associates, Inc.

Mertens, D. M. (2009). *Research methods in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods* (3rd Ed.). Thousand Oaks, CA: Sage.

Meyer, O. L. & Zane, N. (2013). The influence of race and ethnicity in clients' experiences of mental health treatment. *Journal of Community Psychology, 41*(7), 884-901. https://doi.org/10.1002/jcop.21580

Miller, R. L. & Brewer, J. (Eds). (2003). *The A-Z of social research: A dictionary of key Social science research concepts*. London, England: Sage Publications Ltd. https://doi.org/10.4135/9780857020024

Miranda, J., Woo, S., Lagomasino, I., Hepner, K. A., Wiseman, S., & Munoz, R. (2008). *Client's guidebook: Thoughts and your mood*. Unpublished work.

Morrissey-Kane, E. & Prinz, R. J. (1999). Engagement in child and adolescent treatment: The role of parental cognitions and attributions. *Clinical Child And Family Psychology Review, 2*(3), 183-198. https://doi.org/10.1023/A:1021807106455

Mrazek, P. B. & Haggerty, R. J. (1994). *Reducing risks for mental disorders frontiers for preventive intervention research*. Washington, DC: National Academy Press. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK236326/

Mukolo, A., Heflinger, C. A., & Wallston, K. A. (2010). The stigma of childhood mental disorders: A conceptual framework. *Journal of the American Academy of Child and Adolescent Psychiatry, 49*(2), 92–103. http://doi.org/10.1016/j.jaac.2009.12.003.

Murphy, K. R., Myors, B., & Wolach, A. H. (2009). *Statistical power analysis: A simple and general model for traditional and modern hypotheses tests* (3rd ed.). New York, NY: Taylor and Francis Group.

Murray, C., & Murray, K. M. (2004). Child level correlates of teacher-student relationships: An examination of demographic characteristics, academic orientations, and behavioral orientations. *Psychology in the Schools, 41*(7), 751-762. https://doi.org/10.1002/pits.20015

National Research Council and Institute of Medicine. (2009). *Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities*. Washington, DC: The National Academic Press. Retrieved from https://www.nap.edu/read/12480/chapter/1

Newman-Carlson, D. & Horne, A. M. (2004). Bully Busters: A psychoeducational intervention for reducing bullying behavior in middle school students. *Journal of Counseling & Development, 82*(3), 259-267. https://doi.org/10.1002/j.1556-6678.2004.tb00309.x

Nock, M. K., & Kazdin, A. E. (2001). Parent expectancies for child therapy: Assessment and relation to participation in treatment. *Journal of Child and Family Studies, 10*(2), 155-180. https://doi.org/10.1023/A:1016699424731

Nock, M. K. & Kazdin, A. E. (2005). Randomized controlled trial of a brief intervention for increasing participation in parent management training. *Journal of Consulting and Clinical Psychology, 73*(5), 872-879. https://doi.org/10.1037/0022-006X.73.5.872

Nock, M. K. & Photos, V. (2006). Parent motivation to participate in treatment: Assessment and prediction of subsequent participation. *Journal of Child & Family Studies, 15*(3), 333-346. https://doi.org/10.1007/s10826-006-9022-4

Ojeda, V. & Bergstresser, S. (2008). Gender, race-ethnicity, and psychosocial barriers to mental health care: An examination of perceptions and attitudes among adults reporting unmet need. *Journal of Health and Social Behavior, 49*(3), 317-334. https://doi.org/10.1177/002214650804900306

Owens, P. L., Hoagwood, K., Horwitz, S. M., Leaf, P. J., Poduska, J. M., Kellam, S. G., & Ialongo, N. S. (2002). Barriers to children's mental health services. *Journal of The American Academy of Child & Adolescent Psychiatry, 41*(6), 731-738. https://doi.org/10.1097/00004583-200206000-00013

Pajer, K. A., Kelleher, K., Gupta, R., Rolls, J., & Gardner, W. (2007). Psychiatric and medical health care policies in juvenile detention facilities. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46, 1660–1667. https://doi.org/10.1097/chi.0b013e318157d2da

Pas, E., Bradshaw, C. P., & Hershfeldt, P. A. (2012). Teacher- and school-level predictors of teacher efficacy and burnout: Identifying potential areas of support. *Journal of School Psychology, 50*(1), 129–145. https://doi.org/10.1016/j.jsp.2011.07.003

Pescosolido, B. A., Fettes, D. L., Martin, J. K., McLeod, J. D., & Monahan, J. (2007). Perceived dangerousness of children with mental health problems and support for coerced treatment. *Psychiatric Services, 58*(5), 619–625. https://doi.org/10.1176/ps.2007.58.5.619

President's New Freedom Commission on Mental Health (2003). *Achieving the promise: Transforming mental health care in America. Final report for the President's New Freedom Commission on Mental Health (SMA Publication No. 03-3832).* Rockville, MD: Author. Retrieved from http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf

Program for Early Parent Support. (2015). Self-care for parents. Retrieved from http://www.peps.org/ParentResources/by-topic/self-care/self-care-for-parents

Raver, C. C. (2002). Emotions matter: Making the case for the role of young children's emotional development for early school readiness. *Social Policy Report, 16*(3), 3–18. Retrieved from https://www.cde.state.co.us/cpp/emotionsmatter

Reinke, W. M., Stormont, M., Herman, K. C., & Newcomer, L. (2014). Using coaching to support teacher implementation of classroom-based interventions. *Journal of Behavioral Education, 23*(1), 150-167. https://doi.org/10.1007/s10864-013-9186-0

Reinke, W. M., Stormont, M., Herman, K. C., Puri, R., & Goel, N. (2011). Supporting children's mental health in schools: Teacher perceptions of needs, roles, and barriers. *School Psychology Quarterly, 26*(1), 1-13. https://doi.org/10.1037/a0022714

Rescorla, L. A., Bochicchio, L., Achenbach, T. M., Ivanova, M. Y., Almqvist, F., Begovac, I., & ... Verhulst, F. C. (2014). Parent–teacher agreement on children's problems in 21 societies. *Journal Of Clinical Child And Adolescent Psychology, 43*(4), 627-642. https://doi.org/10.1080/15374416.2014.900719

Roberts, M., Joe, V., & Hallbert-Rowe, A. (1992). Oppositional child behavior and parental locus of control. *Journal of Clinical Child Psychology, 21,* 170-177. https://doi.org/10.1207/s15374424jccp2102_9

Rocco, P. L., Ciano, R. P., & Balestrieri, M. (2001). Psychoeducation in the prevention of eating disorders: An experimental approach in adolescent schoolgirls. *British Journal of Medical Psychology, 74*(3), 351–358. https://doi.org/10.1348/000711201161028

Roll, J. M., Kennedy, J., Tran, M., & Howell, D. (2013). Disparities in unmet need for mental health services in the United States, 1997-2010. *Psychiatric Services, 64*(1), 80-82. https://doi.org/10.1176/appi.ps.201200071

Rones, M. & Hoagwood, K. (2000). School-based mental health services: A research review. *Clinical Child and Family Psychology Review, 3*(4), 223-241. https://doi.org/10.1023/A:1026425104386

Rubin, K. H., Coplan, R. J., & Bowker, J. C. (2009). Social withdrawal in childhood. *Annual Review Of Psychology, 60*, 141-171. https://doi.org/10.1146/annurev.psych.60.110707.163642

Russell, P. S., al John, J. K., & Lakshmanan, J. L. (1999). Family intervention for intellectually disabled children. Randomised controlled trial. *British Journal of Psychiatry, 174,* 254–258. https://doi.org/10.1192/bjp.174.3.254

Schensul, J. J. & LeCompte, M. D. (2010). *Designing and conducting ethnographic research: An Introduction*. Walnut Creek, CA: Altamira Press.

Sentell, T., Shumway, M., & Snowden, L. (2007). Access to mental health treatment by English language proficiency and race/ethnicity. *Journal Of General Internal Medicine, 22*(2), 289-293. https://doi.org/10.1007/s11606-007-0345-7

Serwatka, T. S., Dove, T., & Hodge, W. (1986). Black students in special education: Issues and implications for community involvement. *Negro Education Review, 37,* 17–26.

Spence, S. H. (2003). Social skills training with children and young people: Theory, evidence and practice. *Child and Adolescent Mental Health, 8*(2), 84-96. https://doi.org/10.1111/1475-3588.00051

Spirito, A., Boergers, J., Donaldson, D., Bishop, D., & Lewander, W. (2002). An intervention trial to improve adherence to community treatment by adolescents after a suicide attempt. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*, 435–442. https://doi.org/10.1097/00004583-200204000-00016

Stallard, P., Norman, P., Huline-Dickens, S., Salter, E., & Cribb, J. (2004). The effects of parental mental illness upon children: A descriptive study of the views of parents and children. *Clinical Child Psychology And Psychiatry*, *9*(1), 39-52. https://doi.org/10.1177/1359104504039767

Staudt, M. (2007). Treatment engagement with caregivers of at-risk children: Gaps in research and conceptualization. *Journal of Child And Family Studies, 16*(2), 183-196. https://doi.org/10.1007/s10826-006-9077-2

Steinhausen, H. (2009). The heterogeneity of causes and courses of attention-deficit/hyperactivity disorder. A*cta Psychiatrica Scandinavica, 120*(5), 392-399. https://doi.org/10.1111/j.1600-0447.2009.01446.x

Stevens, J., Kelleher, K. J., Ward-Estes, J., & Hayes, J. (2006). Perceived barriers to treatment and psychotherapy attendance in child community mental health centers. *Community Mental Health Journal, 42*(5), 449-458. https://doi.org/10.1007/s10597-006-9048-5

Stormshak, E. A., Connell, A. M., Véronneau, M., Myers, M. W., Dishion, T. J., Kavanagh, K., & Caruthers, A. S. (2011). An ecological approach to promoting early adolescent mental health and social adaptation: Family-centered intervention in public middle schools. *Child Development*, *82*(1), 209-225. https://doi.org/10.1111/j.1467-8624.2010.01551.x

Stormshak, E. A., Fosco, G. M., & Dishion, T. J. (2010). Implementing interventions with families in schools to increase youth school engagement: The family check-up model. *School Mental Health: A Multidisciplinary Research and Practice Journal, 2*(2), 82-92. https://doi.org/10.1007/s12310-009-9025-6

Tashman, N. A., Waxman, R. P., Nabors, L. A., & Weist, M. D. (1998). The Prepare approach to training clinicians in school mental health programs. *Journal of School Health, 68*, 162-172. https://doi.org/10.1111/j.1746-1561.1998.tb06337.x

Task Force on Promotion and Dissemination of Psychological Procedures. (1995). Training in and dissemination of empirically validated psychological treatments: Report and recommendations. *Clinical Psychologist, 48,* 3–23. Retrieved from http://www.div12.org/sites/default/files/InitialReportOfTheChamblessTaskForce.pdf

Taylor, L. & Adelman, H. S. (2001). *Enlisting appropriate parental cooperation and involvement in children's mental health treatment*. In E. R. Welfel & R. E. Ingersoll (Eds.), The Mental Health Desk Reference (pp. 219-224). New York, NY: Wiley. Retrieved from http://web.b.ebscohost.com.lib.pepperdine.edu/ehost/ebookviewer/ebook/bmxlYmtfXzYzNDU2X19BTg2?sid=49f04313bcf14c32833469f82db11203@sessionmgr103&vid=0&format=EB&rid=1

Ton, H., Koike, A., Hales, R. E., Johnson, J., & Hilty, D. M. (2005). A qualitative needs assessment for development of a cultural consultation service. *Transcultural Psychiatry, 42*, 491–504. https://doi.org/10.1177/1363461505055629

Trotter, R. I. (2012). Qualitative research sample design and sample size: Resolving and unresolved issues and inferential imperatives. *Preventive Medicine: An International Journal Devoted to Practice And Theory, 55*(5), 398-400. https://doi.org/10.1016/j.ypmed.2012.07.003

Tseng, W., Kawabata, Y., Gau, S. S., & Crick, N. R. (2014). Symptoms of attention-deficit/hyperactivity disorder and peer functioning: A transactional model of development. *Journal of Abnormal Child Psychology, 42*(8), 1353-1365. https://doi.org/10.1007/s10802-014-9883-8

Uebelacker, L. A., Hecht, J., & Miller, I. W. (2006). The family check-up: A pilot study of a brief intervention to improve family functioning in adults. *Family Process, 45*, 223-236. https://doi.org/10.1111/j.1545-5300.2006.00092.x

United Stats Census Bureau (2015). *QuickFacts Los Angeles County, California*. Retrieved from http://www.census.gov/quickfacts/table/PST045216/06037,06

U.S. Department of Education, Office of Special Education and Rehabilitative Services, Office of Special Education Programs, (2006). *Teaching Children with Attention Deficit Hyperactivity Disorder: Instructional Strategies and Practices*. Washington, DC, 2006. U.S. Retrieved from https://www2.ed.gov/rschstat/research/pubs/adhd/adhd-teaching-2006.pdf

US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2010). *The mental and emotional well-being of children: A portrait of states and the nation 2007*. Rockville, MD: US Department of Health and Human Services. Retrieved from http://www.mchb.hrsa.gov/nsch/07emohealth/moreinfo/pdf/nsch07.pdf

Vaughn, S., & Linan-Thompson, S. (2003). What is special about special education for students with learning disabilities? *The Journal of Special Education*, *37*(3), 140–147. https://doi.org/10.1177/00224669030370030301

Villatoro, A. P., Dixon, E., & Mays, V. M. (2016). Faith-based organizations and the Affordable Care Act: Reducing Latino mental health care disparities. *Psychological Services, 13*(1), 92-104. https://doi.org/10.1037/a0038515

Villatoro, A. P., Morales, E. S., & Mays, V. M. (2014). Family culture in mental health help-seeking and utilization in a nationally representative sample of Latinos in the United States: The NLAAS. *American Journal Of Orthopsychiatry, 84*(4), 353-363. https://doi.org/10.1037/h0099844

Wagner, M., Friend, M., Bursuck, W. D., Kutash, K., Duchnowski, A. J., Sumi, W. C., & Epstein, M. H. (2006). Educating Students With Emotional Disturbances: A National Perspective on School Programs and Services. *Journal Of Emotional And Behavioral Disorders, 14*(1), 12-30. https://doi.org/10.1177/10634266060140010201

Walker, H. M. (2004). Commentary: Use of evidence-based interventions in schools: Where we've been, where we are, where we need to go. *School Psychology Review, 33*, 398-407. Retrieved from https://www.researchgate.net/publication/279558529_Commentary_Use_of_evidence-based_interventions_in_schools_Where_we%27ve_been_where_we_are_and_where_we_need_to_go

Walker, J. S., Coleman, D., Lee, J., Squire, P. N., & Friesen, B. J. (2008). Children's stigmatization of childhood depression and ADHD: Magnitude and demographic variation in a national sample. *Journal of the American Academy of Child and Adolescent Psychiatry, 47*(8), 912–920. https://doi.org/10.1097/CHI.0b013e318179961a

Wallace, S. P., Torres, J., Sadegh-Nobari, T., Pourat, N., & Brown, E. R. (2012). *Undocumented immigrants and health care reform*. Los Angeles, CA: UCLA Center for Health Policy Research. Retrieved from http://healthpolicy.ucla.edu/publications/Documents/PDF/undocumentedreport-aug2013.pdf

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States: Results from the National Comorbidity Survey Replication. *Archives Of General Psychiatry*, *62*(6), 629-640. https://doi.org/10.1001/archpsyc.62.6.629

Ward, E. C. (2005). Keeping it real: A grounded theory study of African American clients engaging in counseling at a community mental health agency. *Journal of Counseling Psychology, 52*, 471–481. Retrieved from http://psycnet.apa.org/index.cfm?fa=buy.optionToBuy&id=2005-13343-002

Webster-Stratton, C. (2011). *The Incredible Years: Parent, teacher, and children's training series*. Seattle, WA: Incredible Years, Inc. Retrieved from http://www.incredibleyears.com/books/iy-training-series-book/

Webster-Stratton, C. (n.d.) *Helping children learn to regulate their emotions*. Retrieved from http://incredibleyears.com/parents-teachers/articles-for-parents/

Webster-Stratton, C. & Herman, K. C. (2010). Disseminating incredible years series early-intervention programs: Integrating and sustaining services between school and home. *Psychology In The Schools, 47*(1), 36-54. https://doi.org/10.1002/pits.20450

Weisz, J., & Kazdin, A. (2010). *Evidence-based Psychotherapies for children and adolescents* (2nd Ed.). New York, NY: Guilford.

Whelley, P., Cash, R. E., & Bryson, D. (2004). *Helping children at home and school II: Handouts for families and educators*. Retrieved from http://www.nasponline.org/resources/

Williams, J. H., Horvath, V. E., Wei, H., Van Dorn, R. A., & Jonson-Reid, M. (2007). Teachers' perspectives of children's mental health service needs in urban elementary schools. *Children and Schools, 29*, 95–107. https://doi.org/10.1093/cs/29.2.95

Zhang, Y. & Wildemuth, B. M. (2009). Qualitative analysis of content. In B. Wildemuth (Ed.), Applications of Social Research Methods to Questions in Information and Library. Retrieved from https://www.ischool.utexas.edu/~yanz/Content_analysis.pdf

APPENDIX B

Institutional Review Board (IRB) Notice of Approval

PEPPERDINE

Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: January 28, 2016

Protocol Investigator Name: Genevieve Lam

Protocol #: 15-11-118

Project Title: A Mixed Methods Study Examining Teacher Impressions of a Psychoeducational Program on Common Issues During Childhood

School: Graduate School of Education and Psychology

Dear Genevieve Lam:

Thank you for submitting your application for expedited review to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

Based upon review, your IRB application has been approved. The IRB approval begins today January 28, 2016, and expires on January 27, 2017.

Your final consent form has been stamped by the IRB to indicate the expiration date of study approval. You can only use copies of the consent that have been stamped with the IRB expiration date to obtain consent from your participants.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and will require a submission of a new IRB application or other materials to the IRB. If contact with subjects will extend beyond January 27, 2017, a continuing review must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the *Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual* at community.pepperdine.edu/irb.

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.

Sincerely,

PEPPERDINE

Pepperdine University
24255 Pacific Coast Highway
Malibu, CA 90263
TEL: 310-506-4000

Kevin Collins, IRB Manager

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives

Mr. Brett Leach, Regulatory Affairs Specialist

APPENDIX C

Recruitment Letter

Judy Ho, Ph. D., ABPP, CMHFE
Assistant Professor, Licensed Clinical Psychologist
Board Diplomate, American Board of Professional Psychology
Board Diplomate, National Board of Forensic Evaluators

[redacted]
Principal
Wiseburn Elementary School District

Dear [redacted]

We are writing to let you know about an extraordinary, no-cost opportunity for the parents and teachers of Juan Cabrillo Elementary School to attend a focus group to evaluate the utility and feasibility of psychoeducational program about common childhood emotional and behavioral problems. This program was developed by Dr. Judy Ho and the doctoral and master students in her clinical research lab at Pepperdine University's Graduate School of Education and Psychology. Dr. Judy Ho is a two-time recipient of the National Institute of Mental Health National Services Research Award, and she has a long track record of doing community mental health research with children, teachers, and families. She is a frequent correspondent on CNN and a variety of other news channels where she speaks about important mental health issues for children and families. Her program is devoted to ensuring those who are at-risk have access to resources and early intervention to ensure a positive developmental trajectory. The program aims to provide parents and teachers with concise and targeted information regarding common childhood issues they may encounter, such as social skills difficulties, attention and concentration problems, acting out behaviors, and sadness and anxiety. We strongly believe that educating parents and teachers about how to identify these common problems in children they work with can help to foster positive development in youth.

We would like to meet with you briefly (20-30 minutes) to discuss the possibility of introducing this training program to help serve the needs and interests of your school.

There has been much research that demonstrates the significance of early intervention to enhance students' learning and positive behavior. Some of the positive outcomes associated with prevention and early intervention include improved standardized test scores, GPA, citizenship ratings, and reduced disciplinary actions (e.g., truancy, suspension). We are interested in partnering and collaborating with your school to introduce the program to teachers and parents, and to gain valuable input from you as to how to better present the material so that it can achieve maximum benefits for the children you serve.

The program is structured and designed to provide parents and teachers with psychoeducation on common emotional and behavioral issues among school-age children, how to help modify these behaviors with scientifically proven behavioral strategies at home and at school, when/how to seek mental health services for a child, and the essential elements of the treatment process. They also aim to provide teachers and parents with information about services and resources available within their community.

We would appreciate a short meeting with you to discuss this training program in more depth. We know you are busy and can come to your school at a time convenient to you. Please let us know if you have any questions or need more information and we will be happy to provide more details.

2/16/2010

Looking forward to meeting you to discuss this exciting project!

Sincerely,

Judy Ho, Ph.D., ABPP, CMHFE
Assistant Professor of Psychology, Clinical Psychologist, Pepperdine University

Emily Blum, M.A.
Genevieve Lam, M. A.
Leanne Mendoza, M. A.
Erika Rajo, M. S.
Clinical Psychology Doctoral Students, Pepperdine University

Joey Farewell
Clinical Psychology Master Students, Pepperdine University

APPENDIX D

Informed Consent

PEPPERDINE UNIVERSITY

INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES

PSYCHOEDUCATIONAL PROGRAM 4 SCHOOL-AGED FAMILIES AND EDUCATORS (PEP4SAFE)

You are invited to participate in a research study conducted by Judy Ho, Ph.D., ABPP, Assistant Professor of Psychology at Pepperdine University, because you are a LAUSD teacher. Your participation is voluntary and will in no way affect your standing at your school or with Pepperdine University. You should read the information below, and ask questions about anything that you do not understand, before deciding whether to participate. Please take as much time as you need to read the consent form. You may also decide to discuss participation with your family or friends. If you decide to participate, you will be asked to sign this form. You will also be given a copy of this form for you records.

PURPOSE OF THE STUDY

The objective of this research study is to evaluate a psychoeducational program for teachers to provide them with knowledge of emotional/behavioral issues common during childhood, strategies for managing such difficulties at home, and when/how to seek mental health services for their child. The study aims to examine potential barriers of teacher attendance to the psychoeducational program and to assess the usefulness and ease of implementation of specific manual content. You will be asked to indicate which aspects of the intervention I find most helpful, which aspects need improvement, and if you would personally use any of the suggested behavioral management strategies in your classroom.

STUDY PROCEDURES

If you volunteer to participate in this study, you will be presented a copy of the psychoeducational manual at the beginning of the focus-group session and will be able to review the manual for the duration of the session (approximately 90 minutes). You will also be directed to review specific parts of the manual throughout the focus-group session. Subsequently, you will be asked to complete a questionnaire that will provide information regarding my background history. You will also be asked open-ended questions about your opinions of the psychoeducational program.

Your answers will be recorded via audiotape by the research associate to ensure accurate transcription; however, no identifying information will be recorded on this audiotape, and only research associates will have access to these tapes. You will not be asked to provide identifying or specific information about my student(s). These tasks, including the manual review, the focus group interview, and filing out the questionnaire, will require approximately 90 minutes total to complete. This study will be conducted in a small focus group format (with a few other teachers) at the school at which you are employed. If your schedule conflicts with the majority of other focus group participants, you can elect to participate in an individual interview (one-on-one with the research associate) also conducted at the school.

POTENTIAL RISKS AND DISCOMFORTS

There are no anticipated significant risks for my participation; however, potential and foreseeable risks associated with participation in this study include boredom and fatigue while completing the aforementioned questionnaires. If you become bored or fatigued, you can take breaks at any time. Also, possible risks include are some uneasy feelings that may arise when asked to answer questions about your personal background.

In the case, you experience discomfort or stress during the interview, you will be encouraged to take breaks, discuss the discomfort with the interviewer, and/or will be provided with referrals for centers where culturally appropriate support or mental health services may be available.

- Airport Marina Counseling Service
  7891 La Tijera Boulevard
  Los Angeles, CA 90045
  T: (310) 670-1410 F: (310) 670-0919
  http://www.airportmarina.org

- National Suicide Prevention Line (24hrs/7days)
  1-800-273-TALK (8255)
  http://www.suicidepreventionlifeline.org

- Psychology Today
  www.psychologytoday.com

You may also contact the principal investigator, Judy Ho, Ph.D., ABPP, by phone at (310) 568-5604 following the session.

Other potential risks include the discovery of cases of suspected child abuse, as all research associates are mandated reporters. You may discontinue the study at any time.

POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY

While there are no direct benefits to the study participants, there are several anticipated benefits to society and the field of psychological research including: increasing understanding and knowledge of potential barriers to as well as benefits of a school-based psychoeducation program on childhood emotional/behavioral issues. The data collected may be used to help attain funding to continue this type of research at no cost to mental health clinics and/or used in research manuscripts or textbooks to help increase public awareness of the barriers to motivation and engagement in youth and family therapy.

PAYMENT/COMPENSATION FOR PARTICIPATION

No compensation will be provided for participation in the study.

CONFIDENTIALITY

The principal investigator and her research associates will take all reasonable measures to protect the confidentiality of your records, and your identity will not be revealed in any publication that may result from this project. You will be assigned a research identification number (RIN) upon enrollment in the study to de-identify your response on questionnaires and interviews. Only the principal investigator and her research associates will have access to your data, and the data is not linked to any identifying information. Your responses to interview questions will be recorded on a hand-held recorder and the audio file will be uploaded onto a password-protected computer (accessible only by the principle investigator and research associates) in a secured facility at Pepperdine University Graduate School of Psychology, West Los Angeles campus. No identifying information, such as my full name, will be recorded on the audio recorder, but the audio files may contain my RIN to link my interview responses to my questionnaire responses. The audio files will then be transcribed and the transcription will be kept on the same password protected computer. Once the hard copy questionnaire data and the audio recorder data has been transferred to the password protected computer and checked for accuracy, the hard copy files and audio recorder data will be destroyed (hard copy files by shredding, and audio recorder by deletion). During data entry and checking, the hard copy questionnaires and audio recorder will be stored in a locked cabinet within a locked office of the principle investigator. A master list containing my name and associated RIN will be kept separately from the de-identified electronic data in a locked cabinet within the office of the principle investigator. De-identified electronic data will continue to be kept in a password-protected computer. The findings of this study may be published in research manuscripts, textbooks, or presented at professional conferences. However, data from this study will only be reported in the aggregate, which ensures my anonymity.

The confidentiality of your records will be maintained in accordance with applicable state and federal laws. Under California law, there are exceptions to confidentiality, including suspicion that a child, elder, or dependent adult is being abused, or if an individual discloses an intent to harm him/herself or others. In the above cases, the researchers are mandated by law to report these issues to the proper authorities, including but not limited to the police department, child protective services, or elder protective services.

If you decide to participate within a small focus group format, all of the above confidentiality considerations apply. In addition, all participants, will sign an additional form stating that they will keep the information revealed within the focus group confidential.

PARTICIPATION AND WITHDRAWAL

Your participation is voluntary and will not affect your standing at your school or with Pepperdine University. Your refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study.

ALTERNATIVES TO FULL PARTICIPATION

The alternative to participation in the study is not participating or completing only the items which you feel comfortable.

INVESTIGATOR'S CONTACT INFORMATION

I understand that the investigator is willing to answer any inquiries I may have concerning the research herein described. I understand that I may contact the principal investigator, Judy Ho, Ph.D. at Pepperdine University, Graduate School of Education and Psychology, 6100 Center Drive, Los Angeles, CA 90045 and/or (310) 568-5604 if I have other questions or concerns about this research.

RIGHTS OF RESEARCH PARTICIPANT – IRB CONTACT INFORMATION

If I have questions about my rights as a research participant, I understand that I can contact Kevin Collins, Manager of the Graduate and Professional Schools Institutional Review Board, Pepperdine University at Pepperdine University, Graduate School of Education and Psychology, 6100 Center Drive, Los Angeles, CA 90045 and/or (310) 568-5753.

APPENDIX E

Informed Consent Script

PEP4SAFE

PSYCHOEDCUATIONAL PROGRAM 4 SCHOOL-AGED FAMILIES AND EDUCATORS

Research Associate Information (Please fill in here as information is gathered)

Research Associate Name: _____

Parent/Teacher Name: _____

Location of first interview: _____

Date and time of first interview: _____

SCRIPT BEGINS HERE

Note: Underlined text indicates directions for script or written information. Parentheses cue you to fill in specific information direct specific actions. All other text indicates what should be said to the parent.

(Make sure you have two copies of the consent form ready for use)

Hi, my name is _____ (research associate name) and I'd like to tell you a little about your participation on this project. I will read you some information now, please stop me at any time if you have questions, ok?

Here is a copy of the form (hand 1 copy of form to parent), you may follow along as I tell you about the project. **Proceed to 1 (Intro)**

1 (Intro)

Read the 1st paragraph of the consent form verbatim.

Do you have any questions about what I just read to you?

If NO: **Proceed to 2**

If YES: What can I answer for you? (After answering questions, **Proceed to 2**)

2 (Purpose of Study)

Read the 2nd paragraph of the consent form verbatim.

Do you have any questions about what I just read to you?

If NO: **Proceed to B3**

If YES: What can I answer for you? (After answering questions, **Proceed to B3**)

B3

Read the 6th and 7th paragraph of the consent form verbatim.

Do you have any questions about what I just read to you?

If NO: **Proceed to B4**

If YES: What can I answer for you? (After answering questions, **Proceed to B4**)

B4

Read the 8th and 9th paragraph of the consent form verbatim.

Do you have any questions about what I just read to you?

If NO: **Proceed to B5**

If YES: What can I answer for you? (After answering questions, **Proceed to B5**)

All the way to 9 with the titles of each numbered item from consent, then follow with consent and signatures

Consent and Signatures

If you understand everything I just read to you, please sign and print your name, and also write today's date, on this line (hand 2nd copy of parent/teacher consent form for parent/teacher signature).

You may keep the copy I gave you for your own information and records.

(Take the signed copy back and store it in your research associate binder)

Thank you!

APPENDIX F

Demographic Questionnaire

PEP4SAFE

PSYCHOEDCUATIONAL PROGRAM 4 SCHOOL-AGED FAMILIES AND EDUCATORS

TEACHER DEMOGRAPHIC QUESTIONNAIRE

The following questions will be asking about you and your school environment. Your responses will remain confidential, so please answer the questions as truthfully as possible.

I. BACKGROUND

1. Age _____

2. Gender
   a) Male
   b) Female
   c) Transgender
   d) Other
   e) None/Prefer Not to Say

II. DEMOGRAPHICS

1. Ethnicity
   a) White, non-Hispanic
   b) Hispanic or Latino
   c) Native American
   d) African-American
   e) Asian-Pacific Islander
   f) Other (please specify) _____

2. Language Preference: _____

III. LEVEL OF EDUCATION – Highest level of education completed

a) Less than High School
b) High School/GED
c) Some College
d) 2-Year College Degree (Associates Degree)
e) 4-Year College Degree (BA, BS)
f) Master's Degree
g) Doctoral Degree
h) Professional Degree (MD, JD, etc.)

IV. OCCUPATION

1. Years Teaching _____

2. Grades Taught _____

3. Current Grade Taught _____

4. What type of school setting do you currently work in?
    a) Public
    b) Private
    c) Magnet
    d) Montessori

5. Current classroom size _____

6. Number of classroom aids (if any) _____

7. Do you hold a valid teaching credential?
    Circle one:
    Yes No

    If yes, what type(s): _____

8. Do you have any training related to childhood mental health?
    Circle one:
    Yes No

    If so, please describe your experience below

APPENDIX G

Interview Protocol

PEP4SAFE

PSYCHOEDCUATIONAL PROGRAM 4 SCHOOL-AGED FAMILIES AND EDUCATORS

TEACHER INTERVIEW/FOCUS GROUP PROTOCOL

For the questions below, please reflect on the psychoeducational program you have reviewed. Your verbal responses will be recorded using a digital recorder to ensure that we accurately obtain all of the feedback you provide us with.

(Research Associate: Please start recorder when participant is ready)

1. How important do you think proactively learning about childhood emotional/behavioral issues is for teachers?

2. Do you think the psychoeducational program would be useful for other teachers? Why or why not?

3. Do you think this program can be feasibly incorporated into the school year as a workshop or series of workshops that teachers are asked to attend?

4. What are some of your suggestions for making the program convenient for teachers to attend (e.g., schedule on weekends, schedule after school, all in one day, etc.)?

5. What are some barriers you foresee in adopting this program in a school setting?

6. How might we help to address the barriers you described?

7. What did you like most about the program? Please be specific (e.g., worksheets, length, range of topics).

8. Which module or aspect of the program do you think is most helpful for teachers? Why?

9. Were there any aspects of the program/modules that you found unhelpful? Why?

10. What other topics, if any, on childhood emotional/behavioral problems do you think teachers would benefit from learning about that were not included in this program?

11. Do you think the psychoeducational program would help teachers more accurately determine when a student is in need of psychological services/when the teachers should refer the student to a mental health professional? Please explain why or why not.

12. Would you personally use any of the suggested behavioral management strategies presented in the psychoeducational program in your classroom? Which ones in particular?

13. Do you have any other suggestions on how the program can be improved?

APPENDIX H

Quantitative Questionnaire

PEP4SAFE

PSYCHOEDCUATIONAL PROGRAM 4 SCHOOL-AGED FAMILIES AND EDUCATORS

TEACHER QUANTITATIVE QUESTIONNAIRE

For the questions below, please rate your response on the following scale from 1 through 5:

Not at All	***Very Little***	***Somewhat***	***Very Much***	***Extremely***
1	***2***	***3***	***4***	***5***

1) Do you think that an educational/psychoeducational program on common childhood emotional/behavioral problems is necessary at your school?

Not at All	***Very Little***	***Somewhat***	***Very Much***	***Extremely***
1	***2***	***3***	***4***	***5***

2) How feasible do you think it would be to implement the presented program at your school?

Not at All	***Very Little***	***Somewhat***	***Very Much***	***Extremely***
1	***2***	***3***	***4***	***5***

3) How effective do you think the program would be at increasing most teachers' and school staff's knowledge of childhood emotional/behavioral problems?

Not at All	***Very Little***	***Somewhat***	***Very Much***	***Extremely***
1	***2***	***3***	***4***	***5***

4) How much did the program increase your own knowledge on childhood emotional/behavioral problems?

Not at All	***Very Little***	***Somewhat***	***Very Much***	***Extremely***
1	***2***	***3***	***4***	***5***

5) How much more equipped do you think teachers who complete the presented program will be at appropriately referring their children in need for mental health services?

Not at All	***Very Little***	***Somewhat***	***Very Much***	***Extremely***
1	***2***	***3***	***4***	***5***

6) How interested do you think teachers would be in attending the presented program if it offered convenient scheduling?

Not at All	***Very Little***	***Somewhat***	***Very Much***	***Extremely***
1	***2***	***3***	***4***	***5***

7) Do you think the behavioral interventions included in the modules will be helpful for you to use with your students if/when they are displaying emotional/behavioral problems?

Not at All	***Very Little***	***Somewhat***	***Very Much***	***Extremely***
1	***2***	***3***	***4***	***5***

APPENDIX I

Transcription Template

PEP4SAFE

PSYCHOEDCUATIONAL PROGRAM 4 SCHOOL-AGED FAMILIES AND EDUCATORS

Transcription Template

Name of Audio Clip:
Transcriber #1:
Transcriber #2:
Final Sign-Off by Lab Manager

0:00	Q: A1: A2:
0:10	
0:20	
0:30	
0:40	
0:50	
1:00	
1:30	
2:00	
2:30	
3:00	
3:30	
4:00	
4:30	
5:00	
5:30	

APPENDIX J

Qualitative Data Training Protocol

Qualitative Data Preparation and Transcription Protocol

TEXT FORMATTING

General Instructions

The **transcriber** shall transcribe all individual and focus group interviews using the following formatting:

1. Arial 10-point face-font
2. One-inch top, bottom, right, and left margins
3. All text shall begin at the left-hand margin (no indents)
4. Entire document shall be left justified

Labeling Focus Group Transcripts

Individual interview transcript shall include the following labeling information at the top of the document:

Example:
Focus Group Location:
Cadre:
Date:
Number of Attendees (if known):
Name of Transcriber:
Number of Tapes:

Audiotape Changes

The transcriber shall indicate when the interview is recorded on a new tape and include information verifying that the second side of the audiotape is blank as well as the total number of audiotapes associated with the focus group. This information shall be typed in uppercase letters.

Example:
END OF TAPE 1 (3 TAPES TOTAL); VERIFIED THAT SIDE B OF TAPE 1 IS BLANK
START OF TAPE 2 (3 TAPES TOTAL)
END OF TAPE 2 (3 TAPES TOTAL); VERIFIED THAT SIDE B OF TAPE 2 IS BLANK

Documenting Comments

Comments or questions by the Interviewer or Facilitator should be labeled with by typing **I:** at the left margin and then indenting the question or comment.

Any comments or responses from participants should be labeled with **P:** at the left margin with the response indented. A response or comment from a different participant should be separated by a return and than a new **P:** at the left margin.

Example

I: OK, before we begin the interview itself, I'd like to confirm that you have read and signed the informed consent form, that you understand that your participation in this study is entirely voluntary, that you may refuse to answer any questions, and that you may withdraw from the study at anytime.

P: Yes, I had read it and understand this.

P: I also understand it, thank you.

I: Do you have questions before we proceed?

End of Interview

In addition, the transcriber shall indicate when the interview session has reached completion by typing

END OF INTERVIEW in uppercase letters on the last line of the transcript along with information regarding the total number of audiotapes associate with the interview and verification that the second side of the tape is blank. A double space should precede this information.

Example:

I: Is there anything else that you would like to add?
P: Nope, I think that about covers it.
I: Well, thanks for taking the time to talk with me today. I really appreciate it.

END OF INTERVIEW—(3 TAPES TOTAL); VERIFIED THAT SIDE B OF TAPE 2 IS BLANK

CONTENT

Audiotapes shall be transcribed verbatim (i.e., recorded word for word, exactly as said), including any nonverbal or background sounds (e.g., laughter, sighs, coughs, claps, snaps fingers, pen clicking, and car horn).

- Nonverbal sounds shall be typed in parentheses, for example, (short sharp laugh), (group laughter), (police siren in background).
- If interviewers or interviewees mispronounce words, these words shall be transcribed as the individual said them. The transcript shall not be "cleaned up" by removing foul language, slang, grammatical errors, or misuse of words or concepts.

- If an incorrect or unexpected pronunciation results in difficulties with comprehension of the text, the correct word shall be typed in square brackets. A forward slash shall be placed immediately behind the open square bracket and another in front of the closed square bracket.

Example:

P: I thought that was pretty pacific [/specific/], but they disagreed.

Filler words such as *hm*, *huh*, *mm*, *mhm*, *uh huh*, *um*, *mkay*, *yeah*, *yuhuh*, *nah huh*, *ugh*, *whoa*, *uh oh*, *ah*, and *ahah* shall be transcribed.

Inaudible Information
The transcriber shall identify portions of the audiotape that are inaudible or difficult to decipher. If a relatively small segment of the tape (a word or short sentence) is partially unintelligible, the transcriber shall type the phrase "inaudible segment." This information shall appear in square brackets.

Example:
The process of identifying missing words in an audiotaped interview of poor quality is [inaudible segment].

If a lengthy segment of the tape is inaudible, unintelligible, or is "dead air" where no one is speaking, the transcriber shall record this information in square brackets. In addition, the transcriber shall provide a time estimate for information that could not be transcribed.

Example:
[Inaudible: 2 minutes of interview missing]

Overlapping Speech
If individuals are speaking at the same time (i.e., overlapping speech) and it is not possible to distinguish what each person is saying, the transcriber shall place the phrase "cross talk" in square brackets immediately after the last identifiable speaker's text and pick up with the next audible speaker.

Example:
P: Turn taking may not always occur. People may simultaneously contribute to the conversation; hence, making it difficult to differentiate between one person's statement [cross talk]. This results in loss of some information.

Pauses
If an individual pauses briefly between statements or trails off at the end of a statement, the transcriber shall use three ellipses. A brief pause is defined as a two- to five second break in speech.

Example:
P: Sometimes, a participant briefly loses . . . a train of thought or . . . pauses after making a poignant remark. Other times, they end their statements with a clause such as but then . . . .

If a substantial speech delay occurs at either beginning or the continuing a statement occurs (more than two or three seconds), the transcriber shall use "long pause" in parentheses.

Example:
P: Sometimes the individual may require additional time to construct a response. (Long pause) other times, he or she is waiting for additional instructions or probes.

Questionable Text
If the transcriber is unsure of the accuracy of a statement made by a speaker, this statement shall be placed inside parentheses and a question mark is placed in front of the open parenthesis and behind the close parenthesis.

Example:
P: I wanted to switch to ?(Kibuli Hospital)? if they have a job available for me because I think the conditions would be better.

Sensitive Information
If an individual uses his or her own name during the discussion, the transcriber shall replace this information with the appropriate interviewee identification label/naming convention.

Example:
P: My supervisor said to me, “P1, think about things before you open your mouth.”

P: I agree with P1; I hear the same thing from mine all the time.

If an individual provides others’ names, locations, organizations, and so on, the transcriber shall enter an equal sign immediately before and after the named information. Analysts will use this labeling information to easily identify sensitive information that may require substitution.

Example:
P: My colleague =John Doe = was very unhappy in his job so he started talking to the hospital administrator at = Kagadi Hospital = about a different job.

REVIEWING FOR ACCURACY
The transcriber/proofreader shall check (proofread) all transcriptions against the audiotape and revise the transcript file accordingly. The transcriber/proofreader shall adopt a three-pass-per-tape policy whereby each tape is listened to three times against the transcript before it is submitted. All transcripts shall be audited for accuracy by the interviewer who conducted the interview or by the study data manager.

SAVING TRANSCRIPTS
The transcriber shall save each transcript as a text file rich text file with an .rtf extension. For focus groups, the title should include the location of the focus group and the cadre.

APPENDIX K

IRB Human Subjects Training Certificates

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COURSEWORK REQUIREMENTS REPORT*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Genevieve Lam (ID: 4242186)
- **Email:** genevieve.lam@pepperdine.edu
- **Institution Affiliation:** Pepperdine University (ID: 1729)
- **Institution Unit:** Graduate School of Education and Psychology

- **Curriculum Group:** Graduate & Professional Schools HSR
- **Course Learner Group:** Graduate & Professional Schools - Psychology Division Human Subjects Training
- **Stage:** Stage 1 - Basic Course
- **Description:** Choose this group to satisfy CITI training requirements for Investigators and staff involved primarily in Social/Behavioral Research with human subjects.

- **Report ID:** 16887608
- **Completion Date:** 08/11/2015
- **Expiration Date:** 08/10/2018
- **Minimum Passing:** 80
- **Reported Score*:** 84

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
Belmont Report and CITI Course Introduction (ID:1127)	08/11/15	3/3 (100%)
History and Ethical Principles - SBE (ID:490)	08/11/15	5/5 (100%)
Defining Research with Human Subjects - SBE (ID:491)	08/11/15	4/5 (80%)
The Federal Regulations - SBE (ID:502)	08/11/15	4/5 (80%)
Assessing Risk - SBE (ID:503)	08/11/15	4/5 (80%)
Informed Consent - SBE (ID:504)	08/11/15	5/5 (100%)
Privacy and Confidentiality - SBE (ID:505)	08/11/15	4/5 (80%)
Conflicts of Interest in Research Involving Human Subjects (ID:488)	07/09/14	4/5 (80%)
Cultural Competence in Research (ID:15166)	08/11/15	3/5 (60%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

CITI Program
Email: citisupport@miami.edu
Phone: 305-243-7970
Web: https://www.citiprogram.org

COLLABORATIVE INSTITUTIONAL TRAINING INITIATIVE (CITI PROGRAM)

COURSEWORK REQUIREMENTS REPORT*

* NOTE: Scores on this Requirements Report reflect quiz completions at the time all requirements for the course were met. See list below for details. See separate Transcript Report for more recent quiz scores, including those on optional (supplemental) course elements.

- **Name:** Erika Rajo (ID: 4871262)
- **Email:** erika.rajo@pepperdine.edu
- **Institution Affiliation:** Pepperdine University (ID: 1729)
- **Institution Unit:** GSEP

- **Curriculum Group:** Graduate & Professional Schools HSR
- **Course Learner Group:** Graduate & Professional Schools - Psychology Division Human Subjects Training
- **Stage:** Stage 1 - Basic Course
- **Description:** Choose this group to satisfy CITI training requirements for Investigators and staff involved primarily in Social/Behavioral Research with human subjects.

- **Report ID:** 16882561
- **Completion Date:** 08/11/2015
- **Expiration Date:** 08/10/2018
- **Minimum Passing:** 80
- **Reported Score*:** 95

REQUIRED AND ELECTIVE MODULES ONLY	DATE COMPLETED	SCORE
Belmont Report and CITI Course Introduction (ID:1127)	08/11/15	3/3 (100%)
History and Ethical Principles - SBE (ID:490)	07/02/15	5/5 (100%)
Defining Research with Human Subjects - SBE (ID:491)	07/02/15	4/5 (80%)
The Federal Regulations - SBE (ID:502)	07/02/15	5/5 (100%)
Assessing Risk - SBE (ID:503)	07/02/15	5/5 (100%)
Informed Consent - SBE (ID:504)	07/02/15	5/5 (100%)
Privacy and Confidentiality - SBE (ID:505)	08/11/15	5/5 (100%)
Conflicts of Interest in Research Involving Human Subjects (ID:488)	07/02/15	5/5 (100%)
Cultural Competence in Research (ID:15166)	08/11/15	4/5 (80%)

For this Report to be valid, the learner identified above must have had a valid affiliation with the CITI Program subscribing institution identified above or have been a paid Independent Learner.

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APPENDIX L

Teacher Codebook

Table 2

Teacher codebook

Category of Questions	Code	Description
Implementation/ Feasibility	Integration with School Programs	Integration of the psychoeducational program into existing school programs targeting needs of children suffering from emotional/behavioral difficulties
	Institutional Support	Support from the school and district identified as crucial to increasing the feasibility of implementation
	Professional Development Programs	Desire for psychoeducational program to be integrated into teacher professional development programming
	Teacher Coaching Component	Provision of direct coaching to teachers in the classroom as teachers utilized skills learned through the didactic presentation of the module(s)
	Modular Implementation	Preference for smaller psychoeducational workshops focused on a singular topic at a time
	High Demands on Teachers	High demands on teachers and their schedules as a barrier to implementation
Feedback on Program	Strength of Relevance of Content	Content included in the psychoeducational program is relevant to many students in elementary school classrooms
	Parent-Teacher Collaboration Strategies	Requests for the inclusion of strategies teachers can utilize to enhance the collaboration with students' parents
	Strength of Organization/Structure	Organization and structure of the manual as a strength of the program
	Strength of the Specificity /Clarity of Content	Specificity and clarity of the content and interventions is a strength of the program

	Intervention Timeline	Requests for the inclusion of suggested timeline that teachers should attempt to utilize the learned interventions before referring a student to mental health services if little progress is made
Program Need	Importance of Teacher Psychoeducation	Importance for teachers to be educated on common childhood problems and how to manage them
	Need for Classroom-Based E/B training	Expressed need for skill they can utilize to manage childhood E/B problems in the classroom
	Academics over E/B functioning	Tendency for academic performance to be prioritized over the E/B functioning of children
	Teacher Responsibility	The potential for teachers to make a significant difference for children's E/B functioning of their students
	E/B Impact on Academics	Impact that childhood E/B difficulties have on academic functioning
	Lack of E/B Training	Lack of teacher training on how to manage emotional/behavioral issues in the classroom
Applicable Content	Social Skills Training	Need for classroom strategies to manage social skills issues
	Bullying Prevention/Intervention	Need for classroom strategies to manage issues of bullying
	Teacher Self-Care	Need for teachers to learn self-care strategies
	Child Emotional Identification	Need for strategies included in the manual that pertained to enhancing a student's ability to label and communicate their emotions
	Attention/Concentration	Need for strategies they can use in the classroom to manage attention/concentration issues
	Referral Process	Need for guidelines for teachers regarding when to refer a student to mental health intervention services

APPENDIX M

Response Code Distribution Charts

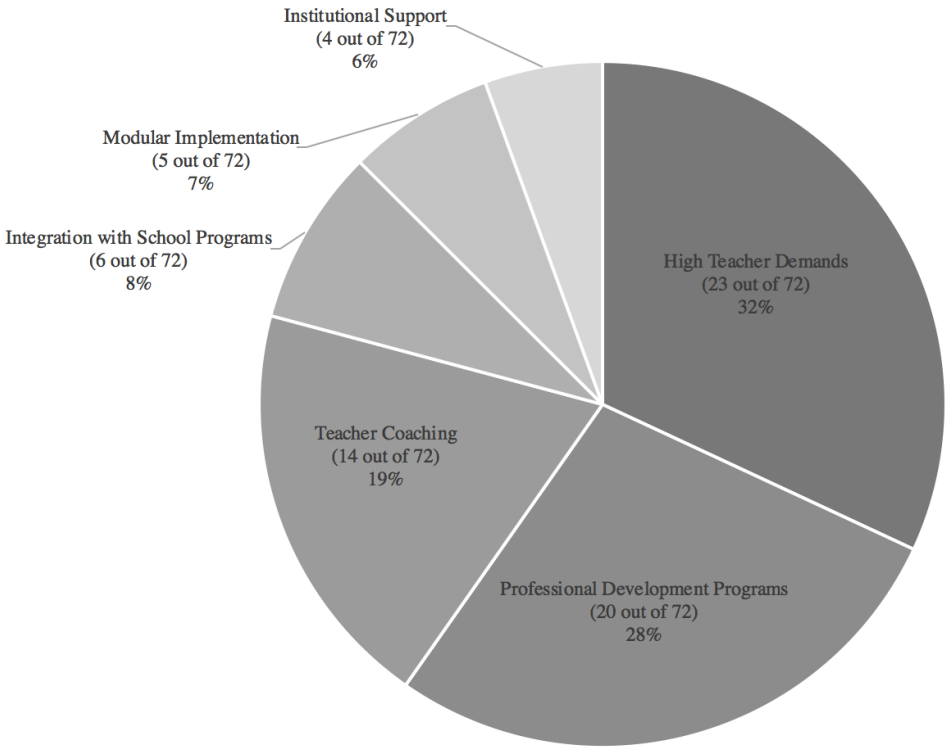

Figure M1. Theme distribution chart for implementation and feasibility category. Chart providing the number of codes identified within each theme. Numbers are provided to indicate how many codes were identified for each theme out of a total of 72 codes. Percentages are also included to denote the percentage of the total data within this category accounted for by each theme.

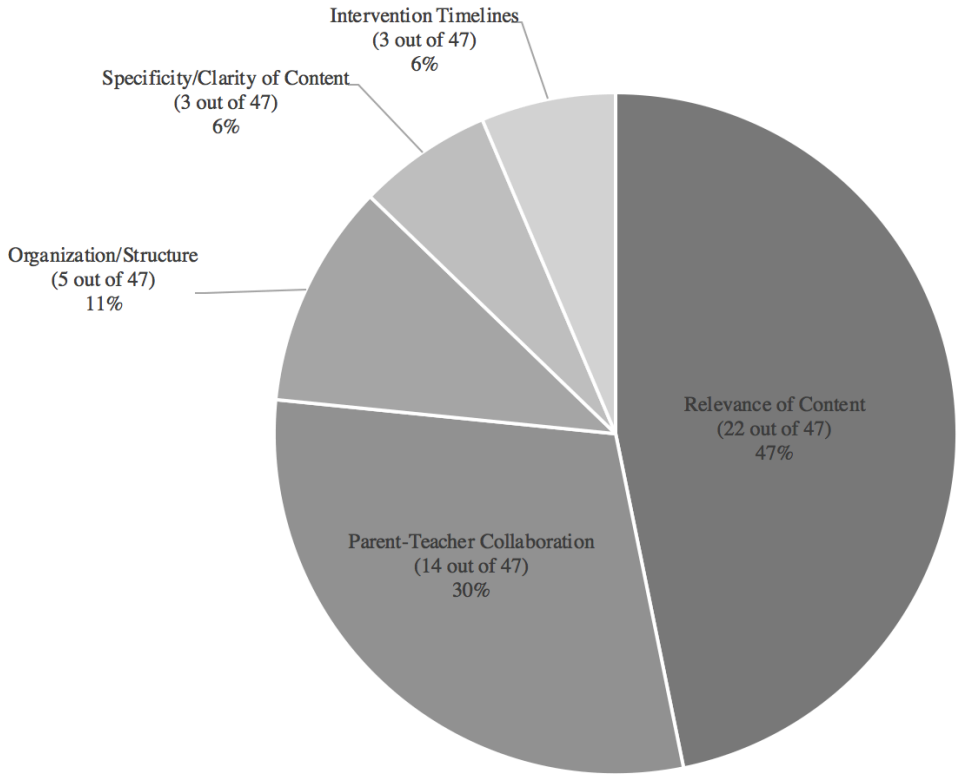

Figure M2. Theme distribution chart for feedback on program cateogry. Chart providing the number of codes identified within each theme. Numbers are provided to indicate how many codes were identified for each theme out of a total of 47 codes. Percentages are also included to denote the percentage of the total data within this category accounted for by each theme.

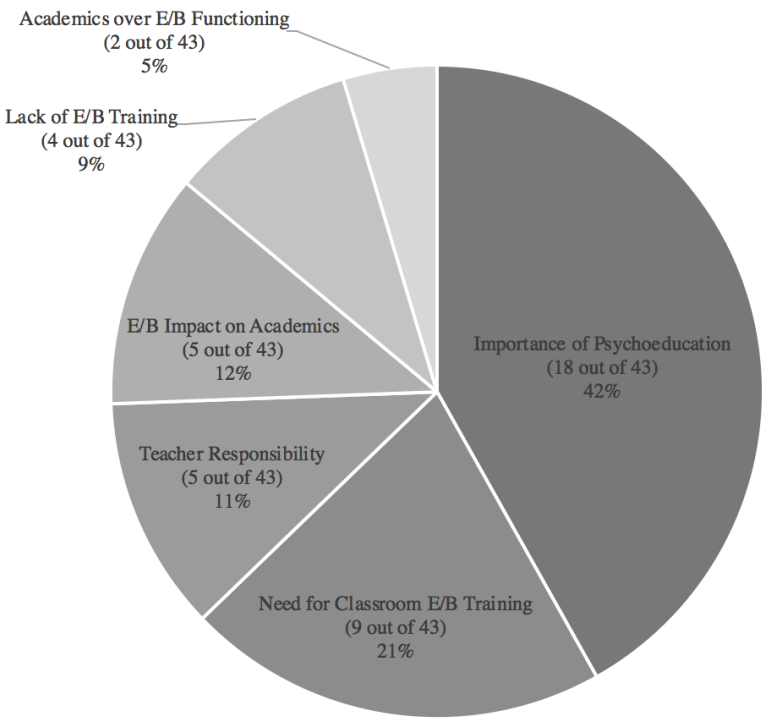

Figure M3. Theme distribution chart for program need category. Chart providing the number of codes identified within each theme. Numbers are provided to indicate how many codes were identified for each theme out of a total of 43 codes. Percentages are also included to denote the percentage of the total data within this category accounted for by each theme.

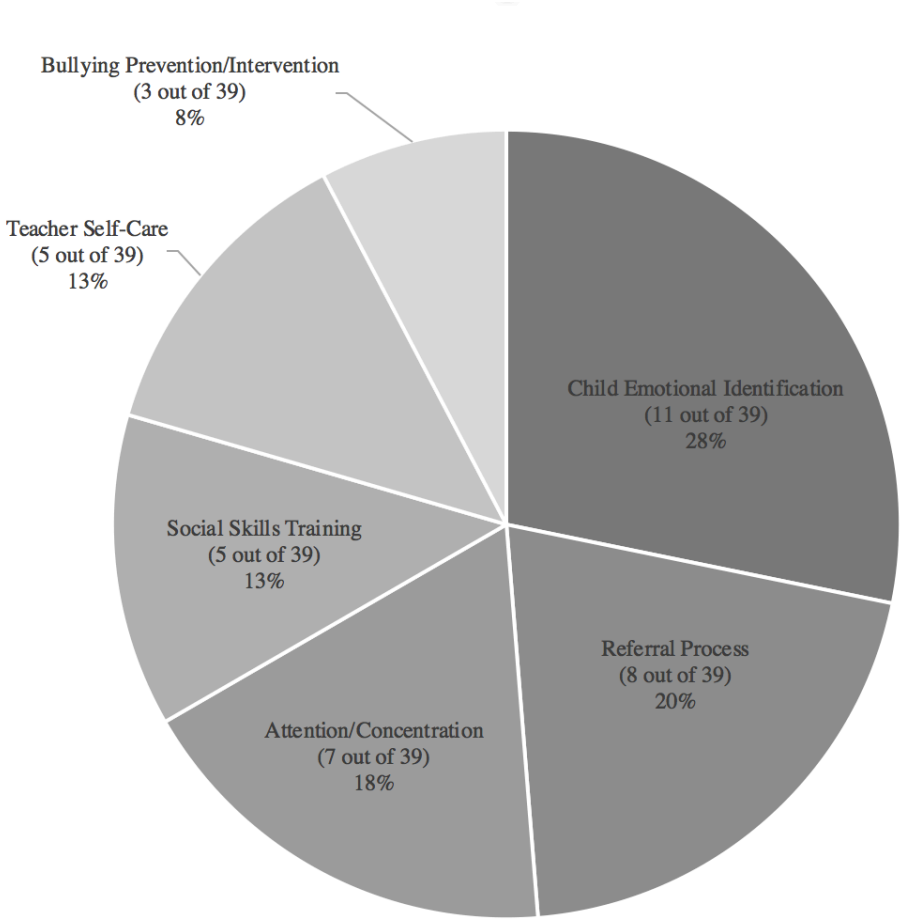

Figure M4. Theme distribution chart for applicable content category. Chart providing the number of codes identified within each theme. Numbers are provided to indicate how many codes were identified for each theme out of a total of 39 codes. Percentages are also included to denote the percentage of the total data within this category accounted for by each theme.