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Pepperdine University
Graduate School of Education and Psychology

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

A clinical dissertation submitted in partial satisfaction of the
requirements for the degree of
Doctor of Psychology

by

Erika Rajo

June, 2017

Judy Ho, Ph.D., ABPP, CFMHE – Dissertation Chairperson

This clinical dissertation, written by

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under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

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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, as well as system barriers (i.e. limited knowledge of mental health difficulties among parents of young children). Parents/caregivers are often the primary gatekeepers to treatment for children suffering from mental health problems. Additionally, psychoeducational programs have increasingly gained support as an effective evidence-based practice that may bolster treatment utilization among youth. A psychoeducational program for parents of school-aged children was developed to teach empirically-based strategies for managing common childhood problems and to help parents understand when and how to refer to professional services. A mixed methods study was conducted as a means to gain teacher impressions of the program's effectiveness in disseminating evidence-based home strategies that can be used by parents 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 importance of parent psychoeducation, need for social skills training, need for effective discipline techniques, preference for modular training, and scheduling with consideration for parental time constraints. Quantitative data analysis revealed that usefulness of behavioral interventions received the highest average rating between *very much* and *extremely* ($M = 4.67$, $SD = 0.52$) from participants, while knowledge increase post program overview had a medium level impact between *somewhat* and *very much* ($M = 3.83$, $SD = 0.98$). Limitations, strengths, and recommendations for future directions are discussed.

Keywords: barriers to treatment, youth, psychoeducation, parents/caregivers

Introduction

Over the past decade, children's mental health has become a major focus of public health agencies in the United States. Increasing efforts are being made to understand, explore, and address the effects that mental health issues among children have on families, communities, and society as a whole. According to the National Research Council and Institute of Medicine (NRC/IOM, 2009), the percentage of youth suffering from mental, emotional and behavioral disorders in a given year is approximately between 14 and 20 percent. Moreover, the Centers for Disease Control and Prevention (CDC, 2013) reported that there are 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 behavior disorders, and many other mental health issues. Comorbidity is also common among this population, as 40% of children with one mental disorder have at least one other mental disorder (US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau [HHS/HRSA/MCHB], 2010). From an economic standpoint, the cost of mental health treatment, lack of contribution to society, and crime that results from these childhood disorders in the U.S. is estimated at \$247 billion annually (NRC/IOM, 2009). More importantly, in addition to experiencing distressing symptoms, children with mental health issues often experience difficulties in multiple areas of their lives including at home, in school, and with peers (CDC, 2013).

Despite the wide-reaching effects of emotional and behavioral issues during childhood, there are a lot of children who need but do not receive mental health services. In fact, the National Survey of Children's Health revealed that only 60% of children (ages 2-17) with an ongoing emotional, developmental, or behavioral problem accessed mental health services in

2007 (HHS/HRSA/MCHB, 2010). Unmet need among youth was examined further by Kataoka, Zhang, and Wells (2002), who found discrepancies associated with ethnicity and health insurance status. Specifically, their findings indicate that the rate of unmet need is significantly higher among Latino children and uninsured children than that among White children and insured children. Given the increasing gap between youth mental health needs and actual service utilization rates (Roll, Kennedy, Tran, & Howell, 2013), many researchers have taken a step back to examine factors underlying these service discrepancies. Particular attention has been focused on identifying barriers to mental health treatment that children may encounter in order to find effective ways of increasing youth treatment utilization across groups and reduce the deleterious effects of mental health issues on children.

Barriers to Treatment for Youth

Barriers to treatment can be defined as “elements of the community, individual, or children’s mental health service system that prevent children in need from receiving care, even though it is available within the community” (Gould, Beals-Erickson, & Roberts, 2012, p. 767). Although barriers to treatment exist for all individuals seeking treatment, youth are subjected to additional barriers in the treatment-seeking process due in part to lack of autonomy and limited insight into their own conditions. Barriers that impact youths’ utilization of services may be conceptualized according to constructs from Gould and colleagues’ (2012) categorization model and Bronfenbrenner’s (1992) Ecological Systems Theory. These constructs, namely, Individual/Family Barriers, Systems Barriers, Community Barriers, and Sociocultural Barriers, will be discussed in the following sections.

Individual and family barriers. Barriers are not only those factors that prevent a child from accessing available treatment, but they can also be in the form of pressures or challenges

that impede treatment progress after it has commenced (Kazdin, Holland, Crowley, & Breton, 1997). As such, types of individual/family barriers include financial issues logistical issues, and parental factors (Gould et al., 2012). Regarding financial barriers, researchers have found that treatment attendance is often negatively impacted by clients' inability to afford treatment costs (Betz et al., 2004; Leigh, Powers, Vash, & Nettles, 2004). Furthermore, participation in treatment is affected by a number of logistical issues, including problems related to transportation (Bannon & McKay, 2005; Williams, Horvath, Wei, Van Dorn, & Jonson-Reid, 2007), childcare (Kernan, Griswold, & Wagner, 2003), and scheduling (Kazdin, Holland, & Crowley, 1997).

Parental factors such as parental mental illness, limited parental formal education, and parental language barriers (Gould et al., 2012) can also interfere with youth treatment utilization. A study conducted by Stallard, Norman, Huline-Dickens, Salter, and Cribb (2004) found that children of parents with mental illness strive to protect other family members from additional distress by minimizing their own struggles, making it more difficult to recognize the child's mental health needs and seek appropriate treatment. Hinojosa, Knapp, and Woodworth (2015) identified formal education level as another important parental factor that families can draw upon to lower or mediate the family strain experienced when a child is suffering from a mental health disorder (Hinojosa et al., 2015). These researchers defined family strain using an adapted form of the Double ABC-X model of family stress, with *double* denoting the effect of both the initial mental/behavioral health diagnosis and the ongoing management/treatment of the disorder. The model purports that there is a relationship among "(A) family stressors, (B) family resources, and (C) family perceptions of health and health care," (p. 1576) which in turn influences outpatient mental health utilization (Hinojosa et al., 2015). This relationship, as illustrated by their findings,

suggests that lower levels of parental education (i.e., parents without a high school diploma) increase family strain and, in turn, impact mental health care utilization (Hinojosa et al., 2015).

From transportation issues to parental mental illness, individual/family barriers can affect whether a child enters or remains in treatment. Moreover, these barriers can influence the degree to which a child participates in treatment in addition to treatment outcomes.

System barriers. System barriers include those aspects of the mental health service system (Gould et al., 2012), the school/teacher system and the home/family system that impede treatment access. For instance, a study by Sentell, Shumway, and Snowden (2007) found that individuals who speak English were more likely than individuals who do not speak English to get the mental health services they needed. This finding highlights a critical defect in the existing mental health service system – individuals that prefer a language other than English have few, if any, options for treatment with a provider who speaks their language (Ton, Koike, Hales, Johnson, & Hilty, 2005). Treatment access is also hindered by insufficient efforts to make available services known within the community, limited or inopportune service hours, inconvenient location of service provision, and restrictive criteria for treatment eligibility (Gould et al., 2012).

Adults can be solely responsible for their own mental health care, while a child's referral to and maintenance of mental health treatment is reliant on a number of other adult individuals and systems. Given that an estimated 70 to 80 percent of children receiving mental health treatment obtain services through the educational setting (Farmer, Burns, Phillips, Angold, & Costello, 2003; Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001; Rones & Hoagwood, 2000), the school system has been identified as the primary gateway for child mental health services (Williams et al., 2007). Although teachers and educators are primarily focused on the

academic achievement and learning of their students, attention to the mental health needs of school-aged children and adolescents also aligns with teacher goals (Spirito, Boergers, Donaldson, Bishop, & Lewander, 2002). Spirito et al. (2002) argue that the mental health of students directly impacts their academic outcomes and that, consequently, good mental health is a precursor to the development of competent and responsible citizens. Despite these clear implications, Williams et al. (2007) note that assessment of mental health needs is often not prioritized simply because educators and school personnel have a number of other responsibilities. In fact, a study by Farmer, et al. (2003) found that school personnel made the fewest referrals for additional services. Another reason for this, aside from the extensive demands placed on teachers, is that teachers may lack the skills or knowledge necessary to identify children in need of services (Williams et al., 2007). Moreover, school personnel might not be fully aware of the resources available outside of the school-based setting, which could possibly prevent them from referring students to more appropriate and beneficial services (Farmer et al., 2003). Thus, intervention is needed to provide school personnel with psychoeducation regarding the prevalence of mental health issues in children, indicators of these difficulties, and the services available to children and families within their community.

In addition to the previously mentioned challenges within the school system, many minority students are also faced with a number of other school-based barriers that make mental health treatment even more difficult to access. The 2013-2014 Civil Rights Data Collection (CRDC; U.S. Department of Education, 2016) revealed significant group differences when various forms of school discipline were examined by race/ethnicity in all U.S. public schools and school districts. For example, the CRDC indicates that black preschool children are 3.6 times as likely to receive one or more out-of-school suspensions as white preschool children (U.S.

Department of Education, 2016, p. 3). Similarly, black K-12 students are 3.8 times as likely to receive one or more out-of-school suspensions as white K-12 students. Furthermore, the CRDC (U.S. Department of Education, 2016) revealed that American Indian or Alaska Native, Latino, Native Hawaiian or other Pacific Islander, and multiracial boys are also disproportionately suspended from school. Regarding expulsions, black students are 1.9 times as likely to be expelled from school without educational services as white students. Moreover, American Indian or Alaska Native, white, and multiracial boys were also found to be disproportionately expelled. As with other forms of school discipline, black students are more likely (2.2 times) than white students to be referred to law enforcement or subjected to a school-related arrest (U.S. Department of Education, 2016).

Ultimately, racial and ethnic disproportionality in school discipline due to racial and ethnic bias (Rudd, 2014) obstructs the pathway to mental health treatment for many students because they are referred to a system (such as juvenile justice) that is not typically equipped to address specialty mental health needs. Moreover, once in a system other than specialty mental health, some minority youths continue to exhibit higher mental health need and incur lower rates of service utilization. One study by Rawal, Romansky, Jenuwine, and Lyons (2004) found that minority children in the juvenile justice system had greater mental health needs and lower rates of mental health service utilization than Caucasian youth in the juvenile justice system. The researchers also showed that many minority youth do not access needed mental health services until they enter the juvenile justice system, which suggests that, up to this point, these youth have limited access to such services (Rawal et al., 2004). The data highlights the need for culturally-informed, school-based mental health services that can be more easily accessed by youth and

increased awareness about the negative consequences associated with exclusionary discipline, both of which are the focus of the U.S. Department of Education's (2016) current initiatives.

Although the goal of school-based mental health services is to reduce barriers for children, the research shows that, like in other systems of care, there are racial/ethnic disparities in school-based referrals for mental health treatment (Guo, Kataoka, Bear, Lau, 2014). Specifically, minority students are less likely to be identified by school personnel as being in need of mental health services and, thus, less likely to be referred to a mental health professional than white children (Guo et al., 2014). On the contrary, minority children are overrepresented in special education and disproportionately identified as having learning disorders, intellectual disabilities, and emotional disabilities (Zhang, Katsiyannis, Ju, & Roberts, 2014). Given that lack of identification and misdiagnosis can clearly prevent children from accessing the treatment they need, these issues further highlight the need for increased psychoeducation among school personnel.

A child's family is another system that can present barriers to treatment. Parents are presumably the most likely referral source for youth with mental health issues; however, many parents do not seek professional services even when they have concerns about their child. Hectic schedules and financial constraints may deter parents from seeking treatment for their child (Morrissey-Kane & Prinz, 1999). Parental perception of the problem is another factor. For instance, parents may view a child's difficulties as static and uncontrollable in which case the motivation to seek treatment as a way to improve upon the problem is low (Roberts, Joe, & Rowe-Hallbert, 1992). In addition, Kourany, Garber, and Tornusciolo (1990) found that when a child has periods during which their difficulties appear to be improving, parents may believe that professional intervention is not warranted and, thus, are less likely to seek treatment.

Furthermore, research by Angold et al. (1998) indicates that a parent who perceives treatment to be burdensome (stigmatizing, time-consuming, etc.) is also less likely to initiate treatment for their child. Even when parents do take the necessary steps to initiate the treatment process, they commonly do not follow through on bringing their child to the first session (Morrissey-Kane & Prinz, 1999).

While a child's school and family are the two dominant systems linked directly to his/her receipt of mental health services, the people within these systems often do not collaborate with one another in their efforts to support the same child. In some cases, parents who receive referrals from school staff regarding their child's mental health needs believe it is the school staff's responsibility to follow through on these treatment recommendations without significant parent input or support (Williams et al., 2007). This supports the findings of a study by Williams et al. (2007) in which teachers surveyed for their perspectives on children's mental health services reported feeling a lack of respect. The same teachers reported facing many challenges when seeking consent for school-based services from parents and guardians, including a lack of parent follow-through with referrals (Williams et al., 2007). Lack of collaboration is not the only matter involving parents and teachers that can interfere with youth treatment utilization.

Numerous studies have demonstrated that there are often discrepancies between parent and teacher reports or ratings of youth behavior and emotional problems (De Los Reyes et al., 2011; Korsch & Petermann, 2014; Lane, Paynter, & Sharman, 2013; Major, Seabra-Santos, & Martin, 2015). Moreover, as noted by De Los Reyes and Kazdin (2005), "informant discrepancies" (p. 484) can negatively impact the evaluation, identification, and treatment of mental health issues among children.

In addition to barriers between parents and teachers, there are barriers that exist between parents and mental health service providers. Researchers have found that there is often a disconnect between the therapist's perspective of treatment engagement and the parent's/child's perspective of treatment engagement (Baker-Ericzén, Jenkins, & Haine-Schlagel, 2013). In a study conducted by Baker-Ericzén et al. (2013), therapists reported valuing parent participation and utilizing a family-focused therapy; however, parents reported feeling blamed, unsupported, and unheard by their child's therapist. Like other barriers, such conflicting perspectives and misaligned treatment expectations can negatively impact the course of treatment as well as treatment outcomes.

It is clear that the numerous barriers embedded in the mental health service system, the school system, and the family system are a major source of the unmet treatment needs among youth. However, many children also face barriers to treatment that are by-products of where they live.

Community barriers. According to Gould et al. (2012), community barriers refer to the attitudes and characteristics of the community in which services are provided. The barriers in this category can be broken down into two subtypes – barriers related to stigma and barriers related to community factors. In particular, stigma attached to mental health issues and mental health treatment has been identified as a community barrier for some parents (Larson et al., 2013). Hinshaw (2005) defines stigma as “an invisible, internal mark of shame related to membership in a deviant or castigated subgroup” (p. 715). Key elements of stigma include concealability, chronicity, controllability, and threat related to mental illness (Hinshaw, 2005). For example, parents may worry about what might happen if their neighbors find out about their child's

diagnosis. In addition, stigmas are perpetuated by the media's common portrayal of violence and dangerousness as an associated factor of mental illness.

During the past four decades, there has been a growing sense of shame associated with mental health treatment despite movements to de-stigmatize mental illness (Mackenzie, Erickson, Deane, & Wright, 2014). The way a person responds to stigma, whether positively or negatively, may possibly predict how they manage the treatment process. Morrissey-Kane and Prinz (1999) found that children with parents who believed that they were capable of enacting change in their child through therapy were more engaged in the treatment process and had better outcomes. The perceptions of others can also influence a parent's decision to seek treatment. Some parents believe that people in their support systems would be disapproving of their child receiving mental health services (Larson et al., 2013). Thus, these parents are less likely to seek such services for their child. In addition, parents may also believe their children will not be receptive to going to a mental health clinic, suggesting that they believe their children may perceive stigma towards mental health services. This is not surprising given that children who receive school-based services are often subjected to stigma even though such services are extremely common among youth (Bowers, Manion, Papadopoulos, & Gauvreau, 2013).

Other community barriers pertain to aspects of the particular community in which the children and family reside, such as the level of poverty and prevalence of violence. For example, even when controlling for other barriers (i.e., affordability and parental level of education), research has shown that urban youths are less likely than other youths to utilize the mental health services available within their own communities (Hoberman, 1992). This is surprising given that urban minority youth have a greater number of risk factors for mental health problems. In order to reach some of the children who are in most need, community

factors and stigma cannot be neglected as elements that impact a child and his or her family's likelihood of accessing treatment. It is also important to consider those barriers that some children may encounter regardless of where they live.

Sociocultural barriers. Many of the barriers to youth treatment utilization arise within a family's social and cultural context. Barriers within this category can be linked to factors such as race, ethnicity, religion, and gender. Ojeda and Bergstresser (2008) maintain that an individual's perception of and approach to treatment-seeking is often associated with their racial or ethnic identity. Moreover, help-seeking behavior is influenced by the social norms maintained in an individual's cultural group. For instance, it is commonplace for members of collectivistic societies to seek support from someone in their community rather than seeking an outside source (Kouyoumdjian, Zamboanga, & Hansen, 2003). Kouyoumdjian et al.'s (2003) examination of the Latino community provides another illustration of the link between culturally-informed barriers and unmet treatment need. Their findings suggest that, while many Latinos are in need of mental health services, there is a tendency to prioritize physical symptoms over psychological symptoms within this community. As a result, it is more likely that Latinos will seek treatment from medical doctors rather than mental health clinicians.

Treatment-seeking resistance among members of minority groups is reinforced by racial prejudice and discrimination within the mental healthcare system (Eiraldi, Mazzuca, Clarke, & Power, 2006). Furthermore, a sense of apprehension or suspicion exists in the African American community and other minority communities that have been treated unjustly by the healthcare system (Ojeda & Bergstresser, 2008). Understandably, if a parent has been exposed to some form of discrimination in the past, this experience likely weighs heavily into their decision of whether or not to seek treatment for their child. The presence of inequity within the healthcare

system also raises questions about the quality of services being rendered to ethnic minority groups. (Eiraldi et al., 2006). One example of such inequity is reflected in providers' diagnostic impressions. Morgan, Staff, Hillemeier, Farkas, and Maczuga (2013) found that racial/ethnic minority children were less likely than whites to be diagnosed with or treated with medication for Attention-deficit/hyperactivity disorder (ADHD). Similar racial/ethnic disparities have been found in the identification of children with Autism Spectrum disorders (Mandell et al., 2009). Moreover, previous encounters with or knowledge of others' experiences with mental health providers who lack cultural sensitivity can give ethnically diverse individuals the impression that treatment is not effective for members of their community (Flores, Olson, & Tomany-Korman, 2005). Similarly, language barriers or differences in communication patterns (Dow, 2011) can lead individuals to feel misunderstood by mental health professionals and confused by the information they are being given.

Although treatment-seeking attitudes can vary across and within ethnic groups, there are particular barriers that many minority groups in the U.S. share with regard to accessing and using mental health treatment. Gary (2005) proposed the concept of *double stigma* to explain the “deleterious outcomes associated with discrimination based on minority group status and the burden of having to live with a mental disorder” (p. 981). For example, stereotypes about members of ethnic minority groups may serve as a treatment-seeking deterrent. Moreover, 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 (Gary, 2005). Another common stressor experienced by parents of a child with mental health issues is guilt related to a lack of resources available for treatment. In addition to the emotional toll of having a child with mental

health difficulties, ethnic minority families must also deal with the resultant stigma and treatment-related stress, which may cause them to avoid seeking treatment in the first place.

Barriers to treatment are often discussed within the context of race and ethnicity; however, it is important for mental health professionals to consider other diversity factors that may pose alternative challenges. For many individuals, religion informs their sense of self, their worldview, and how they live (Schnall et al., 2014). Thus, religion/spirituality can greatly influence one's psychological functioning and the manner in which one deals with mental health issues. Schnall et al. (2014) conducted a 25-year follow-up study to a mental health needs assessment in the Orthodox Jewish denomination. Their findings suggest that stigma is also a significant treatment barrier within religious communities, as seeking help from a mental health professional may give other community members the impression that their Religion cannot solve all problems (Schnall et al., 2014). Furthermore, Bignall, Jacquez, and Vaughn (2015) maintain that, when compared to Whites, ethnic minority groups are more likely to attribute mental illness to spiritual causes. In addition, some religious individuals may be reluctant to seek treatment due to the perception that religion is at variance with psychology (Schnall et al., 2014). For all of these reasons, an individual may turn to a religious or spiritual leader for help rather than seeking a mental health professional (Schnall et al., 2014; Smolak et al., 2013). Research suggests that such individuals can receive counseling by clergy members, who are often lacking formal training in counseling; yet, it is uncommon for these religious leaders to provide referrals to mental health professionals (Farrell & Goebert, 2008; Moran et al., 2005).

Gender is another factor influencing help-seeking behavior and pathways to treatment (Albizu-Garcia, Alegria, Freeman, & Vera, 2001; Hinton, Zweifach, Tang, Unützer, & Oishi, 2006). Ojeda and McGuire (2006) maintain that there are systematic differences between males'

and females' mental health treatment seeking behaviors. Moreover, research shows that the rate of mental health treatment among males is lower than that of females (Wang et al., 2005). Once again, stigma is deemed to be a contributing factor to this gender difference in treatment utilization (Ojeda & Bergstresser, 2008). Other diversity factors correlated with barriers to treatment in the literature include socioeconomic status (Alegría, Green, McLaughlin, & Loder, 2015), age (Dupree, Herrera, Tyson, Jang, & King-Kallimanis, 2010), and sexual orientation (Grella, Cochran, Greenwell, & Mays, 2011). It is important to recognize that one's encounter with and response to barriers can be largely influenced by intersectionality or the overlapping of social categories (Ojeda & Bergstresser, 2008).

Though it may seem daunting, the solution to reducing the gap between unmet need and treatment utilization lies in the identification of effective ways to overcome treatment barriers.

Factors that Reduce Barriers to Youth Treatment

There is a breadth of literature corroborating the existence of barriers to mental health care for children; thus, researchers have shifted their focus to decreasing such barriers in an effort to boost utilization of evidence-based practices. Given that a child's access to and engagement in treatment is highly dependent upon systems operating in his or her life, the barriers posed by these systems are a primary concern among researchers. Langley, Nadeem, Kataoka, Stein, and Jaycox (2010) found that three factors play significant roles in overcoming barriers, specifically those impacting the provision of evidenced-based treatment within the school system. The first factor is the establishment of greater organization within the school system, particularly between the school administration and district personnel. Secondly, the researchers found that extensive networking and communication with community clinicians implementing evidenced-based treatments to youth improved a school's ability to provide similar

services (Langley et al., 2010). Lastly, administrative support for service implementation was paramount to reducing barriers to service utilization.

It has been well established in the literature that a child's ability to access treatment and their treatment outcomes are highly dependent upon parental involvement over the course of treatment. Liang (2010) found that children whose parents are involved in the treatment process exhibit enhanced psychological functioning and are less inclined to terminate treatment prematurely. Moreover, research shows that parents who do not feel invested in their child's treatment may stop bringing their child to sessions and/or discourage the child's ongoing participation (Taylor & Adelman, 2001). Given the previous finding, it is not surprising that high levels of parental motivation predict better treatment compliance, retention, and outcomes among children (Chaffin et al., 2009; Nock & Kazdin, 2005; Nock & Photos, 2006). Successful efforts to promote parental engagement have involved psychoeducating parents about the process of treatment, discussing potential barriers to treatment that they may encounter, and brainstorming possible ways to overcome these barriers (Nock & Kazdin, 2005). By increasing parental engagement, these psychoeducation program have also effectively increased youth treatment attendance and compliance. Consequently, there is a high demand for more interventions that attend to those barriers present within the home/family system.

In regards to addressing sociocultural barriers, research has shown that matching providers and families based on similar race or ethnicity is associated with increased treatment utilization and lower treatment dropout (Eiraldi et al., 2006; Meyer & Zane, 2013). Given that racial matching is not always feasible, it is crucial that referrals for ethnic minority families seeking treatment are referred to culturally sensitive providers. A study by Meyer and Zane (2013) found that provider knowledge of both race/ethnicity as well as discrimination/prejudice

was more important to ethnic minorities than Whites. For minority parent-focused interventions in particular, the following elements of treatment are conducive to increasing adherence: consideration for family values and cultural factors, promotion of family strengths, and content that can be adapted for ethnically diverse families (Stormshak et al., 2011). Additionally, any effort to reduce practical constraints (e.g., work schedule, childcare, transportation) for ethnic minority families seeking treatment will likely facilitate regular attendance and ongoing adherence.

Treatment Engagement

Treatment engagement is a concept that is frequently discussed in the literature; however, there does not appear to be consensus on what is meant by this term (Staudt, 2007). Ellis, Lindsey, Barker, Boxmeyer, and Lochman (2013) have identified a number of other terms that are often used to refer to treatment engagement, such as involvement, retention, and participation. Researchers are now working to establish a clear conceptualization of treatment engagement informed by those indicators of engagement that are supported by the literature. In the section, aspects of treatment engagement that are pertinent to the current study are discussed.

Treatment engagement can be broadly understood as a multifaceted construct that comprises attitudinal and behavioral components (Morrissey-Kane & Prinz, 1999; Staudt, 2007). According to Staudt (2007), attitudinal engagement refers to the “emotional investment in and commitment to treatment that follows from believing that [treatment] is worthwhile and beneficial” (p. 185). A multitude of factors influence attitudinal engagement, such as the strength of the therapeutic alliance, treatment satisfaction, familial stressors, barriers to treatment, and perceptions of treatment efficacy (Becker et al., 2014). Moreover, Staudt (2007) suggests that a family’s attitudinal engagement can influence their level of behavioral engagement or

“performance of the tasks that are necessary to implement treatment... to ultimately achieve outcomes” (p. 185). While the specific tasks vary across treatment settings and theoretical orientations, these often include treatment attendance/retention, homework completion, and participation in discussions of feelings (Karver, Handelsman, Fields, & Bickman, 2005).

The current body of research on treatment engagement maintains that the concept should be thought of as a process that is both dynamic and enduring in nature and has a constant effect on the child's relationship with the therapist and his/her family (Becker et al., 2014; Ellis et al., 2013; Staudt, 2007; McGinty, Diamond, Brown, & McCammon, 2003). McKay and Bannon (2004) conceptualize treatment engagement as a three-phase process. The first phase involves supportive adults in a child's life, such as parents or teachers, identifying concerns about the child's emotional or behavioral functioning. During the next phase, appropriate referrals are provided to the parents and/or the child in need of mental health services. The third phase of engagement involves assuring that the child identified as needing services is actually receiving these services. The attitudinal and behavioral aspects of engagement mentioned previously relate most to this third engagement phase. Although researchers have focused heavily on the latter phase, there is a lack of information on the first two phases of treatment engagement.

Programs Designed to Decrease Barriers and Increase Engagement

In recent years, programs have been developed to address the process of engagement, which encompasses the pathway from problem recognition to service utilization and treatment retention for youth with mental health needs. Through studies of clinical trials and community settings, psychoeducation has recently gained increasing support as an effective evidence-based practice that may significantly bolster the engagement process for youth (Lukens & McFarlane, 2004). Psychoeducational models reduce isolation and stigma associated with mental health by

normalizing experience and response patterns of individuals who participate in these psychoeducational programs. With increasing support for psychoeducational intervention, the Task Force on Promotion and Dissemination of Psychological Procedures (1995) has developed criteria for empirically supported psychoeducational programs which specify a prescribed treatment manual or clearly delineated outline for intervention (Chambless & Hollon, 1998).

Depending on its intended purpose and the manner in which it is designed, a psychoeducational program can be classified as universal, selective, or indicated. At the universal level, a program is designed to enhance the psychological functioning of all the people in a population (Gordon, 1983; Mrazek & Haggerty, 1994). Other programs are intended for people who are deemed at-risk for mental illness; these programs fall in the selective intervention category. Lastly, indicated interventions are designed for people that have exhibited warning signs of a psychological disorder (Gordon, 1983). While there is substantial support for indicated psychoeducational programs and their positive impact on the last two phases of treatment engagement, there is much less of a focus on programs that address the identification and referral aspects of the engagement process (Herman, Reinke, Stormont, Puri, & Agarwal, 2010). Nevertheless, there are many programs (universal, selective, and indicated) that have strong potential to reduce barriers to treatment and increase treatment utilization among youth.

Indicated psychoeducational programs. The Multi-Family Psychoeducation Group (MFPG) Therapy Program is an indicated psychoeducational program designed for children (age range not specified in article) diagnosed with a variety of mood disorders and their families (Fristad, Gavazzi, & Soldano, 1998; Fristad, Goldberg-Arnold, & Gavazzi, 2002). The core tenets of the program focused on decreasing symptoms, improving coping and communication, expanding social support resources, and facilitating the use of stress management techniques.

This program was implemented in an eight-session group format for multiple families, with smaller subgroups for children and adolescents. To enhance the feasibility of the program for children and families, the group sessions were offered in the late afternoons and evenings. Preliminary research on the efficacy of the program revealed improvement in the family climate. More specifically, results indicated that parents reported an increase in positive attitude/behavior and a decrease in negative attitude/behaviors toward their child (Fristad et al., 1998). Parents also reported increased positive attitude/behaviors and decreased negative attitude/behaviors of their child towards them (Fristad et al., 1998). These improvements were found immediately following and four months following intervention, which was particularly notable for father participants.

A modified version of the MFPG Therapy Program was subsequently developed for youth diagnosed with bipolar disorder and major depressive disorder or dysthymia (Fristad, Gavazzi, & Mackinaw-Koons, 2003). The program consisted of 16 psychoeducational sessions, eight attended by the child and eight attended by their parents. Parents were also present for the opening and closing portions of each child session. The results showed positive outcomes for child participants. Specifically, these participants reported a substantial gain in knowledge about symptoms of bipolar disorder and major depressive disorder/dysthymia, increased awareness of support services available to them, and greater support from their parents.

Ferrin et al. (2014) developed and evaluated an unnamed manualized psychoeducational program for parents of children and adolescents ranging in age from five to 18 years with Attention-Deficit/Hyperactivity Disorder (ADHD). The 12-week program was conducted in weekly 90-minute group sessions for parent participants only. The first nine weeks focused on educating parents about 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.

On the indicated level, Russell, John, and Lackshmanan (1999) developed an unnamed psychoeducational program targeting parents of youth under 13 years of age who have been diagnosed with an intellectual disability. The program consisted of weekly parent-only sessions and lasted for 10 weeks. Gains in parents' knowledge of intellectual disability were seen. Additionally, parents demonstrated improvement in their attitudes about childrearing and in their capacity to manage their child's intellectual disability.

Selective prevention programs. The Incredible Years (IY) is a parent, teacher, and child training series that targets what the developers describe as *high-risk* (i.e., socially disadvantaged) families, child protective service referred families, foster parents, children with conduct problems, and children with attention deficit disorders and internalizing problems (Webster-Stratton, 2011). The parent training portion ranges between nine and 20 weekly sessions based on group needs (with longer program length for higher risk families) and has curriculums designed for different age groups, including baby, toddler, preschool, and school-age. The teacher training program is conducted over a six-month period through monthly workshops aimed at improving teachers' classroom management skills. The children's training series is divided into two categories. The first program is an indicated intervention for children presenting with conduct problems or ADHD conducted with small groups outside of the classroom setting for two-hour weekly sessions over the span of 18-22 weeks. The second is a universal prevention program provided within the preschool to early primary grade classrooms and delivered to all students two to three times a week throughout the year. Although IY has

primarily been used as a selective prevention program, it can also be utilized as an indicated program or a universal prevention program. The IY Training Series (Webster-Stratton & Herman, 2010) has gained increasing support as an evidence-based practice; however, despite the detailed strategies the IY creators prescribed, schools continue to find implementation of such programs daunting.

Research on the efficacy of the IY program has shown a range of findings. Menting, de Castro, and Matthys (2013) found that, when parents participated in the indicated intervention program, there was a significant decrease in their child's disruptive behavior and an increase in positive social skills. However, parent participation in the universal prevention program yielded weaker effects on children. In regards to the child training program, significant improvement was seen in children's ability to manage problems and deal with conflict (Webster-Stratton & Herman, 2010). Similarly, the teacher program yielded positive findings, as teachers showed an increase in utilization of behavior management techniques, enhanced perceptions of the value of such techniques, and increased assurance in their ability to handle behavioral concerns in the classroom (Fergusson, Horwood, & Stanley, 2013). Of note, the most promising findings with regards to long-term outcomes for children with behavioral issues were demonstrated by studies that combined parent training with either the child training component or the teacher training component (Webster-Stratton & Herman, 2010).

Universal prevention programs. A few programs have been geared towards children within the general youth population, conceptualized as universal prevention programs. One such unnamed program developed for adolescent girls focused on normal developmental transitions and promoting healthy body images with the aim of preventing eating disorders (Rocco, Ciano, & Balestrieri, 2001). The universal prevention program was administered to female students in

the 1st, 3rd, and 5th grades, while the 2nd and 4th grade female students served as the control group. Girls who participated in the nine monthly sessions showed reduced bulimic attitudes, ineffectiveness, anxiety, and fears about maturity.

Comparable to the previous program, a universal program was developed by Cohen and Irwin (1983) with the primary goal of providing psychoeducation on normative development to parents of adolescents (ages 11 to 14). This program, Parent-Time, was implemented as a series of 90-minute sessions over the course of five weeks. The emphasis was not placed on the child's symptomology; rather, the program was designed to provide parents with an outlet as they face the challenges associated with their child's transition into adolescence. In particular, parents were offered emotional support, instructional guidance, and practice using problem-solving strategies. Upon completing the program, parents were more knowledgeable about normative behavior during adolescence, felt more confident in their parenting abilities, had a greater appreciation for respecting and setting limits, and were more likely to openly discuss worries about their child.

Kenny (2009) developed a universal psychoeducational program, Parents as Teachers of Safety (PaTs), intended for children ages 3 to 5 years and their parent with the aim of preventing child sexual abuse. The groups met for approximately one hour, twice a week for eight weeks with separate parent and child groups. This prevention program significantly increased children's knowledge about sexual abuse and safety, particularly how to recognize sexually abusive touches. Parents also rated their children as being more assertive in their overall behavior and better able to communicate their thoughts about sexual abuse post treatment.

Herman et al. (2010) developed the Family Check-Up (FCU), a school-based prevention program comprised of universal, selected, and indicated interventions. A primary goal of FCU is to help families evaluate the ways in which they operate and identify aspects of the family

system that could be improved. Areas for improvement can range from utilizing available mental health resources or treatment services to making particular adjustments to typical family behavior (Uebelacker, Hechet, & Miller, 2006). Regarding the universal implementation of the FCU program, any student or parent can access information or services for a variety of concerns (e.g., parenting, youth mental health). The program involves three meetings with parents to accomplish the following: evaluation, feedback, dialogue, and goal identification (Stormshak, Fosco, & Dishion, 2010). Participation in the FCU was associated with improved emotional regulation skills among children, enhanced school engagement, and decrease in symptoms of depression (Stormshak et al., 2010). Furthermore, the program serves as a bridge that provides children and their families with access to other evidence-based treatments (Herman et al., 2010).

What Works in Engagement Programs?

Ingoldsby (2010) identified commonalities of programs that were effective at improving family engagement and treatment retention of children. Most of the interventions surveyed were aimed at youth and their families once the child entered treatment and focused on retaining them in services. Extant findings revealed that all of the successful interventions addressed family members' individual needs, concerns, and barriers to receiving services. Moreover, engagement in treatment was addressed multiple times throughout the therapeutic process with multiple family members. Further, successful interventions were grounded in a strong theoretical framework (Ingoldsby, 2010). Many of these effective and promising interventions have also been manualized to facilitate the implementation and dissemination processes while also promoting engagement of children and families in mental health treatment.

A Universal Psychoeducational Program for Parents and Teachers

The effectiveness of psychoeducational programs as a means of decreasing barriers to treatment utilization is supported by existing research. Much of this literature pertains to treatment retention once a child has entered treatment, and limited attention is paid to the identification and treatment-seeking stages of the engagement process. Moreover, review of the literature indicates a lack of universal prevention programs, as majority of the psychoeducational programs examined are classified as selective or indicated prevention. Although many of these programs are designed to engage one of the primary stakeholders of child mental health services (parents or teachers), most do not involve *both*.

The two major tasks of the present study were (a) the development of a psychoeducational program with two parallel tracks (accompanied by two sets of participant-specific manuals for parents and teachers, respectively) to be implemented with both parents and teachers of children in a public elementary school, and (b) the process of obtaining feedback about the program from parents and teachers. The purpose of the program itself is to educate both parents and teachers on common childhood difficulties and behavioral strategies to help manage these issues by relying on evidence-based techniques and scientific information regarding youth mental health problems. By providing such education, the underlying aim is to reduce the stigma attached to mental health issues and treatment. The program also purports to help parents and teachers recognize problem behaviors and learn when it is appropriate to seek a professional referral. Thus, another program objective seeks to facilitate the early stages of the treatment engagement process and reduce the gap between youth mental health need and treatment utilization at the community level.

A key feature of the present psychoeducational program is its modular implementation design. This design was inspired by Chorpita, Dalaiden, and Weisz's (2005) delineation of modularity as the fragmentation of a composite into smaller components that effectively stand alone. As such, the manualized intervention consists of five separate modules, and each module covers one category of common emotional or behavioral issues during childhood. Regarding module content, each contains psychoeducational information and scientifically-driven behavioral management techniques related to the module's respective topic. To increase feasibility of program attendance, parents and teachers are given the option to attend the entire workshop series, which covers all five modules, or only the workshop(s) of particular interest/relevance to them.

Please contact the researchers, Erika Rajo (emrajo@gmail.com) and Genevieve Lam (gen.v.lam@gmail.com), to view the aforementioned psychoeducational manual.

Hypothesis for Investigation

In order to gain a comprehensive understanding of the utility and feasibility of the proposed psychoeducational program, a qualitative and quantitative examination will be conducted of teacher and parent impressions of the program's effectiveness in potentially reducing barriers to treatment for youth and their families. Both groups will be asked about perceived strengths and weaknesses of the manualized intervention in general and with regard to specific manual content/format. Parents and teachers were selected for examination in this study because they are two of the primary gatekeepers to the treatment of children suffering from mental health issues. Given substantial amount of contact teachers have with their students, schools serve as the primary gateway for child mental health services (Williams et al., 2007). Teachers are critical to the referral process, as much of childhood difficulties manifest through

emotional and/or behavioral problems in the school setting. While teachers serve an instrumental role in the lives of school-aged children, their parents are ultimately responsible for following up with referrals for service and must consent to the treatment of their child as well as participate in the therapeutic process. Therefore, the specific aim of the overarching study is to examine the potential for a psychoeducational program on common childhood emotional/behavioral difficulties targeting both parents and teachers to effectively reduce some of the barriers to treatment commonly encountered by children and their families. The present study focuses on the parent arm of the investigation. Our objective was to explore parent responses to the psychoeducational program for the purpose of obtaining opinions about the program's purported effectiveness, collecting ideas about how to improve the contents of the manual, and learning how to best facilitate administration of the program to parents in the community. As this study is exploratory in nature, no specific hypotheses were formulated.

Method

Description of the Program

The parent psychoeducation program is geared towards parents of early school-aged children. The manualized intervention is designed to provide parents 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(ren). In addition to parent participants, teacher participants of the parallel teacher program will be invited to the introductory workshop, which will allow facilitators the opportunity to emphasize the importance of continuous collaboration between teachers, parents, and mental health care providers. To increase the feasibility of implementation and applicability of content, the program is divided into five distinct modules that can each be implemented as stand-alone workshops or as part of a sequence of psychoeducational workshops. The five modules are (a) Social Skills; (b) Disruptive Behaviors; (c) Internalizing Behaviors; (d) Attention/ Concentration Difficulties; (e) Staying Connected with Your Child. Two 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 parent participants, which parents can take notes in and keep as a resource. Each module was designed to be conducted within a 60-90-minute group session and is structured to include a didactic portion, group activities to enhance learning and retention, and semi-structured discussions. Content included in each module was developed through a comprehensive review of the literature on evidence-based psychoeducation and intervention practices for childhood emotional/behavioral issues. The present study examined potential barriers of parent attendance to the psychoeducational program and assessed the usefulness and ease of implementation of specific manual content.

Research Design

In order to evaluate which aspects of a newly developed manualized intervention are effective and which areas need to be improved, the researchers determined that a mixed-methods approach would be utilized for the present study. Using mixed-methods research, the researchers had the benefit of 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 is rooted in grounded theory, was conducive to the researcher team's overarching goal of learning more about the intervention 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 during the same stage and at the same time point for the purpose of exploring parents' perspectives of the proposed intervention. A mixed-method analysis was then 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 pertained to the proposed intervention.

Recruitment

After obtaining full IRB approval, parent participants were recruited for the study. The first step in the recruitment process involved contacting the principal of Juan Cabrillo Elementary School, a public school within Los Angeles County, California, to request permission to send a flyer to parents of students enrolled in the school (see Appendix C for

Recruitment Letter). Once permission was granted, the research team members provided the school administration with the flyer to disseminate as they deemed appropriate. Following distribution of recruitment flyers, interested parents contacted the research team either by phone or email as directed by flyer. The contact information for the project was a centralized confidential voicemail system and email address accessible by research associates only. Research associates reached out to interested potential participants by phone to schedule an in-person small group meeting. During the initial phone contact prior to the in-person meeting, research associates reviewed the procedures and purpose of the project with interested parents, emphasized the voluntary nature of participating in the study, and ensured the potential participants understood that they could withdraw participation at any time. During the in-person meeting, the following tasks were accomplished: an overview of the project was provided once again, consent forms were completed, the proposed psychoeducational manual was reviewed, and the questionnaire and interview were administered. The consent process involved reviewing the consent form (see Appendix D for Informed Consent for Parent Participation form), accompanied by a script (see Appendix E for Consent Script), in its entirety with each participant. The script that was utilized to review the consent form reiterated 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 would 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 would be 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 individual reviewed a waiver of consent and were told they can ask any questions of the researchers regarding the data collection process. No compensation was provided for participation in the study.

Data Collection and Interviewing

All data was collected during a focus group interview conducted on March 17, 2016 by two research interviewers (a Masters in Psychology student and the research supervisor/dissertation chair). There were nine parent participants in attendance. A Focus Group Confidentiality Statement was distributed to each participant; the research interviewer(s) reviewed this form with participants to ensure understanding and solicit their agreement to abide by the guidelines. During the interview, each participant was invited to complete a self-report questionnaire and also to provide narrative answers to verbal questions. The duration of the entire interview and questionnaire completion process was approximately 45 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 (see Appendix F for the Demographic Questionnaire). The demographic questionnaire asked parent participants to report the following information: age, gender, race/ethnicity, preferred language, marital/relationship status, number of children/adults in household, education attained, employment status, primary occupation, and previous training/work experience in childhood mental health.

Quantitative self-report data. The second part of the data collection process involved the distribution of a brief written quantitative questionnaire, which was completed individually by each participant. The parent 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 G for the Quantitative Questionnaire).

Focus group interview. The final step of the data collection process involved a focus group interview with parents conducted by the two researchers described above. Interviews followed a standard protocol containing a semi-structured interview script (see Appendix H for the 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 believed the psychoeducational program would/would not be useful for other parents and how to conveniently schedule workshops for parents 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 in particular. Lastly, the interviewer asked specifically about potential benefits of the program (i.e., practical behavioral management strategies to use at home, more accurate identification of/referrals for children in need of psychological services).

Participants

Parent participants. Participants were recruited for the study if they were primary caregivers of children currently enrolled in Juan Cabrillo Elementary School, a public school in Hawthorne, California, and able to speak and read English. 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 were not primary caregivers of a child enrolled in the elementary school within the Wiseburn Elementary School District. During the 2015-2016 school year, 466 students were enrolled at Juan Cabrillo Elementary with 50 % of these students being female and 50% male. The ethnic distribution was as follows: 59.7% Hispanic/Latino, 21.2% White, 9.2% Two or More Races, 4.7% Black/African American, 3.2% Asian, 1.1% Filipino, 0.4% American Indian or Alaska Native, and 0.4% Native Hawaiian or Pacific Islander (California Department of Education [CDE], 2016). Twenty-two percent of Juan Cabrillo Elementary students were classified as English Learners, and 27% of these students were diagnosed with a learning disability. Given that only 22% of the entire student population was diagnosed with a learning disability, there is an apparent over-representation of English Learners in this category. The data also shows that 6% of the student population was chronically absent (missed 15 or more school days), and 4.1% of students at this school were held back a grade (StartClass, 2016).

The study sample consisted of 8 parents and 1 grandparent of students from Juan Cabrillo Elementary School. The participant sample consisted of 7 females (87.5%) and 1 male (12.5%); one participant did not identify his/her gender. The age range of the 8 participants who responded to this item spanned from 28 to 56 years old ($M = 43.88$, $SD = 9.23$). In terms of ethnicity, 5 participants identified as White non-Hispanic (62.5%), 3 participants identified as Hispanic or Latino (37.5%), and one participant did not respond to this item. Seven of the 9 participants responded to the language preference item; all of these participants indicated that English is their preferred language. Seven participants reported their marital status as married (87.5%), and one participant reported being single/never married (12.5%); one participant did

not respond to this item. Participants' highest level of education consisted of 37.5% 4-year college degree, 37.5% some college, 12.5% Master's degree, and 12.5% High School/GED. One participant did not respond to the level of education item. Six participants (75%) described their employment status as Working full time (>30 hours/week), and 2 participants reported being full-time homemakers (25%). One participant did not respond to the employment status item. Participants were employed in a variety of positions including property management, teaching jobs, work for the city manager, and stay-at-home parent. The number of children in participants' households ranged from 0 to 8 ($M = 3.00$, $SD = 2.67$), and the number of adults in participants' households ranged from 2 to 10 ($M = 3.38$, $SD = 2.88$). One participant did not answer either of these items. Lastly, 5 participants indicated that they have had training or work experience related to childhood mental health (62.5%), three participants have had no such training (35.5%), and one participant did not respond to this question. Participants endorsed a variety of experience including early childhood education and parent advocate, and some held certifications and degrees in psychology and behavioral analysis.

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 acted as the auditor. The background of each researcher was considered in order to address potential biases and desired outcomes of the study.

The first 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 10 (her mother from Cuba and her father from Honduras). Her parents divorced when she was 16 years old and

neither has remarried since. She attended Catholic parochial and private schools from elementary school until her third year of graduate school when she began her current doctoral program at a private Christian university. Although she does not currently practice any particular 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 about treatment.

The second researcher is a 26-year-old, Asian American female clinical psychology student. She was raised in the Greater Los Angeles area in a middle-class family with one sibling and divorced parents. Throughout her upbringing, she was exposed to the differing religious backgrounds of her parents, including Buddhism and Catholicism. Although she does not currently practice any specific religion, she maintains her belief in a higher power. Based upon her background, previous experiences, and clinical training, she understands that a multitude of barriers exist in obtaining adequate knowledge of mental health difficulties and services, but firmly believes that every child deserves access to cost-effective mental health services.

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 and immigrated to the U. S. at the age of 8, 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 and they became part of the upper income class. Her parents have been married for 38 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 transcription process was completed by the first and second researchers on this study (Erika, the 30-year-old Latina, and Genevieve, the 26-year-old Asian American female). Prior to working with the data for the study, the transcribers were personally trained by the auditor of this study to transcribe sessions verbatim using a system adapted from the University of Washington's Thesis Manual. Each transcriber was instructed to utilize a standardized template that lists the time stamp in the first column and the questions posed by interviewers as well as the answers provided by parent participants in the second column. The audio recording of the focus group interview was transcribed by an initial transcriber (Erika) then reviewed and edited by a second transcriber (Genevieve). A third transcriber (auditor) reviewed the transcript against the audio recording to ensure accuracy and subsequently signed off on the finalized transcript. The transcription template and training protocol can be found in the Coding Manual (please see Appendices I and J for the Transcription Template and Training Protocol, respectively).

Coding

The two primary researchers and the auditor completed the coding for this study. The coders received training on the essential concepts, terms, and issues relevant to the present study.

The coders were also trained on the techniques of the coding method being employed in this study.

Human Subjects and Ethical Considerations

Confidentiality and maintenance of ethical standards for the treatment of research participants was maintained in several ways. First, limits of confidentiality for interviews and for research database inclusion was reviewed with parent participants. All participants were provided waiver of consent forms to review (see Appendix D for the Informed Consent for Parent Participation form). All identifying information was redacted in the interview documents in order to preserve confidentiality upon transfer to the research database. In order to maintain confidentiality, each participant was assigned a research identification number that was indicated on demographic questionnaires and associated interview responses (Mertens, 2009). All individuals involved in the transfer of clinical data to the research database completed an Institution Review Board (IRB) certification course (see Appendix K for IRB Human Subjects Training Certificate).

Precautions were also taken with regards to the handling of de-identified data. Prior to accessing research database content, research team members completed an IRB Humans Subjects Training course to ensure that the ethical standards for research involving human subjects and confidential health information were upheld. Additionally, prior to accessing study data, research coders confirmed that there was no personal connection between themselves and the parent participants.

Research Bias and Quality of Study

For quality purposes, each interviewer received individual training from the study auditor based on standardized instructions for conducting interviews. The researchers and the auditor

made efforts to identify potential biases that could have influenced coding procedures. This process involved proactively exploring their personal expectations and biases by engaging in dialogue about their preconceived notions of participants' future responses. Furthermore, the researchers and the auditor acknowledged elements of their individual experiences (both personal and professional) that may have influenced particular expectations. 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 while coding and analyzing data by asking themselves a sequence of questions and subsequently reflecting on how their answers may have influenced the data collected as well as the data analysis (Miller & Brewer, 2003). By engaging in the reflexive process throughout the study, researchers were able to anticipate potential threats to the integrity of the findings and proactively address them. Additionally, the researchers were able to consider how diverse elements of their perceived realities may have influenced the study's findings.

Reliability. Coding was conducted on the focus group interview transcript by two doctoral-level raters and the auditor of this study using Microsoft Excel. Coding and data integrity procedures were implemented to reflect similar studies. Exceptional inter-rater reliability is indicated by a score approaching .90; however, Lombard, Snyder-Duch, and Bracken (2002) maintain that Kappas .80 or higher are deemed sufficient in majority of cases and scores of .70 are often considered to be adequate levels for exploratory qualitative research. In addition, Hruschka et al. (2004) found that coding teams who produced significantly different codes during the initial coding phase have been able to establish strong intercoder reliability by means of subsequent codebook revisions and recoding. Inter-rater reliability among coders for

the present study was calculated and evaluated based on the aforementioned standards and procedures.

Two rounds of inter-rater reliability tests were conducted in order 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 researcher (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

Qualitative data analysis procedures were implemented for the purpose of coding and extracting meaning from the data collected. The researchers coded the transcript using Microsoft Excel. Following data preparation, the coders examined the data for particular themes that emerged from the parent participants' responses based on suggested guidelines for inductive content analysis (Elo & Kyngas, 2008; Hsieh & Shannon, 2005; Zhang & Wildemuth, 2009). In accordance with standards for qualitative data analysis, the first step researchers took when coding the raw interview data was agreeing on the units to be coded. Next, the researchers coded all of the text and developed categories. Lastly, conclusions about the coded data were drawn through the process of consolidating the identified categories into overall themes.

The three-part process described above involves open coding, creation of categories, and abstraction (Elo & Kyngas, 2008). Open coding began with the three researchers (including the

auditor) reading through the transcription as many times as necessary. While reading, each researcher took notes and wrote down thoughts/ideas until she believed she had identified the essential headings to capture aspects of the transcriptions that answered the research question (Elo & Kyngäs, 2008).

During the next step, the two graduate student researchers grouped similar codes independently and generated category/concept labels for each of the groupings. The researchers then submitted the concept groups to the auditor for review and to identify idiosyncratic analyses or mislabeled data (Hsieh & Shannon, 2005). To ensure reliability of the researchers' approach and findings, the auditor reviewed the codes and categories as well as any notes taken by researchers during the coding process. This step was completed to ensure dependability and confirmability of the researchers' findings (Zhang & Wildemuth, 2009). After reviewing data and notes from each researcher, the auditor separately coded the transcribed data and made notes about her personal approach and thought process. She subsequently reviewed the data and flagged instances of agreement with the researchers' codes as well as areas that needed further consideration. The two researchers and the auditors then agreed on an approach to organize and code the data into concept groups, the researchers and auditor each coded the transcript independently, identifying concepts that appeared throughout the data. Sections of the text (i.e., words or phrases) were then assigned to represent a concept. At least two occurrences of a concept were required in order for the concept to qualify as a code.

After coding, the two graduate student researchers organized groups hierarchically and identified Parent Themes or theme labels that described one or several concept groupings (Elo & Kyngäs, 2008). The two researchers compared the themes they identified and agreed on how they would collapse the categories into larger themes. This step involved exploring the initial

categories, conducting cross-analysis procedures by organizing like themes into categories, and looking for patterns and links between the themes and categories (Zhang & Wildemuth, 2009).

During this process of abstraction, the research team (graduate students and auditor) alternated between hierarchical concept levels (codes, concept categories/child codes, and parent themes), ensuring that each level could be related back to the research question (Elo & Kyngäs, 2008). The two graduate student researchers then submitted the theme hierarchy to the auditor for review and to identify idiosyncratic analyses or mislabeled data (Hseih & Shannon, 2005). After reviewing the abstracted codes, concept sub-categories and Parent Themes, the auditor offered feedback informed by her own experience of coding transcripts, reviewing codes, and thinking about the data hierarchically. Following this review, the two graduate student researchers incorporated the auditor's feedback by modifying codes and themes within the hierarchy accordingly. The auditor reviewed the hierarchy a second time before the final codes were determined. The coding was then rechecked by each graduate student researcher for consistency and subsequently examined for accuracy by the auditor. Using Microsoft Excel, the researchers determined the basic frequencies of coded responses.

It could not be assumed that the coding system agreed upon by researchers during the data analysis phase of this study would undoubtedly result in consistent coding of all data (Zhang & Wildemuth, 2009). Thus, the checking process during open coding and abstraction served the following purposes: to minimize the impact of coder fatigue on coding, to account for potential influence of each researcher's pre-existing biases on their selection of coding themes, and to establish inter-coder verification (Zhang & Wildemuth, 2009).

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

Results

Qualitative Findings

In the current study, nine participating parents were asked open-ended questions about their perspectives of the presented manualized intervention program. Three major categories of questions were posed during the focus group interview: (a) specific manual content, (b) need for the program, and (c) implementation and feasibility of the program. References to specific manual content included the applicability of the existing, and suggestions for future, topics, accounting for 42% of the data set. Responses related to program need (i.e., references to the specific aspects of the program that participants believe parents need) made up 31% of the data. Lastly, responses related to the implementation and feasibility of the program, including suggestions for easing the implementation process, accounted for 27% of the data set (see Figure B1).

Specific content. As previously mentioned, the majority of parent responses to the psychoeducational program pertained to specific manual content, making up 22 out of the 52 total codes (42%). Within this category, six major themes that emerged were

- *need for social skills training* (i.e., need for parental strategies to promote children's prosocial behaviors and manage social skills issues);
- *need for effective discipline techniques* (i.e., parents' need to learn techniques that they can use at home to correct their child's disobedient or inappropriate behavior in the moment and decrease the frequency of such behavior in the future);
- *need for bullying prevention/intervention* (i.e., need for parent-focused psychoeducation and strategies to prevent bullying or to intervene if children are being bullied, bullying others, or witnessing bullying);

- *need for understanding online parental monitoring* (i.e., parents' need for tips to effectively monitor their child's online activity/presence and to set limits for Internet usage);
- *need for understanding normal v. abnormal child development* (i.e., parents' need for psychoeducation on the stages of child development to help them determine whether or not their child's behavior is concerning or normative);
- *need for techniques to improve family dynamics* (i.e., need for parental strategies to promote healthy relationships among family members and to address family related conflicts/difficulties).

Figure B2 illustrates the thematic code distribution within this category.

There was considerable agreement among participants regarding the *need for social skills training*, as this theme comprised 27% of the codes in the specific content category (6 out of 22 codes). For instance, when asked which of the modules would be most helpful for parents, one participant stated, "For me, out of all of them, it's number one [Module One: Social Skills] because it has a ripple effect into all the other areas [of emotional/behavioral functioning]." Another participant agreed stating, "I think that it [social skills training] is very important in the long run." In addition to a need for social skills training, participants identified the *need for effective discipline techniques*; this theme comprised 18% of codes within the specific content category (4 out of 22 codes). One participant suggested the inclusion of additional content focused on "effective discipline tactics" and other participants subsequently expressed agreement. Another theme discussed by parents was the *need for bullying prevention/*

¹All quotes were obtained from participants of this study through personal communication with research assistants (March, 2016).

intervention, which made up 14% of the codes in this category (3 out of 22 codes). References to the importance of psychoeducation on and strategies for bullying prevention/ intervention included statements such as “What if your child is the bully... parents need to know what they can do to help their child if that’s the case,” and “I just think that the B-word is being thrown out so much now, and people use it sometimes in the wrong way because it’s all they know.”

Parents also identified the *need for understanding online parental monitoring*, accounting for 14% of the codes within the specific content category (3 out of 22 codes). For example, one participant highlighted the importance of online parental monitoring stating, “There’s so many new avenues as opposed to when we were kids... now everything is through Facebook and Snapchat. As parents, trying to keep on top of that, being able to monitor your child’s phones [is difficult].” Another participant noted that such monitoring is important because “[children] don’t understand the repercussions [of what they post on social media sites].” When asked if there were any topics that might be helpful to include in the manual, parents expressed the *need for understanding normal v. abnormal child development*, which comprised 14% of the codes in this category (3 out of 22 codes). One participant explained that this information would be particularly helpful for fathers raising daughters and “not ever experiencing [hormonal changes associated with puberty in females].” Another participant agreed stating, “... [D]istinguish[ing] something that’s happening because it is developmental is really important for me to know.” Lastly, participants discussed the *need for techniques to improve family dynamics*; this theme accounted for 14% of the codes in this category (3 out of 22 codes). One participant suggested including information related to “the squabbling between siblings and [helping] them learn to communicate with each other in a more helpful manner.” Another parent expressed the need for information on managing a different kind of family dynamic stating, “I’m a parent of an only

child, so it's always a challenge because she engages in disruptive behaviors to get our attention." Overall, participants identified specific manual content that they believed would be useful for parents of early school-age children (i.e., social skills training strategies and effective discipline techniques) and made valuable suggestions for additional content to be included in the manual.

Program need. The need for the proposed psychoeducational program was a category of inquiry examined throughout the focus group interview; codes within this category made up 31% of all codes (16 out of 52 total codes). The following themes emerged within this category (see Figure B3):

- *importance of parent psychoeducation* (i.e., importance for parents to be educated on common childhood problems and how to manage them);
- *need for home-based emotional/behavioral skills training* (i.e., need for parents to learn effective skills for managing childhood emotional/behavioral problems in the home environment);
- *need for parental community* (i.e., need for parents to spend time with and feel supported by other parents);
- *need for parental idea sharing* (i.e., need for parents to learn from one another's experiences of parenting and to seek advice from each other on particular issues).

The most commonly referenced theme within this category was the *need for home-based emotional/behavioral skills training*, accounting for 31% (5 out of 16) of the program need category codes. For instance, one participant stated, "I think a grandparent has the child's ear often, and I need to know what to say and what not to [say]." Another participant agreed about the need for such skills stating, "We [parents] are out in large settings together, and you can

always see certain parents trying different things [strategies to address a child's emotional/behavioral problems] ... and I think that something like this [home-based emotional/behavioral skills training] would prove to be much more beneficial." Another commonly discussed theme was the *importance of parent psychoeducation*, accounting for 25% (4 out of 16) of the codes in this category. One client stated, "I think [proactively learning about childhood emotional/behavioral issues] is essential to understanding [children] and to raising a good human being." Another participant pointed out that some children may not get the mental health services they need because "their parents may not know that their child need[s] support services." Moreover, there was agreement among participants that the presented program would help them and other parents know when it is necessary to bring their child to a mental health professional.

Another theme discussed by participants was the *need for parental community*, which comprised 25% of codes within the program need category (4 out of 14 codes). References to this theme included statements such as "A lot of families that we get don't have a big community experience," and "[Parents] may be limited in their experience of watching other parents parent... and learning new processes is really big, especially for parents that don't have a big support system." Another similar but less commonly discussed theme among participants was the *need for parental idea sharing* (3/16 = 19% of program need codes). For instance, one participant stated, "I think there is power in parents sharing with each other." Additionally, a participant added that an important aspect of the presented program for parents would be "knowing that somebody else went through what you're going through and getting ideas from peers." In general, there was consensus among participants regarding the importance of parents being knowledgeable about emotional/behavioral difficulties common among children.

Implementation and feasibility. A significant portion of the focus group interview was comprised of parent feedback regarding implementation and feasibility of the psychoeducational program (14/52 = 27% of total codes). The four major themes that emerged in this category of questions were

- *program integration* (i.e., integration of the psychoeducational program into existing school programs targeting needs of children suffering from emotional/behavioral difficulties);
- *preference for modular training* (i.e., provision of smaller psychoeducational workshops focused on a singular topic at a time);
- *scheduling with consideration for parental time constraints* (i.e., desire for workshops to be scheduled parents' demanding schedules);
- *advance notice* (i.e., request for written notification to be sent home with students to inform parents of upcoming workshops at least two weeks prior).

Figure B4 illustrates the thematic code distribution within this category.

Many participants indicated a *preference for modular training*, as this theme accounted for 43% of the implementation/feasibility category codes (6 out of 14 codes). For instance, one participant explained, "I like the idea of once a month [workshops] because my brain, as a parent, could not take all that [psychoeducation on five different topics related to childhood emotional/behavioral issues] in one afternoon." After reviewing the psychoeducational manual, another participant expressed a similar opinion stating, "There's a lot of great stuff [content] and you want to be able to take a small piece, go home, execute it, get excited about it, and then come back." The preference for modular treatment was summed up by another participant who noted, "I just think smaller chunks would work best."

When asked to provide feedback on ways to implement the program in a feasible manner, the theme of *scheduling with consideration for parental time constraints* began to emerge (4/14 = 29% of implementation/ feasibility codes). One example of parental time constraints was provided by a participant who explained, “It’s hard to get there [school] at 6:00pm... I work across town and it’s a stretch to take off work.” Another participant described scheduling challenges as well stating, “Weekends for me unfortunately are just hard with three kids and six sports... 6:00pm [on weekdays] is kind of hard too... 7:00pm would be ok.” In response, one participant suggested “alternat[ing] [between] a weekend [workshop] and a 7:00pm [weekday workshop] because nobody is going to be able to do all of one kind of all of another.”

Another noteworthy, briefly discussed theme was *program integration*, accounting for 14% of the codes in this category (2 out of 14 codes). One participant stated, “Coming to school is better because we [parents] are coming here anyway.” Another participant agreed stating, “I think a program like this embedded in a school would be a fabulous idea.” In addition to *program integration*, the importance of *advance notice* was briefly discussed with regard to program feasibility (2/14 = 14% of implementation/feasibility codes). Specifically, one parent stated, “I’d like to know about it [upcoming workshops] far enough in advance to be able to find childcare or decide whether or not I can invest this time.” When researchers mentioned that written notification of upcoming workshops would potentially be sent home with students along with their usual set of weekly announcements, one participant suggested that the notification be “the only thing that’s sent out [on the day it is distributed to students]” and explained “that would be better because you don’t see [the notification within a set of unrelated announcements] and it gets lost.” Overall, there was a general consensus among participants that efforts to increase the feasibility of implementation should be prioritized.

Quantitative Findings

Quantitative self-report data was obtained through a brief 7-item questionnaire generated by research team members to elicit participant impressions of the psychoeducational program. Descriptive statistics were analyzed using Microsoft Excel. For each item, participants were asked to respond using the following Likert scale: 1 = *Not at all*, 2 = *Very little*, 3 = *Somewhat*, 4 = *Very much*, 5 = *Extremely*. Data analysis revealed that parents rated the usefulness of behavioral interventions highest with an average rating of 4.67 out of 5, in between *very much* and *extremely* ($SD = 0.52$). When asked how effective the program would be at increasing most parents' knowledge of childhood emotional/behavioral problems, the average participant rating was 4.63, in between *very much* and *extremely* ($SD = 0.52$). Similarly, participants, on average, rated a 4.57 ($SD = 0.53$), in between *very much* and *extremely*, in response to the question "How much more equipped do you think parents who complete the program will be at appropriately referring their children in need for mental health services?" Regarding participants' perception of parent interest in attending the program if scheduling is convenient, the average rating was 4.43, in between *very much* and *extremely* ($SD = 0.53$). Participants also rated somewhere in between *very much* and *extremely* in response to being asked if a psychoeducational program such as the one presented is necessary in their child's school ($M = 4.38$, $SD = 0.52$). When asked about the feasibility of implementing the program at their child's school, the average participant rating was 4.13, slightly more than *very much* ($SD = 0.6$). Lastly, the lowest average rating ($M = 3.83$, $SD = 0.98$), falling in between *somewhat* and *very much*, was indicated for the item pertaining to the level in which participants' knowledge of childhood emotional/behavioral problems increased as a result of the program overview.

Discussion

The purpose of this study was to examine parent impressions of a manualized psychoeducational program on common childhood emotional/behavioral difficulties. Findings of this study may help to enhance the program to best meet the needs of parents of school-aged children 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.

Qualitative findings indicate parents in our study were invested in the specific content covered in the psychoeducational program when considering the program's potential effectiveness, as 22 out of the 52 total codes (42%) pertained to this category. The discussion centered around reflections on existing manual content and ideas for additional content. The most commonly discussed themes within this category were *need for social skills training* and *need for effective discipline techniques*, which are both addressed in the current psychoeducational program. Other research studies involving parent surveys have also shown that parents believe social skills are an important part of their child's development (Adams, Womack, Shatzer, & Caldarella, 2010; Burton, 2015; Frey, Elliot, & Kaiser, 2014). Moreover, there is a large body of literature highlighting the need to increase parents' knowledge of positive discipline techniques and effective ways to manage their child's disruptive behaviors (Sanders, Markie-Dadds, Rinaldis, Firman, & Baig, 2007).

Additionally, parent feedback on program content allowed researchers to increase the applicability and usefulness of the manual by adding suggested content. For instance, participants' suggestions to expand on the current content related to bullying were consistent

with extant research on effective evidence-based interventions for youth, such as Second Step (Cooke et al., 2007) and Steps to Respect (Brown, Low, Smith, & Haggerty, 2011). As a response to parents' expressed need for more information pertaining to this topic, a sixth module was created to address Bullying and Cyberbullying in the revised version of the manual. In addition, future pilot studies will implement six modules instead of the original five modules to assess parental response. Another improvement was made in response to parents' reported interest in learning effective ways to monitor their children's online activity, a need that is supported by recent research which shows that parental online monitoring is an important component of effective parenting (Livingstone & Helsper, 2008; Vaala & Bleakley, 2015). Given the pervasive use of technology by youth along with the many risks involved, it is slightly shocking that more parents in the present study did not share these concerns about their child's online activity whether it be through social media outlets, interactive video games, or any other internet platform. Nevertheless, to address this important aspect of contemporary parenting, additional content pertaining to best practices for parental monitoring of online activities was added to the fifth module (i.e., *Staying Connected with your Child*). By incorporating participant feedback into the ongoing development of the current program, the researchers hope to increase parent interest and engagement in the program as vested stakeholders, while also strengthening the program as a whole.

The results of this study also suggested that parent participants recognize the need for the presented psychoeducational program, with 16 out of 52 total codes (31%) referring to particular aspects of the program that parents need. Specifically, participants expressed the importance of parent psychoeducation on common childhood issues in addition to identifying the need for home-based skills to manage a child's emotional/behavioral difficulties, parental community,

and parental idea sharing in the qualitative portion of our study. Quantitative findings also support that parents believe this type of psychoeducational program is necessary in schools, as participants rated this item between *very much* and *extremely* ($M = 4.38, SD = 0.52$). These findings are not surprising given the significant rise in mental health disorders among children in the U.S. (CDC, 2013); however, this study illuminates the fact that it is not only scientific researchers and mental health professionals that recognize the need for practical solutions for childhood mental health issues but the parents themselves are acknowledging their own need for resources, education, and assistance.

The focus group interview also elicited feedback from participating parents regarding implementation and feasibility of the psychoeducational program, as 14 out of 52 total codes (27%) referenced ways to help ease the implementation process and to increase feasibility for potential parent participants. The present program's modular training approach aligns with participants' preference for singular topic workshops and accommodates parents with limited availability, as they can choose to attend the workshops that might pertain most to their own child's behaviors and plan accordingly. Additionally, participants discussed integrating the psychoeducational program into an existing school program as a means of easing implementation. Parent participants also noted that attending the program workshops would be feasible if the workshops were conducted at their child's school and if parents were given advance notice about upcoming workshops so they can plan ahead for attendance. These results support documented findings regarding importance of program design and execution, which warns researchers of the negative impact that implementation issues can have on program outcomes (DuBois, Holloway, Valentine, & Cooper, 2002; Smith, Schneider, Smith, & Ananiadou, 2004). Our findings will inform the work of upcoming pilot studies in various

communities, as parental suggestions for implementation will be incorporated into future program administrations and results will be compared and analyzed to determine the most effective implementation strategy for each specific community.

In addition to the feedback obtained via the focus group interview, quantitative findings provided valuable information about participants' impressions of particular program features and revealed important implications for future studies. As previously mentioned, usefulness of behavioral interventions received the highest average rating ($M = 4.67$, $SD = 0.52$) suggesting that, in general, participants considered the behavioral intervention training included throughout each module to be a strength of the program. This is consistent with the qualitative finding noted earlier regarding participant references to the need for home-based skills training, and it also supports the work of other evidence-based behavioral management programs that have demonstrated effectiveness by increasing parenting skills (e.g., Cohen & Irwin, 1983; Ferrin et al., 2014; Herman et al., 2010; Webster-Stratton, 2011). In addition, it is likely that this portion of each module is the most active and engaging to parents compared to the more didactic/teaching portions in which parents are engaging in more passive, albeit important, learning of factors contributing to childhood problems. These findings raise an important consideration for future revisions of the manual, which may be enhanced by expanding on the active practice of behavioral strategies sections of each module and streamlining the didactic portions as much as possible without sacrificing information quality.

The data also revealed high ratings (between *very much* and *extremely*) for perceived effectiveness of the program in terms of both increasing parents' knowledge of childhood emotional/behavioral issues ($M = 4.63$, $SD = 0.52$) and providing parents with the information necessary to determine when they should refer their child for professional mental health services

($M = 4.57$, $SD = 0.53$). These findings may be indicative of parent participants' confidence in the program's potential to yield positive outcomes for parents who attend, which is a positive precursor of engagement in the actual program when it is implemented in this particular parent community.

Both perceived parent interest level ($M = 4.43$, $SD = 0.53$) and need for a school-based psychoeducational program ($M = 4.38$, $SD = 0.52$) had an average rating between *very much* and *extremely* on the scale. These ratings suggest that participants believe other parents will be interested in attending the program workshops and that there is significant need for such a program in their children's school. While these findings provide further support for the future implementation of the psychoeducational program, it should be noted that the impressions of the parents in this study may not reflect the impressions of parents in the general population. For instance, the parents who attended our focus group (which was purely on a volunteer basis without compensation) might be more motivated than the average parent is to learn about childhood emotional/behavioral issues and strategies for managing such issues.

Although findings revealed that parent participants believe integrating the program into existing school programs will facilitate the implementation process, the average rating for feasibility of school integration was 4.13 out of 5.00 ($SD = 0.6$) suggesting that most participants do not perceive this to be an extremely easy process. Consequently, implementation of the current psychoeducational program will need to involve comprehensive planning and ongoing collaboration with school administration who are the ones to notify parents of these parent psychoeducational sessions.

Lastly, the item pertaining to amount of knowledge gained from the program overview received the lowest average rating ($M = 3.83$, $SD = 0.98$). This rating suggests that most

participants did not report an exceptional increase in knowledge after being presented with an overview of the program manual content. The overview of the program occurred over the course of 30-45 minutes, whereas actual program implementation time is estimated to be five sessions of 60-75 minutes each. Therefore, we did not expect a significant increase in learning gained from previewing the program in such a cursory manner. In addition, three of nine participants did not respond to this particular item, representing the most missing data on any quantitative questionnaire item. Therefore, it is possible that this rating is not fully representative of the opinions of our participants. Finally, given that the majority of participants have previous experience related to childhood mental health, it is likely that parents in the general population who do not have such experience would come into the program with less knowledge on these topics and may subsequently report a greater increase in knowledge after the program overview when compared to the current group of participants.

Limitations

The present study has a number of limitations that should be taken into account. First, the sample size is small and does not allow for reasonable inferences to be made from the parents in this study to parents in the general population. In addition, the participants of this study were all associated with the same urban public elementary school in Los Angeles County, California. Thus, the data collected in this study may not be meaningfully generalized to all parents whose kids are enrolled in other elementary schools in California or around the country. In addition, the program was merely presented as a brief overview (with examples of specific content from each module) and not implemented in full to assess more specific responses to its content. However, parents who choose to attend the program once it begins pilot implementation will have the opportunity to attend up to five 60-75 minute workshops comprised of a didactic component,

group activities to enhance learning and retention, and semi-structured discussions. Considering the difference between the program overview experience and the program workshop experience, future parent attendees will be provided with significantly more information on childhood mental health issues and will likely report a greater increase in knowledge post-program than the participants in this study. In turn, the brief nature of the overview may have limited the amount and quality of participant feedback and negatively influenced their ratings. Finally, this study did not analyze patterns within groups or significant differences across groups (e.g. parents with childhood mental health experience versus parents without childhood mental health experience) indicated by responses to quantitative questionnaire items. Therefore, it would be beneficial for future studies to conduct such statistical analyses using data collected from a large sample of parent participants.

Strengths

Despite its limitations, the present study has many strengths. Most notably, this study provided insight into parents' perspectives of psychoeducational programs in general and the current psychoeducational program in particular. In addition, there were multiple advantages to utilizing a mixed-methods design. Specifically, the researchers had the opportunity to obtain parents' responses to both the open-ended interview questions and the Likert scale questionnaire items. The collection of both qualitative and quantitative data allowed researchers to examine detailed perspectives as well as common trends (Creswell & Creswell, 2009). The study design also allowed researchers to draw comparisons between participants' verbal responses during the interview and the quantitative data. Overall, both forms of data yielded useful information about how to increase parent interest and engagement in the program. Furthermore, by providing parents with this education and training, the psychoeducational program has the potential to

increase the likelihood that parents who attend the program will seek mental health treatment if/when their child is in need of additional support, therefore preventing the potential negative outcomes for youth with unmet need. Another notable strength of the present study is that it provided an opportunity for collaboration among parents, school personnel, and mental health professionals. By providing the parent participants with a positive, collaborative, and hopefully de-stigmatizing experience among the key stakeholders of a child's mental health, it is possible that they will be more inclined to reach out to school personnel or mental health professionals in the future.

Lastly, this study allowed researchers the opportunity to elicit feedback on the relevance and usefulness of specific content of the program. Not only did participants share positive feedback on the existing content, but they also provided constructive feedback about what they perceived the manual to be lacking or areas in which they desired additional information. In response to participant feedback, suggestions have already been incorporated in the next iteration of the manual. Specifically, two new modules have been included, one focused on bullying and cyberbullying and another on best practices for parental monitoring of online activities. Preliminary work on an additional module to focus on childhood trauma has also commenced. This module will include psychoeducational content on the various types of trauma as well as common reactions to trauma during childhood. It will also consist of scientifically-based strategies to help children with building resilience to and coping with trauma (such as an introduction to Trauma-Focused Cognitive Behavioral Therapy techniques).

Future research is needed to examine the effectiveness of this psychoeducation program with regards to the degree to which it increases parental knowledge of common emotional and behavioral issues during childhood and the actual utilization of scientifically-driven behavior

management strategies in the home setting. Moreover, researchers could conduct a follow-up study to analyze potential changes in the child's emotional and behavioral functioning and parents' application of program information and tools. Furthermore, as there are plans to develop a module on trauma, future research is needed on the additional treatment barriers that families with a history of trauma may encounter in accessing psychoeducational programs like the present one and in seeking specialty mental health services.

Conclusion

In an effort to bridge the gap between the number of children struggling with mental health issues and the number of children receiving mental health treatment, our program aims to provide all parents, not just those whose child has a diagnosed mental disorder, with psychoeducation on common childhood issues, dissemination of research techniques, and information about the professional referral process. The present study, though small, may potentially have far-reaching implications. On the individual level, this study highlights important needs among parents of early school-aged children that can be incorporated into a psychoeducational program to maximize both parents' and children's benefits from the program. Specifically, we hope that parents will learn valuable information that will allow them to recognize warning signs for emotional and behavioral difficulties, understand and support their child using empirically-supported strategies, and refer their child for mental health services if needed as early as possible to prevent negative outcomes.

Furthermore, by focusing on factors to increase parent engagement in our program, this study may have positive effects in the school setting. As Kim, Sheridan, Kwon, and Koziol (2013) emphasized, a child's functional ability in many areas (e.g., social, emotional, and achievement) is positively influenced when parents and teachers unite, linking the child's home

and school. Thus, our program increases the likelihood of such collaboration by not only encouraging parents to communicate with teachers regularly, but also by offering parallel teacher program that sets these two groups up for a like-minded team approach. In addition, research shows that untreated mental health issues during childhood significantly hinder academic success (DeSocio & Hootman, 2004). Therefore, if our program leads to an increase in parent referrals and youth mental health service utilization, then it may also contribute to positive outcomes in academic functioning among children with mental health issues as they learn to cope with their symptoms. Specifically, children who are getting the services they need may be better equipped to manage their difficulties and more capable of accomplishing day-to-day school tasks.

Lastly, we believe that our study has the potential to reach far beyond the limits of one elementary school by informing local policy. If even one school district made it a requirement for parents of students in that district to attend the program, it would reduce a major barrier to treatment for many families and also provide parents with tools to manage common childhood issues that disrupt family dynamics and impact youth daily functioning at home. The number of parents knowledgeable about childhood mental health issues would rise, decreasing the likelihood that children with significant issues would go unidentified, and reducing the stigma associated with youth mental illness. It is hoped that we will be able to continue advocating for changes at local schools and to eventually influence the conversation in larger communities.

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APPENDIX A

Extended Review of the Literature

Author(s) and Year	Title	Summary of Pertinent Information
Adams, M. B., Womack, S. A., Shatzer, R. H., & Caldarella, P. (2010)	Parent involvement in school-wide social skills instruction: perceptions of a home note program	<p>Parents must be involved in teaching and reinforcing social skills at home in order for students to become proficient at utilizing such skills.</p> <p>Nearly all surveyed parents (98.1%) agreed with the importance of knowing about the social skills being taught in school.</p>
Albizu-Garcia, C. E., Alegria, M., Freeman, D., & Vera, M. (2001)	Gender and health services use for a mental health problem	Predictors of help-seeking vary for men and women. There are also gender differences observed in the process of seeking help.
Alegria, M., Green, J. G., McLaughlin, K. A., & Loder, S. (2015)	Disparities in Child and Adolescent Mental Health and Mental Health Services in the U.S.	<p>Across the lifespan, there is evidence to suggest that the prevalence of mental illness varies considerably based on race and ethnicity.</p> <p>African-American, Latino, and Asian-American children utilize mental health services at a significantly lower rate than non-Latino white children.</p>
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	<p>Weighted estimates indicated that 10.7% of parents in the general population perceived burden resulting from their children's symptomatology.</p> <p>At every level of psychopathology, the presence of parental perceived burden was a powerful predictor of the use of specialty mental health service.</p>
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	<p>Treatment barriers to receiving family-focused child mental health services for youths with disruptive behavior problems are described.</p> <p>Although therapists support parent involvement in family focused therapy, parents report feeling unsupported by their therapist, blamed, and unheard by service providers, which impacts their attitude about service delivery and level of participation.</p>

Author(s) and Year	Title	Summary of Pertinent Information
<p>Bannon, W. M., & McKay, M. M. (2005)</p>	<p>Are barriers to service and parental preference match for service related to urban child mental health service use?</p>	<p>85% of caregivers ($n = 146$) reported having a particular preference regarding the type of service their child receives; however, only 45% of these caregivers ($n = 66$) reported that they received the services they requested. The duration of a family's involvement in child mental health treatment was associated with whether or not the services matched the parents' preference.</p> <p>The anticipated barriers most commonly reported by caregivers were transportation issues ($n = 55$; 38%) and time constraints making it difficult to bring child to treatment ($n = 44$; 30%).</p> <p>Regarding perceived barriers to use of youth mental health services, 55% ($n = 80$) of the caregivers in this study ($n = 146$) reported at least one concrete barrier (e.g., transportation issues, lack of child care), 38% ($n = 56$) reported at least one stressful barrier (e.g., grief from friends/family about mental health treatment, feeling too tired to attend), and 23% ($n = 34$) reported at least one doubt barrier (e.g., unsure if treatment is necessary, unsure if treatment will be effective).</p>
<p>Becker, K. D., Kiser, L. J., Herr, S. R., Stapleton, L. M., Barksdale, C. L., & Buckingham, S. (2014)</p>	<p>Changes in treatment engagement of youths and families with complex needs</p>	<p>Child and parent reports indicate that treatment engagement increases over the course of treatment.</p> <p>The more intensive the program, the lower the levels of treatment engagement were reported. Thus, the treatment demands may influence child/parent perceptions of alliance, satisfaction, and burden.</p>

Author(s) and Year	Title	Summary of Pertinent Information
Betz, C. L., Baer, M. T., Poulsen, M., Vahanvaty, U., Bare, M., Haddad, Y., & Nwachukwu, G. (2004)	Secondary analysis of primary and preventative services accessed and perceived service barriers by children with developmental disabilities and their families	Lack of information was found to be the primary identified service barrier for all therapy services followed by lack of available services and parental satisfaction with services. Other reported concerns were lack of transportation, lack of family priority, lack of coverage for services, and lack of language services.
Bignall, W. J. R., Jacquez, F., Vaughn, L. M. (2015)	Attributions of mental illness: An ethnically diverse community perspective	Mental health attributions may contribute to the large disparity in service utilization across ethnic groups. When compared to Whites, ethnic minority groups are more likely to attribute mental illness to spiritual causes.
Bowers, H., Manion, I., Papadopoulos, D., & Gauvreau, E. (2013)	Stigma in school-based mental health: Perceptions of young people and service providers	Both young people (ages 13-20) and service providers perceive stigma as a significant barrier to youth utilization of school-based mental health programs. Young people report that there is limited information about existing mental health services available in their schools.
Bronfenbrenner, U. (1992) in R. Vasta (Ed.)	Ecological systems theory in <i>Six theories of child development: Revised formulations and current issues</i>	The multiple systems within a child's environment as well as the interaction among these systems influence the developmental process. There is a bi-directional influence between the environment (including significant people in it) and a child, with both influencing the other.
Brown, E. C., Low, S., Smith, B. H., & Haggerty, K. P. (2011)	Outcomes from a school-randomized controlled trial of Steps to Respect: A bullying prevention program	Bullying prevention effectiveness is maximized when intervention occurs at multiple levels.

Author(s) and Year	Title	Summary of Pertinent Information
Burton, K. (2015)	<i>Parent perceptions of their involvement in and the effectiveness of an integrated social skills program</i>	Data showed that parents believe it is important for them to be involved in teaching social skills to their children. Parent responses also indicated that they believe it is important to include a school-wide social skills program in the school curriculum.
California Department of Education. (2016)	<i>California Longitudinal Pupil Achievement Data System</i>	The ethnic distribution of students at Juan Cabrillo Elementary is 59.7% Hispanic/Latino, 21.2% White, 9.2% Two or More Races, 4.7% Black/African American, 3.2% Asian, 1.1% Filipino, 0.4% American Indian or Alaska Native, and 0.4% Native Hawaiian or Pacific Islander.
Centers for Disease Control and Prevention (2013)	Mental health surveillance among children – United States, 2005-2011	<p>13-20% of children living in the U.S. experience a mental disorder in a given year, and the prevalence of these disorders appears to be increasing.</p> <p>ADHD (6.8%) was the most prevalent parent-reported current diagnosis among children aged 3–17 years, followed by behavioral or conduct problems (3.5%), anxiety (3.0%), depression (2.1%), autism spectrum disorders (1.1%), and Tourette syndrome (0.2% among children aged 6–17 years).</p>
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	<p>Combining motivational pretreatment with PCIT significantly improved retention among individuals with initially low to moderate motivation.</p> <p>No effect or negative effects were found among parents whose initial motivation was relatively high.</p>

Author(s) and Year	Title	Summary of Pertinent Information
Chambless, D. L., & Hollon, S. D. (1998)	Defining empirically supported therapies	<p>Independent replication before a treatment is established in efficacy is extremely important.</p> <p>It is also important to evaluate the soundness of studies supporting a treatment's efficacy by consider factors such as overall research design, sample description, outcome assessment, treatment implementation, data analysis, single-case experiments, resolution of conflicting results, and limitations of efficacy.</p> <p>Evaluation of effectiveness should take into account factors such as generalizability, treatment feasibility, and cost-effectiveness.</p>
Chorpita, B. F., Daleiden, E. L., & Weisz, J. R. (2005)	Modularity in the design and application of therapeutic interventions	<p>The term modularity means dividing complex tasks into easier components that can stand alone.</p> <p>Preliminary findings support the efficacy of modular protocols and suggest that modular designs have the potential to enhance the efficacy of manualized treatment protocols.</p> <p>Modularity provides flexibility, prescription, and structure to treatment and is efficient in nature.</p>
Cohen, M., & Irwin, C. E. (1983)	Parent-Time: Psychoeducational groups for parents of adolescents	<p>Results suggest that a program for caregivers of adolescents with subclinical issues led to improved parental ability to listen, set limits for their children, and open up to other caregivers.</p>

Author(s) and Year	Title	Summary of Pertinent Information
<p>Cooke, M. B., Ford, J., Levine, J., Bourke, C., Newell, L., & Lapidus, G. (2007)</p>	<p>The effects of city-wide implementation of “Second Step” on elementary school students’ prosocial and aggressive behaviors</p>	<p>An intervention designed to promote consistent behavioral expectations for children and widespread use of modeling and verbal coaching/cueing by teachers, school staff, parents, and community workers who regularly interact with children led to significant improvements in positive-approach coping, caring-cooperative behavior, suppression of aggression, and consideration of others.</p> <p>The program was successfully implemented with high fidelity and engaged a wide range of participants from the community.</p>
<p>Creswell, J. W., & Creswell, J. D. (2009)</p>	<p><i>Mixed Methods Research: Developments, Debates, and Dilemma</i></p>	<p>Collecting both qualitative and quantitative data allows for examination of common trends across data.</p>
<p>Cunningham, C. J. L., Weathington, B. L., & Pittenger, D. J. (2013)</p>	<p><i>Understanding and conducting research in the health sciences</i></p>	<p>Mixed-methods can be used if the researcher believes s/he will learn more about their topic than from using just quantitative techniques. Additionally, mixed-methods is useful when the research questions are focused on developing an understanding rather than identifying differences.</p> <p>Grounded theory utilizes an inductive approach by which theory is derived from the data collected.</p>
<p>De Los Reyes, A., & Kazdin, A. E. (2005)</p>	<p>Informant discrepancies in the assessment of childhood psychopathology: A critical review, theoretical framework, and recommendations for further study</p>	<p>Different informants’ ratings of childhood mental illness are often discrepant, impacting assessment, diagnosis, and treatment planning.</p>

Author(s) and Year	Title	Summary of Pertinent Information
De Los Reyes, A., Youngstrom, E., Pabon, S., Youngstrom, J., Feeny, N., & Findling, R. (2011)	Internal consistency and associated characteristics of informant discrepancies in clinic referred youths age 11 to 17 years	<p>Parents and children have different but valid perspectives on problematic youth behavior. Parents may recognize behaviors that children do not attend to, while children may recognize behaviors that parents do not observe.</p> <p>Discrepancy between parent and child reports does not necessarily indicate bias.</p>
DeSocio, J., & Hootman, J. (2004)	Children's Mental Health and School Success	<p>A review of the literature showed that poor academic functioning and inconsistent school attendance are early signs of emerging or existing mental health problems during childhood and adolescence.</p> <p>The research shows that early manifestations of childhood mental health disorders affect and are affected by school performance.</p> <p>Recognition of early warning signs of psychosocial distress and poor school functioning could lead to mental health promotion and prevention activities to disrupt the worsening of symptoms and the development of disorders.</p>
Dow, H. D., (2011)	Migrants' mental health perceptions and barriers to receiving mental health services	Mental health systems are rooted primarily in Western principles, which can lead minorities to feel as though the services these systems offer are not applicable to them. Thus, these individuals may not enter treatment.
DuBois, D. L., Holloway, B. E., Valentine, J. C., & Cooper, H. (2002)	Effectiveness of mentoring programs for youth: A meta-analytic review	Poorly implemented programs targeting at-risk youth might possible have a negative impact on participating youth. Thus, the design and implementation process should be extensive.
Dupree, L. W., Herrera, J. R., Tyson, D. M., Jang, Y., King-Kallimanis, B. L. (2010)	Age group differences in mental health care preferences and barriers among Latinos: Implications for research and practice	Younger Latino adults endorse professional mental health services more than older Latino adults. Older adults prefer medication and seeking advice from a family physician.

Author(s) and Year	Title	Summary of Pertinent Information
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	<p>The stages in the help-seeking process for parents with children and adolescents with ADHD include problem recognition, decision to seek help, service selection, and service utilization patterns. These stages are hypothesized to be influenced by characteristics of the disorder and the informant (disorder and informant profile), the predisposition to use services (predisposing characteristics), factors that enable or impede the pursuit of services (barriers and facilitators), and variables that promote or diminish service use over time (service promoters).</p> <p>Adherence and attrition rates for behavioral treatments may also be impacted by particular parent characteristics</p>
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	<p>Results suggest that child and parent levels of engagement varied dissimilarly over the course of the intervention.</p> <p>Parents' level of engagement at the middle of the intervention process appeared to be influenced by child levels of engagement early on.</p> <p>Parent attendance was influenced by child engagement.</p> <p>Parent attendance was influenced by the family environment during the initial intervention phase but there was no such influence during later stages.</p>
Elo, S., & Kyngäs, H. (2008)	The qualitative content analysis process	<p>Inductive content analysis is useful when there has been no previous research on the particular topic being examined. The three phases of inductive content analysis are preparation, organizing, and reporting. The concepts are extracted from the data.</p>

Author(s) and Year	Title	Summary of Pertinent Information
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	<p>54% of youths have utilized mental health services at some point in their lives.</p> <p>Children most commonly access mental health services through the school setting followed by specialty mental health settings. Children who entered the mental health system through school are less likely than those who entered through a specialized setting to utilize services outside of the school setting.</p>
Farrell, J. L., & Goebert, D. A. (2008)	Collaboration between psychiatrists and clergy in recognizing and treating serious mental illness	<p>Research shows that women, widow/widowers, and elder persons have a tendency to go to a religious clergy member instead of a mental health specialist.</p> <p>Many clergy have limited training in counseling or mental illness.</p>
Fergusson, D. M., Horwood, L. J., & Stanley, L. (2013)	A Preliminary Evaluation of the Incredible Years Teacher Programme	<p>Participation in the IYT program resulted in increased use of positive behavior management strategies and an increase in teacher perceptions of the usefulness of these strategies.</p> <p>Over 90 of teachers positively rated the program as a whole, the usefulness of teaching strategies, specific teaching techniques, and group leaders.</p> <p>Overall, the program increased the level of teacher knowledge and competence in classroom behavior management.</p>
Ferrin, M., Moreno-Granados, J. M., Salcedo- Marin, M. D., Ruiz-Veguilla, M., Perez-Ayala, M., & Taylor, E. (2014)	Evaluation of a psychoeducation programme for parents of children and adolescents with ADHD: immediate and long-term effects using a blind randomized controlled trial	<p>A psychoeducation program for parents of children and adolescent with ADHD led to reductions in ADHD index and cognitive/inattention levels as well as long-term improvement in children's pro-social functioning.</p>

Author(s) and Year	Title	Summary of Pertinent Information
Flores, G., Olson, L., & Tomany-Korman, S. C. (2005)	Racial and ethnic disparities in early childhood health and health care	Minority children experience disparities related to health status (less likely than Whites to be in excellent health), insurance coverage (more likely than Whites to be uninsured), topics discussed during pediatric visits (minority parents asked more often than White parents about violence, smoking, drinking, and drug use), parents feeling understood by providers (minority parents more often reported that providers never or only sometimes understood their child-rearing preferences and their child's needs), parental satisfaction, and referrals to specialists (referred to specialists significantly less often than White children).
Frey, J. R., Elliott, S. N., & Kaiser, A. P. (2014)	Social skills intervention planning for preschoolers: Using the SSiS-rating scales to identify target behaviors valued by parents and teachers	<p>Parents and teachers value particular social skills and these skills should be taken into account when developing social skills interventions.</p> <p>Targeting the skills that are most important to parents and teachers increased the likely that children will retain and generalize the skills they are taught.</p>
Fristad, M. A., Gavazzi, S. M., & Mackinaw-Koons, B. (2003)	Family psychoeducation: An adjunctive intervention for children with bipolar disorder	Findings indicate that child participants significantly increased knowledge about symptoms of bipolar disorder and major depressive disorder/dysthymia, use of support services, and report of parental support.

Author(s) and Year	Title	Summary of Pertinent Information
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	<p>Data suggests that participants perceived the program positively, as family members reported increased understanding of mood disorders and medications as well as increased awareness of positive and negative family interactions. Participant ratings also suggest that they perceived the topics covered by the program were appropriate and adequately addressed.</p> <p>Participants reported that the most helpful aspects of the group were having separate groups for parents and children and having the opportunity to be supported by peers.</p>
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 for families of children with bipolar disorder resulted in increased knowledge, skills, support, and favorable attitudes regarding treatment.
Gary, F. A. (2005)	Stigma: Barrier to mental health care among ethnic minorities	Members of ethnic minority groups may not seek treatment or sufficiently engage in treatment because of the stigma associated with mental illness and minority status (double stigma).
Gordon, R. S. (1983)	An operational classification of disease prevention	<p>Prevention measures are defined as those utilized by or for individuals who are not presently experience the effects of a disease for the purpose of reducing the risk that the individual will be affected by the disease in the future.</p> <p>Universal prevention is intended for all individuals. Selective prevention is intended for particular subgroups of the population that are in good health. Indicated prevention is intended for those individuals who are at increased risk of developing a disease in the future.</p>

Author(s) and Year	Title	Summary of Pertinent Information
Gould, S. R., Beals-Erickson, S. E., & Roberts, M. C. (2012)	Gaps and barriers in services for children in state mental health plans	<p>90% of the state plans analyzed identified at least one type of barrier to accessing their children's mental health system, while 84% of plans discussed at least one type of service gap in the system.</p> <p>Lack of providers was the gap in mental health services most frequently recognized by state mental health plans (74%).</p> <p>Lack of funding was the most common barrier to mental health services identified by state mental health plans (52%).</p>
Grella, C. E., Cochran, S. D., Greenwell, L., & Mays, V. M. (2011)	Effects of sexual orientation and gender on perceived need for treatment by persons with and without mental disorders	Gender and sexual orientation influence treatment utilization differentially, especially among individuals without a diagnosis but a perception that treatment is needed.
Guo, S., Kataoka, S. H., Bear, L., & Lau, A. S. (2014)	Differences in school-based referrals for mental health care: Understanding racial/ethnic disparities between Asian American and Latino youth	<p>Asian Americans are less likely than Latino youth to be referred for school-based mental health services.</p> <p>Ethnic minority youth are at increased risk of unmet mental health need when compared to non-Hispanic white children.</p>
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	Issues related to dissemination should be considered early on in the process of developing an intervention to make sure that evidence based practices will be developed and utilized as planned.
Hinojosa, M., Knapp, C., & Woodworth, L. (2015)	Family strain among white and Latino parents of children with mental and behavioral health disorders	Data obtained from a survey of 268 parents of children with a mental or behavioral health condition indicates that family strain differs between White and Latino families. Predictors of Latino family strain include parent age, perceptions of treatment quality, and burden of child's current symptom. Predictors of White family strain include the health status of the child, symptom burden, and parental education level.

Author(s) and Year	Title	Summary of Pertinent Information
Hinshaw, S. P. (2005)	The stigmatization of mental illness in children and parents: Developmental issues, family concerns, and research needs	<p>Stigma can influence the parenting practices of a parent with mental illness as well as their child's development. Likewise, parents of children with mental illness are often blamed for their child's difficulties, which may prevent them from reaching out for the mental health services their child needs.</p> <p>Stigma exists at multiple levels (individual, family, school, community, public media, and social policy), and stigmatized conditions have multiple dimensions (concealability, chronicity, threat/peril, and controllability) that influence how features of the condition are perceived within a social context.</p>
Hinton, L., Zweifach, M., Tang, L., Unützer, J., & Oishi, S. (2006)	Gender disparities in the treatment of late-life depression: Qualitative and quantitative findings from the IMPACT trial	Factors contributing to gender differences in depression presentation and treatment include the manner in which men experience and express depression, traditional masculine values, and stigma of mental illness.
Hoagwood, K., Burns, B.J., Kiser, L., Ringeisen, H., & Schoenwald, S. K. (2001)	Evidence-based practice in child and adolescent mental health services	<p>Evidenced-based practices found to be effective for one age group may not be effective for another age group. Developmental issues as well as individual, family, and environmental factors are important elements to consider when evaluating the evidence base for particular treatments. Caregiver involvement is an essential component of a child's diagnostic presentation and treatment.</p> <p>Service venues utilized for evidence-based practice for adults differ from those utilized for evidence-based practice for children.</p> <p>New models of treatment development and enhancement of current effectiveness studies must be adopted to improve implementation of evidence-based practice for children.</p>

Author(s) and Year	Title	Summary of Pertinent Information
Hoberman, H. M. (1992)	Ethnic minority status and adolescent mental health services utilization	Despite the expanding research, there is insufficient knowledge of the implications of adolescents' ethnicity on mental health service utilization.
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	Although a team of coders may generate considerably different codes initially, subsequent revising of the codebook and recoding can result in high levels of intercoder reliability.
Hsieh, H. F., & Shannon, S. E. (2005)	Three approaches to qualitative content analysis	The three approaches to content analysis are conventional, directed, and summative content analysis. Conventional content analysis involves defining codes during data analysis and extracting them from the data itself.
Ingoldsby, E. M. (2010)	Review of interventions to improve family engagement and retention in parent and child mental health programs	Effective methods of improving families' engagement and retention in parent and child mental health programs are individualized and address families' specific needs, concerns, and barriers; intensive, addressing engagement on a continuous basis with multiple family members using different approaches over the course of treatment; developed from a strong theoretical framework, and integrated effortlessly into the underlying treatment or prevention program structure.
Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007)	Toward a definition of mixed methods research	Mixed methods research is a combination of intellectual and practical components informed by qualitative and quantitative research.
Karver, M. S., Handelsman, J. B., Fields, S., & Bickman, L. (2005)	A theoretical model of common process factors in youth and family therapy	The therapeutic relationship with caregivers can potentially impact treatment outcomes. Pretreatment characteristics are brought into the treatment process by both clients and therapists. Such characteristics may influence therapist perceptions and behaviors, which then influence how a client responds (emotionally, cognitively, and behaviorally) to the clinician and the treatment.

Author(s) and Year	Title	Summary of Pertinent Information
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	<p>Approximately 80% of youth ages 6-17 who were considered in need of mental health services did not receive mental health treatment.</p> <p>Latino children and uninsured children have a higher rate of unmet treatment need than White children and publicly insured children.</p>
Kazdin, A. E., Holland, L., & Crowley, M. (1997)	Family experience of barriers to treatment and premature termination from child therapy	<p>Barriers to treatment participation (e.g., socioeconomic challenges, minority status, single parent, young parent) contributed significantly to dropping out of therapy.</p> <p>Perceived barriers to treatment were not explained by family, parent, and child characteristics that also predicted dropping out.</p> <p>Among families at high risk for dropping out of treatment, the perception of few barriers reduced risk.</p> <p>Parent perceptions of the difficulties of participating in treatment influenced who dropped out.</p>
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	Results showed that barriers to treatment participation were linked to significantly higher drop-out rates, shorter duration of treatment, and more missed sessions.
Kenny, M. C. (2009)	Child sexual abuse prevention: Psychoeducational groups for preschoolers and their parents	A primary prevention group successfully educated children and their caregivers about childhood sexual abuse by increasing communication between children and their parents, teaching them about child sexual abuse, and providing behavioral training for parents to talk to their children. Children's knowledge was also increased and they learned adaptive ways of responding to inappropriate advances by others.

Author(s) and Year	Title	Summary of Pertinent Information
Kernan, J. B., Griswold, K. S., & Wagner, C. M. (2003)	Seriously emotionally disturbed youth: A needs assessment	Results highlight a need for improvements to case management, service coordination, services specific to children and families, and expanded community-based services.
Kim, E. M., Sheridan, S. M., Kwon, K., & Koziol, N. (2013)	Parent beliefs and children's social-behavioral functioning: The mediating role of parent-teacher relationships	<p>Results showed that parents' motivational beliefs were positively linked to children's social and adaptive functioning but negatively linked to children's externalizing behaviors. Parental motivational beliefs were also related to improved teacher-parent relationship quality.</p> <p>Teachers rated children higher in adaptive functioning and lower in externalizing behaviors in cases where parents reported that it was their responsibility to be involved in their child's education and perceived their involvement as valuable.</p>
Korsch, F., & Petermann, F. (2014)	Agreement between parents and teachers on preschool children's behavior in a clinical sample with externalizing behavioral problems	There was a considerable lack of agreement between parent and teacher ratings of externalizing behavioral problems within a clinical preschool sample. However, the combination of these reports is useful for predicting the presence of externalizing behavior issues in children.
Kourany, R. F., Garber, J., & Tornusciolo, G. (1990)	Improving first appointment attendance rates in child psychiatry outpatient clinics	<p>Parental time constraints and scheduling conflicts are a major reason why parents did not make it to appointments at a child psychiatry outpatient clinic.</p> <p>Follow-up contact after the initial contact decreased the rate of "no shows" more often than no contact did.</p>

Author(s) and Year	Title	Summary of Pertinent Information
Kouyoumdjian, H., Zamboanga, B. L., & Hansen, D. J. (2003)	Barriers to community mental health services for Latinos: Treatment considerations	To improve the accessibility and effectiveness of community mental health services for Latinos, efforts should be taken to reduce the existing socioeconomic (business hours, transportation, lack of childcare), cultural (perceptions of mental illness, fatalism, spirituality, familism, cultural commitment, and language proficiency), and psychotherapeutic barriers (client/therapist communication, inappropriate assessment techniques, lack of cultural sensitivity and responsiveness, limited knowledge of the Latino culture among providers).
Lane, B. R., Paynter, J., & Sharman, R. (2013)	Parent and teacher ratings of adaptive and challenging behaviours in young children with autism spectrum disorders	<p>Parent-teacher ratings tend to have higher agreement for adaptive behaviors than for challenging behaviors.</p> <p>It is recommended that clinicians have multiple sources rate challenging behavior of children.</p>
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	<p>A number of barriers can impede the implementation of evidence-based practices for children in the school setting, such as parental consent, administrator/teacher support, financial resources, and competing responsibilities.</p> <p>Successful implementation was associated with better organizational structure for school service delivery, administrative support, and a social network of other clinicians implementing the same program.</p>
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	<p>Concerns that parents have about mental health treatment can influence their level of treatment engagement.</p> <p>Fewer reported intangible barriers related to stigma and perceptions of mental health treatment were associated with greater likelihood of attendance at a mental health evaluation.</p>

Author(s) and Year	Title	Summary of Pertinent Information
Leigh, I. W., Powers, L., Vash, C., & Nettles, R. (2004)	Survey of psychological services to clients with disabilities: The need for awareness	Barriers to service provision for clients with disabilities include funding, accessibility, lack of provider knowledge, limited training in disability issues and services, and lack of sensitivity.
Liang, J. (2010)	<i>Parental involvement in mental health services for diverse youth</i>	<p>Preferred and actual involvement of parents led to a reduction of children's functional impairment.</p> <p>Higher levels of preferred involvement were reported among African American and Hispanic parents when compared to non-Hispanic White parents. Nevertheless, in some cases, Hispanic parents reported less actual involvement.</p> <p>Parents who preferred to be involved and actually were involved in their child's mental health treatment perceived improvement in their child's mental health and/or continue to utilize services.</p>
Livingstone, S., & Helsper, E. J. (2008)	Parental mediation of children's internet use	<p>Child and parent reports indicate that 12-17-year-olds are faced with a variety of risks online.</p> <p>Parent strategies such as co-use and enforcing interaction rules were not very effective in reducing online risks for children.</p> <p>Restricting online peer-to-peer interactions was linked to reduced risk.</p>
Lombard, M., Snyder-Duch, J., & Bracken, C.C. (2002)	Content analysis in mass communication: Assessment and reporting of intercoder reliability	It is important for researchers to identify the index that was used for reliability calculations and to report intercoder reliability clearly.

Author(s) and Year	Title	Summary of Pertinent Information
Lukens, E. P., & McFarlane, W. R. (2004)	Psychoeducation as evidence-based practice: Considerations for practice, research, and policy	<p>Psychoeducation is one of the most effective evidence-based practices that has been examined in clinical trials and community settings.</p> <p>Psychoeducation groups increase social support among participants and help increase recognition and normalization of their experiences and response patterns.</p> <p>A review of randomized trials of psychoeducation for caregivers of children and adolescents with mental health issues showed positive outcomes.</p>
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	Although there has been increasing awareness of the low rates of mental health service utilization, these services are still being underutilized due to stigma attached to seeking mental health services.
Major, S. O., Seabra-Santos, M. J., & Martin, R. P. (2015)	Are we talking about the same child? Parent-teacher ratings of preschoolers' social-emotional behaviors	Possible reasons for parent-teacher discrepancies on ratings of social-emotional functioning include the fact that they observe a child's behavior in different settings with different contextual demands, and they may have different levels of tolerance for particular behaviors.
Mandell, D. S., Wiggins, L. D., Carpenter, L. A., Daniels, J., DiGuseppi, C., Durkin, M.S., ... Kirby, R. S. (2009)	Racial/ethnic disparities in the identification of children with autism spectrum disorders	Autism spectrum disorders are commonly diagnosed many years after symptoms began or misclassified as other disorders. This tendency is even more common among ethnic and racial minority groups.
McGinty, K. L., Diamond, J. M., Brown, M. B., & McCammon, S. L. (2003) In A. J. Pumariega & N. C. Winters (Eds.)	Training child and adolescent psychiatrists and child mental health professionals for systems of care in <i>The handbook of child and adolescent systems of care: The new community psychiatry</i>	The term engagement refers to the process by which families and clinicians join together and share information, needs, attitudes, and values.

Author(s) and Year	Title	Summary of Pertinent Information
McKay, M. M., & Bannon, W. M. J. (2004)	Engaging families in child mental health services	<p>To increase the involvement of urban youth and their families in needed mental health services, child mental health agencies and providers should consider doing the following: (1) Examine intake procedures and develop interventions to overcome specific barriers to service use (2) give providers training and supervision to increase their focus on engagement in the initial face-to-face meetings with youth their families (3) consider service delivery options with input from consumers regarding types of services offered.</p> <p>Most importantly, the research emphasizes the importance of involving youth and their families in efforts to increase engagement.</p>
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	Parent, teacher, and observer reports indicate that Incredible Years Parent Training is effective at decreasing disruptive behavior and increasing prosocial behavior.
Mertens, D.M. (2009)	<i>Research methods in education and psychology: Integrating diversity with quantitative, qualitative, and mixed methods (3rd Ed.)</i>	When data is collected from human participants, researchers must consider the sensitivity of such information and take every effort to maintain confidentiality. This can be accomplished by assigning all participants a research identification number and removing any identifying information from research materials.
Meyer, O. L. & Zane, N. (2013)	The influence of race and ethnicity in clients' experiences of mental health treatment	Results showed that ethnic minority clients typically perceived issues pertaining to race and ethnicity as more important than White clients did. Lower rates of client satisfaction were reported when these issues were deemed important and were not a component of their treatment process.

Author(s) and Year	Title	Summary of Pertinent Information
Miller, R.L. & Brewer, J. (Eds). (2003)	<i>The A-Z of social research: A dictionary of key social science research concepts</i>	It is important for researchers to be reflexive or self-examining in their view of the research process, data analysis, and report of the results because each of these components is influenced by the unique way in which each researcher perceives reality.
Moran, M., Flannelly, K. J., Weaver, A. J., Overvold, J. A., Hess, W., & Wilson, J. C. (2005)	A study of pastoral care, referral, and consultation practices among clergy in four settings in the New York City area	Given that many individuals with mental health issues turn to clergy for support and counseling, it is important for them to be aware of mental health services available in their community. Increased awareness of such services will allow them to make appropriate referrals.
Morgan, P. L., Staff, J., Hillemeier, M. M., Farkas, G., & Maczuga, S. (2013)	Racial and ethnic disparities in ADHD diagnosis from kindergarten to eighth grade	Minority children were less likely than white children to receive a diagnosis of ADHD and to be prescribed medication.
Morrissey-Kane, E., & Prinz, R. J. (1999)	Engagement in child and adolescent treatment: The role of parental cognitions and attributions	<p>Help seeking, treatment engagement, and treatment outcomes are influenced by parental attributions.</p> <p>Parents who believe their child's difficulties are beyond their control appear to utilize a more authoritarian parenting approach, do not perceive behavioral parent management techniques as useful, and have poorer treatment outcomes. Parents with an internal locus of control are more engaged in the treatment process and have more successful outcomes.</p> <p>The literature shows that treatment can lead to changes in parents' attributions.</p>
Mrazek, P. B., & Haggerty, R. J. (1994)	<i>Reducing risks for mental disorders frontiers for preventive intervention research</i>	A universal prevention measure is intended to improve the mental health of all individuals within a population or society in general. Such interventions are advantageous when they are low-cost, low-risk, and effective and applicable for the population.

Author(s) and Year	Title	Summary of Pertinent Information
National Research Council and Institute of Medicine. (2009)	<i>Preventing mental, emotional, and behavioral disorders among young people: progress and possibilities</i>	<p>There are substantial costs (psychosocial and financial) for youth who suffer from mental, emotional and behavioral disorders.</p> <p>Resources and effort should be applied to researching effective prevention practices and using the research for implementation.</p>
Nock, M. K., & Kazdin, A. E. (2005)	Randomized controlled trial of a brief intervention for increasing participation in parent management training	<p>An adjunctive intervention used in the context of treatment for child conduct problems addressed the importance of attendance and adherence with parents, elicited motivational statements related to treatment attendance and adherence, and helped parents identify potential barriers to treatment and possible ways of overcoming these barriers if they came up during the treatment process.</p> <p>Both parent and therapist report revealed that parents who received the brief intervention described above attended considerably more treatment sessions, had greater adherence to treatment, and had higher motivation.</p>
Nock, M. K., & Photos, V. (2006)	Parent Motivation to Participate in Treatment: Assessment and Prediction of Subsequent Participation	Greater treatment attendance by parents of children with conduct problems was associated with fewer perceived barriers to participation in treatment. As parents' motivation increased, they perceived fewer barriers to treatment participation.
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	Racial-ethnic and gender disparities in utilization of mental health services may be partially due to psychosocial barriers (e.g. attitudes toward treatment, stigma avoidance, mistrust, social status, help-seeking behaviors). Such barriers should be examined within specific gender, social, and cultural contexts.
Ojeda, V., & McGuire, T. (2006)	Gender and racial/ethnic differences in use of outpatient mental health and substance use services by depressed adults	Latinas and African Americans suffering from depression are much less likely than depressed whites to initiate mental health services.

Author(s) and Year	Title	Summary of Pertinent Information
<p>Rawal, P., Romansky, J., Jenuwine, M., & Lyons, J. S. (2004)</p>	<p>Racial differences in the mental health needs and service utilization of youth in the juvenile justice system</p>	<p>The juvenile justice system appears to many youths' initial contact with the state service system, including the mental health sector.</p> <p>Children involved in the juvenile justice system have high rates of mental illness and a wide range of diagnosable disorders.</p>
<p>Roberts, M., Joe, V., & Rowe-Hallbert, A. (1992)</p>	<p>Oppositional child behavior and parental locus of control</p>	<p>The effectiveness of parent training can be mitigated by low socioeconomic status, as parents may struggle with the structured nature of educational settings typically associated with parent training. Emotional or behavioral demands at home may hinder parents' ability to apply the new skills they learn through parent training. Some parents might believe that they cannot possibly change their child's behavior.</p> <p>If a parent does not see improvements in his/her child's oppositional behavior over time or in response to the parent's consistent parenting efforts, the parent is likely to assume an external locus of control for parenting. Such an attitudinal reaction may prevent the parent from seeking help for their child and decrease their efforts.</p>
<p>Rocco, P. L., Ciano, R. P., & Balestrieri, M. (2001)</p>	<p>Psychoeducation in the prevention of eating disorders: An experimental approach in adolescent schoolgirls</p>	<p>After participating in the psychoeducational program, all participants showed improvement on the EDI-2 measures of bulimic attitudes, asceticism, and feelings of ineffectiveness.</p> <p>Findings show that preventive programs can be advantageous.</p>

Author(s) and Year	Title	Summary of Pertinent Information
<p>Roll, J. M., Kennedy, J., Tran, M., & Howell, D. (2013)</p>	<p>Disparities in unmet need for mental health services in the United States, 1997-2010</p>	<p>From 1997 to 2011, unmet need for mental health care grew from 4.3 million to 7.2 million.</p> <p>Based on cross-sectional analyses of 2010 data, unmet need for mental health care was considerably higher among people age 18-64, women, single individuals, people with lower income, and individuals with fair or poor health.</p>
<p>Rones, M., & Hoagwood, K. (2000)</p>	<p>School-based mental health services: A research review</p>	<p>The findings of this research review revealed evidence of existing school-based mental health programs that successfully target a variety of emotional and behavioral problems in youth.</p> <p>The following aspects of implementation were found to increase the likelihood that the program will be upheld over time: implementing the program consistently; including parents, teachers, or peers; utilizing multiple modalities; integrating program content into existing classroom curriculum; and ensuring that program components are developmentally appropriate.</p> <p>A program's success, dissemination, and maintenance is influenced by a school's atmosphere and culture, how cooperative the school administration is, the manner in which the program is funded, and the fidelity of the program.</p>
<p>Rudd, T. (2014)</p>	<p><i>Racial disproportionality in school discipline: Implicit bias is heavily implicated</i> [Issue brief]</p>	<p>African American students are disciplined more frequently than white students. This is also the case when it comes to out-of-school suspensions and expulsions.</p> <p>Implicit bias can influence a teacher's expectations for academic success and, in turn, lead to differential treatment for minority students.</p>

Author(s) and Year	Title	Summary of Pertinent Information
Russell, P. S., al John, J. K., & Lakshmanan, J. L. (1999)	Family intervention for intellectually disabled children. Randomised controlled trial	Interactive group psychoeducation is effective for modifying the attitudes of parents with intellectually disabled children and is a feasible option when resources are limited.
Sanders, M. R., Markie-Dadds, C., Rinaldis, M., Firman, D., & Baig, N. (2007)	Using household survey data to inform policy decisions regarding the delivery of evidence-based parenting interventions	Data obtains from surveying 4,010 parents of children under the age of 12 revealed that 1 in 3 respondents reported that, within the last 6 months, their child exhibited a behavioral or emotional problem. One in 4 parents reported that they had participated in a parent education program.
Schnall, E., Kalkstein, S., Gottesman, A., Feinberg, K., Schaegger, C. B., & Feinberg, S. S. (2014)	Barriers to mental health care: A 25-year follow-up study of the Orthodox Jewish community	Given that religion is a major component of personal and cultural identity, mental health clinicians must incorporate these into treatment. Some individuals do not seek mental health treatment because they believe that psychology and religion are incompatible.
Sentell, T., Shumway, M., & Snowden, L. (2007)	Access to mental health treatment by English language proficiency and race/ethnicity	Individuals who could not speak English were less likely to receive needed mental health services. Other predictors of not receiving needed services included being younger, being married, being Latino or African American, being less educated, living in a nonurban area, and not having health insurance. Racial-ethnic disparities in mental health care are a major concern, particularly with regards to Asian/Pacific Islanders and Latinos due to their limited English proficiency
Smith, J. D., Schneider, B. H., Smith, P. K., & Ananiadou, K. (2004)	The effectiveness of whole-school anti-bullying programs: A synthesis of evaluation research	Whole-school programs that were continuously monitored for implementation integrity were found to be more effective than programs without such monitoring.

Author(s) and Year	Title	Summary of Pertinent Information
Smolak, A., Gearing, R. E., Alonzo, D., Baldwin, S., Harmon, S., & McHugh, K. (2013)	Social support and religion: Mental health service use and treatment of schizophrenia	Many individuals with schizophrenia seek help from spiritual healers before going to a mental health professional.
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	<p>At 3-month follow-up, the difference between the number of sessions attended by the compliance enhancement group (7.7 sessions) and the number attended by the standard disposition group (6.4 sessions) was not statistically significant. Nevertheless, after covarying barriers to receiving services in the community, the compliance enhance group attended significantly more treatment sessions than the standard disposition group (mean = 8.4 versus 5.8 sessions).</p> <p>Community barriers to service utilization must be accounted for when designing interventions to improve treatment attendance.</p>
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	<p>More than half the parents with mental illness reported that their child has emotional or behavioral problems that either started or worsened when the parents became ill. Most parents reported that their child did not understand their illness and that their relationship with their child was impacted by their illness.</p> <p>The mental health needs of children with parents suffering from mental illness are often unrecognized due to barriers such as the desire to protect parents/children from possible distress.</p>

Author(s) and Year	Title	Summary of Pertinent Information
StartClass. (2016)	Public schools	Twenty-two percent of Juan Cabrillo Elementary students were classified as English Learners, and 27% of these students were diagnosed with a learning disability. Twenty-two percent of the entire student population was diagnosed with a learning disability. Six percent of the student population was chronically absent (missed 15 or more school days), and 4.1% of students at this school were held back a grade.
Staudt, M. (2007)	Treatment engagement with caregivers of at-risk children: Gaps in research and conceptualization	<p>Clarification of the term engagement is needed in order to develop interventions for increasing engagement and to examine how engagement impacts other aspects of the treatment process.</p> <p>The following elements are identified as necessary for clients to meaningfully engage in the treatment process: (1) treatment must be viewed by client as relevant and appropriate for their needs (2) clients must have a positive relationship with the clinician, whom they must perceive as having genuine concern and care for them (3) the client must be able to deal with their daily stressors to the extent that they do not distract from the treatment process.</p>
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	Findings support previous literature showing that a family-centered approach to supporting children in the public school context lessened the growth of antisocial behavior and alcohol, tobacco, and marijuana use over the course of middle school.

Author(s) and Year	Title	Summary of Pertinent Information
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	<p>Results indicate that the brief, family-focused, school-based approach to intervention has a positive effect on self-regulation (i.e. effortful control).</p> <p>Direct results of the family-centered intervention on self-regulation skills were found to have led to reductions in mental health problems, such as depression and school engagement, during students' transition to high school.</p>
Task Force on Promotion and Dissemination of Psychological Procedures. (1995)	Training in and dissemination of empirically validated psychological treatments: Report and recommendations	Increasing evidence shows that treatment manuals successfully standardize treatment.
Taylor, L., & Adelman, H. S. (2001)	Enlisting appropriate parental cooperation and involvement in children's mental health treatment	<p>To facilitate parent involvement in the treatment process, therapist should openly discuss the importance of and potential barriers to their involvement.</p> <p>It is also recommended that therapists focus on the motivation level of the family from the outset of treatment and make efforts to minimize reductions in motivational readiness and to increase motivation when needed.</p>
Ton, H., Koike, A., Hales, R. E., Johnson, J., & Hilty, D. M. (2005)	A qualitative needs assessment for development of a cultural consultation service	<p>Ethnic matching between clinician and patient was difficult to effectively apply to an ethnically diverse and extremely unified patient population.</p> <p>Time limitations and language barriers make it difficult for mental health clinicians to apply information from cultural competency training.</p>

Author(s) and Year	Title	Summary of Pertinent Information
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	An intervention designed to minimize barriers to treatment for families by helping families identify and become motivated to make needed changes in any aspect of their family functioning was found to be sought out by the target audience, sought out by people with elevated depression symptoms or prior treatment for depression or anxiety, feasible to conduct, acceptable to families, and associated with changes in family functioning and depression symptoms over time.
U.S. Department of Education. (2016)	<i>2013-2014 civil rights data collection: A first look</i>	Students of color are more likely to be identified as having a disability and receive harsher discipline than their white peers.
US Department of Health and Human Services, Health Resources and Services Administration, Maternal and Child Health Bureau. (2010)	<i>The mental and emotional well-being of children: a portrait of states and the nation 2007</i>	<p>40% of children with one mental disorder have at least one other mental disorder.</p> <p>The National Survey of Children's Health conducted in 2007 revealed that only 60% of children (ages 2-17) with an ongoing emotional, developmental, or behavioral issue received mental health services during the previous year.</p> <p>Having an emotional, behavioral, or developmental disorder can impact a child's developmental and social functioning.</p> <p>Childhood mental health issues impact the entire family system and the family system impacts the child's condition.</p>
Vaala, S. E., & Bleakley, A. (2015)	Monitoring, mediating, and modeling: Parental influence on adolescent computer and internet use in the United States	<p>Parents serve as models for their children's internet use.</p> <p>General parental monitoring predicted less teen engagement in IM/chat, social networking site use, video streaming, and multiplayer online games; however, parental tracking of internet use predicted more teen IM/chat.</p>

Author(s) and Year	Title	Summary of Pertinent Information
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	The highest rates of unmet treatment need are found among elderly persons, racial-ethnic minorities, people with low income, people without insurance, and people living in rural areas. Men have higher rates of unmet need than women.
Webster-Stratton, C. (2011)	<i>The Incredible Years: Parent, Teacher, and Children's Training Series</i>	Research on IY has been conducted using only selective and indicated prevention populations and diagnosed children.
Webster-Stratton, C., & Herman, K. C. (2010)	Disseminating incredible years series early intervention programs: Integrating and sustaining services between school and home	Necessary steps for successfully implementing evidence-based programs, such as the IY Series, into real-world settings include choosing optimal group facilitators to deliver the program; providing facilitators with quality training and continuous support, mentoring, consultation, etc.; and ongoing program evaluation and monitoring of program dissemination fidelity.
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	<p>Participants reported that the relationship between parents and school was the most important issue related to service utilization among youth. A teacher's views of the motivation and level of involvement by parents may directly impact if and how they make a referral for mental health services.</p> <p>Parents, schools, and communities can act as potential barriers to students and families accessing mental health services.</p>
Zhang, D., Katsiyannis, A., Ju, S., & Roberts, E. (2014)	Minority representation in special education: 5-year trends	Minority overrepresentation in special education is an ongoing challenge. African Americans were the most represented in special education, while Asian/Pacific Islanders were the least represented. African Americans have the highest rates of disabilities even when racial representation was examined across three major categories (learning disabilities, intellectual disabilities, and emotional disabilities).

Author(s) and Year	Title	Summary of Pertinent Information
Zhang, Y., & Wildemuth, B. M. (2009) In B. Wildemuth (Ed.)	Qualitative analysis of content in <i>Applications of social research methods to questions in information and library science</i>	Qualitative content analysis typically focuses on individual themes rather than individual words. The goal of qualitative content analysis is to identify significant themes or categories within the content and describe the social reality of these themes or categories as they pertain to the setting of interest.

APPENDIX B

Response Code Distribution Charts

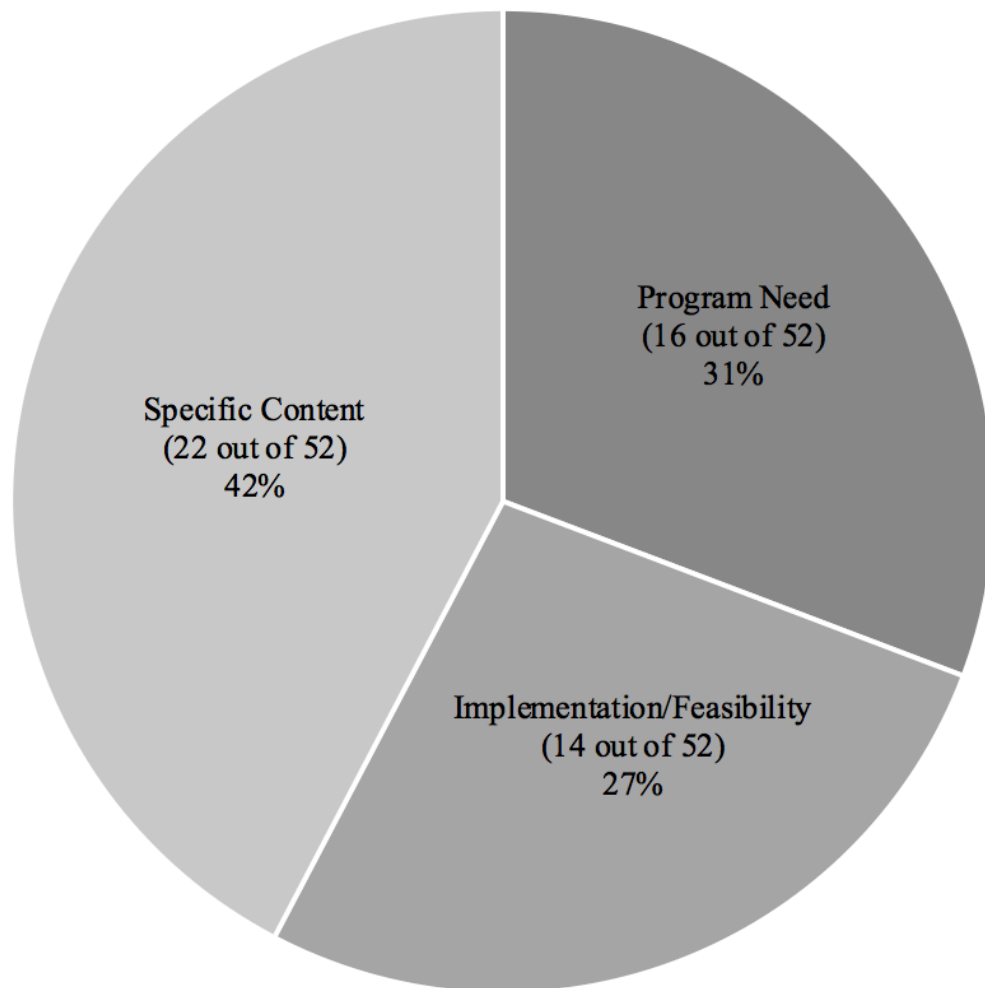


Figure B1. Code distribution by category chart. The chart provides the number of codes identified within each category. The numbers next to each category indicate how many codes within the category were identified out of the total 52 codes. Percentages are also included to denote the percentage of the total data accounted for by each category.

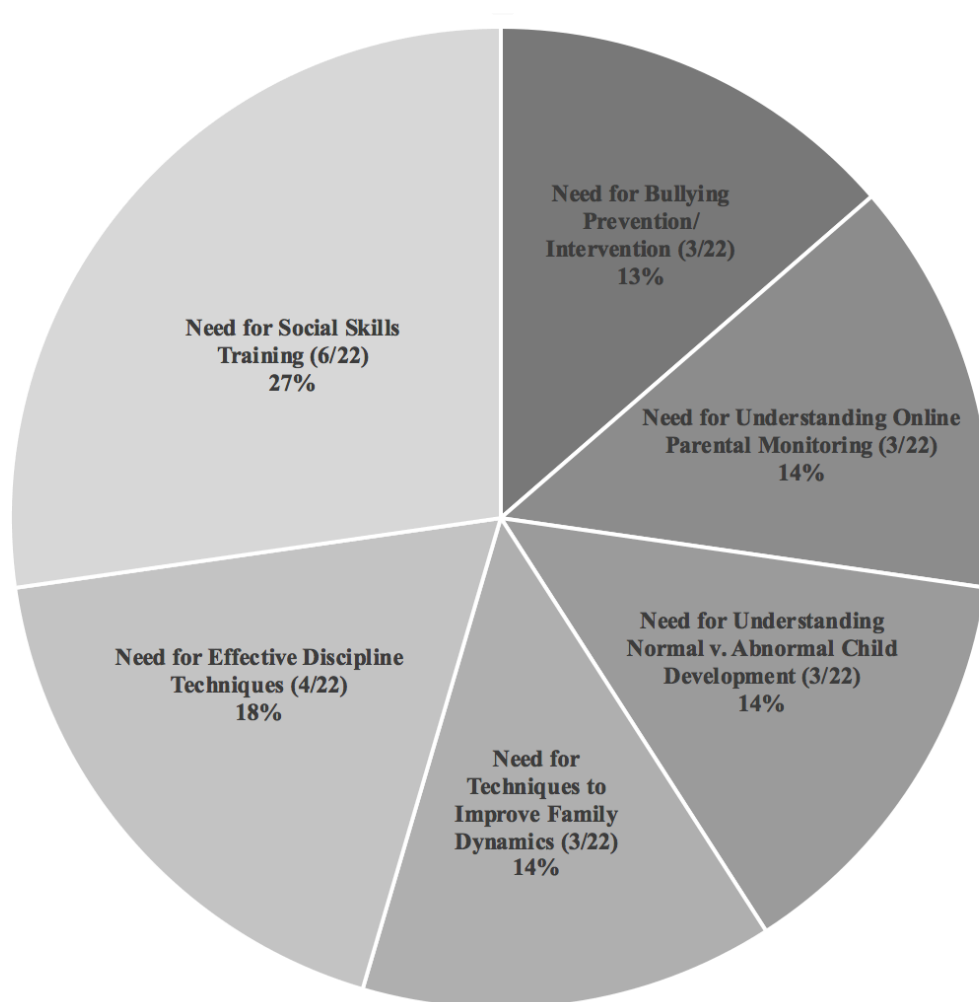


Figure B2. Specific content code distribution chart. The chart provides the number of codes identified within each theme. The numbers next to each theme indicate how many codes within the theme were identified out of the 22 specific content codes. Percentages are also included to denote the percentage of the total specific content data accounted for by each theme.

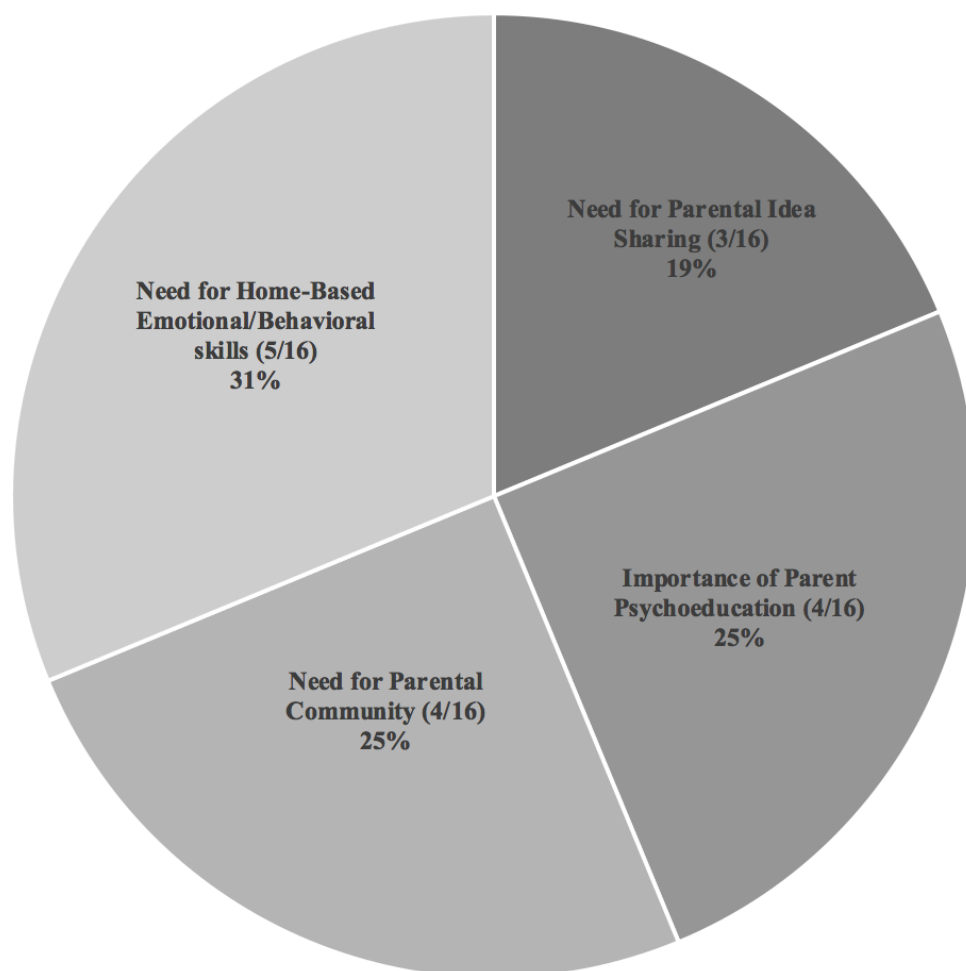


Figure B3. Program need code distribution chart. The chart provides the number of codes identified within each theme. The numbers next to each theme indicate how many codes within the theme were identified out of the total 16 program need codes. Percentages are also included to denote the percentage of the program need data accounted for by each theme.

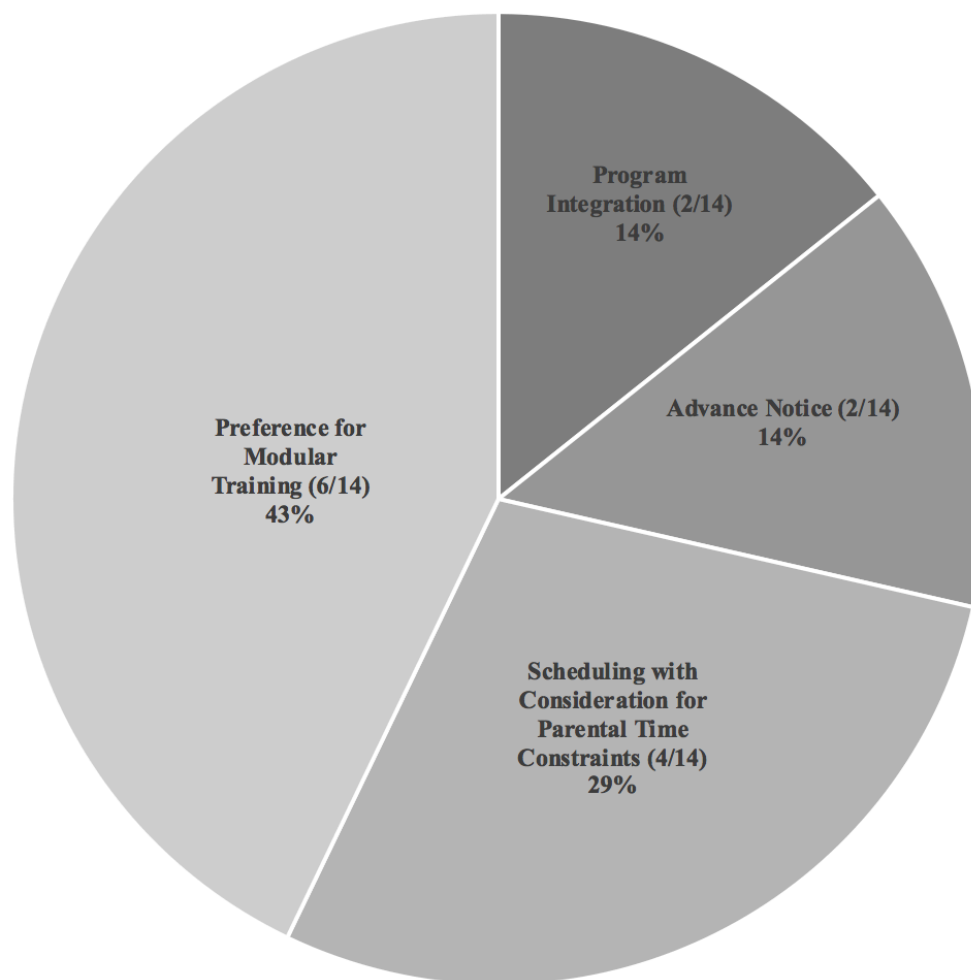


Figure B4. Implementation/feasibility code distribution chart. The chart provides the number of codes identified within each theme. The numbers next to each theme indicate how many codes within the theme were identified out of the 14 implementation/feasibility codes. Percentages are also included to denote the percentage of the implementation/feasibility data accounted for by each theme.

APPENDIX C

Recruitment Letter

PEP4SAFE

PSYCHOEDUCATIONAL PROGRAM 4 SCHOOL-AGED FAMILIES AND EDUCATORS

[NAME OF PRINCIPAL]

Principal, Juan Cabrillo Elementary School
Wiseburn Elementary School District

Dear [NAME OF PRINCIPAL]:

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 psychoeducational program about common childhood emotional and behavioral problems. This program was developed by Dr. Judy Ho and the doctoral and master's 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. You can call [Research Assistant] at (###) ###-#### or email him at researchassistant@pepperdine.edu.

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's Students, Pepperdine University

APPENDIX D

Informed Consent for Parent Participation

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 parent, guardian, or caregiver of a child currently enrolled in a school within the Los Angeles Unified School District (LAUSD). 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 your records.

PURPOSE OF THE STUDY

The objective of this research study is to evaluate a psychoeducational program for parents/caregivers 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 parent/caregiver 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 you find most helpful, which aspects need improvement, and if you would personally use any of the suggested behavioral management strategies in your home.

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 your child(ren). 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 parents/caregivers) 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)
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

Consent Script

PEP4SAFE

PSYCHOEDUCATIONAL PROGRAM 4 SCHOOL-AGED FAMILIES AND EDUCATORS

Consent Script

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. Thank you!

APPENDIX F

Demographic Questionnaire

PEP4SAFE

PSYCHOEDUCATIONAL PROGRAM 4 SCHOOL-AGED FAMILIES AND EDUCATORS

PARENT DEMOGRAPHIC QUESTIONNAIRE

The following questions will be asking about you and your family. 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) Non/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. FAMILY MEMBERS AND MARITAL STATUS

1. What is your marital status?
 - a) Single, never married
 - b) Married
 - c) Separated
 - d) Divorced
 - e) Widowed
 - f) In a relationship but living apart
 - g) Cohabiting
2. How many children live in your household? _____
3. How many adults (including yourself) live in your household?

IV. 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.)

V. OCCUPATION

1. What is your current employment status?

- a) Working full time (more than 30 hours per week)
 - b) Working part time (8-30 hours per week)
 - c) Homemaker (full time)
 - d) Student
 - e) Temporarily unemployed but actively seeking employment
 - f) Unemployed
 - g) Retired
 - h) Other (please specify):
-

2. What is/was your primary occupation?

3. Do you have any training or work experience related to childhood mental health? Circle one:

Yes

No

If so, please describe your experience below.

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. WE GREATLY APPRECIATE YOUR TIME AND COOPERATION. ☺

APPENDIX G

Quantitative Questionnaire

PEP4SAFE

PSYCHOEDUCATIONAL PROGRAM 4 SCHOOL-AGED FAMILIES AND EDUCATORS

PARENT QUANTITATIVE QUESTIONNAIRE

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

<i>Not at All</i>	<i>Very Little</i>	<i>Somewhat</i>	<i>Very Much</i>	<i>Extremely</i>
<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>

- 1) Do you think that an educational/psychoeducational program on common childhood emotional/behavioral problems is necessary in your child's school?

<i>Not at All</i>	<i>Very Little</i>	<i>Somewhat</i>	<i>Very Much</i>	<i>Extremely</i>
<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>

- 2) How feasible do you think to would be to implement the presented program at your child's school?

<i>Not at All</i>	<i>Very Little</i>	<i>Somewhat</i>	<i>Very Much</i>	<i>Extremely</i>
<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>

- 3) How effective do you think the program would be at increasing most parents' knowledge of childhood emotional/behavioral problems?

<i>Not at All</i>	<i>Very Little</i>	<i>Somewhat</i>	<i>Very Much</i>	<i>Extremely</i>
<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>

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

<i>Not at All</i>	<i>Very Little</i>	<i>Somewhat</i>	<i>Very Much</i>	<i>Extremely</i>
<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>

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

<i>Not at All</i>	<i>Very Little</i>	<i>Somewhat</i>	<i>Very Much</i>	<i>Extremely</i>
<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>

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

<i>Not at All</i>	<i>Very Little</i>	<i>Somewhat</i>	<i>Very Much</i>	<i>Extremely</i>
<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>

- 7) Do you think the behavioral interventions included in the modules will be helpful for you to use with your child if/when (s)he is displaying emotional/behavioral problems?

<i>Not at All</i>	<i>Very Little</i>	<i>Somewhat</i>	<i>Very Much</i>	<i>Extremely</i>
<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE. WE GREATLY APPRECIATE YOUR TIME AND COOPERATION. ©

APPENDIX H
Interview Protocol

PEP4SAFE

PSYCHOEDUCATIONAL PROGRAM 4 SCHOOL-AGED FAMILIES AND EDUCATORS

PARENT 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 parents?
2. Do you think the psychoeducational program would be useful for other parents? 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 parents are asked to attend?
4. What are some of your suggestions for making the program convenient for parents 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 parents? 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 parents would benefit from learning about that were not included in this program?

11. Do you think the psychoeducational program would help parents more accurately determine when their child is in need of psychological services/when the parents should seek the help of 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 home? Which ones in particular?

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

APPENDIX I

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	
6:00	
6:30	
7:00	
7:30	
8:00	

APPENDIX J
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 **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 then 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 Certificate

**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.

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

Collaborative Institutional
 Training Initiative
 at the University of Miami

APPENDIX L
IRB Notice of Approval



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: Erika Rajo

Protocol #: 15-11-129

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

School: Graduate School of Education and Psychology

Dear Erika Rajo:

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 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