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Psychoeducation and parental engagement in mental health services for youth

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ABSTRACT OF THE DISSERTATION

Psychoeducation and parental engagement in mental health services for youth

by

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Youth and families, particularly those from ethnic minority backgrounds, demonstrate high levels of unmet need (Kataoka, Zhang, & Wells, 2002), and when they do initiate care, they often experience significant barriers to engagement in child mental health services (MHS; Kazdin, 1993; McCabe, 2002; Morrisey-Kane & Prinz, 1999). Active parent participation in child MHS has been associated with improved outcomes compared to individual child treatment (Dowell and Ogles 2010). Yet, parents are often uninvolved in their child's therapy, and this may be a particular problem in school-based mental health services (SBMHS). SBMHS offer the advantage of increasing access to care (Atkins, 2003), but there appears to be an overreliance on individual counseling (Cerio, 1997; Weist, 1997). Psychoeducation, a therapeutic practice used to present factual information about MH problems and treatments, may be a powerful tool for preparing families for treatment, thereby promoting parental engagement in care.

Study 1 examined the unique effect of therapists' use of psychoeducation strategies, over and above use of engagement strategies, on promoting parental engagement among an ethnically diverse sample of 46 families that received community-based child MHS for disruptive behavior problems. Families were randomized to receive treatment in an evidenced-based (a modular

manualized treatment, MMT) or usual care (UC) treatment within the same community agencies. An observational coding system was developed to code recorded therapy sessions for therapists' in-session use of psychoeducation and engagement strategies in the early phase of treatment. Findings revealed that psychoeducation strategies employed by therapists early on uniquely predicted later parent attendance in treatment, over and above the use of other engagement strategies. Furthermore, therapists in MMT provided more psychoeducation and other engagement strategies compared to therapists in UC. Finally, treatment condition predicted parent attendance with parents in MMT attending a greater proportion of treatment sessions than parents in UC, and this difference was mediated by therapist's use of psychoeducation strategies.

Study 2 employed a mixed methods approach to investigate patterns of parental participation in a sample of ethnic minority families who received SBMHS. Administrative data on parent involvement was assessed, and a sample of 20 Latino and Chinese American parents of children that received SBMHS were interviewed to assess their level of participation in services and to document therapist implementation of basic psychoeducation practices in care. Findings from quantitative, administrative data suggest that parent participation in SBMHS was quite low. Qualitative interviews suggested that parents were motivated to be involved in their child's services, but encountered barriers to treatment participation, and their participation was often not solicited by therapists. A majority of parents reported that they were uninformed about their child's presenting problems and various aspects of the treatment process, suggesting limited use of even basic psychoeducation by therapists in their child's SBMHS. Together, findings from Study 1 and 2 suggest that there is a major opportunity to implement psychoeducation-based engagement practices upon entry into care to promote parent involvement in child MHS, whether in community clinics or school-based services.

The dissertation of Jonathan Martinez is approved.

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Chapter I. Unmet Mental Health Need for Ethnic Minority Youth

In recent decades, there have been important advances in the child mental health (MH) evidence base, including an understanding of the etiology of child MH problems as well as evidence-based treatments for child MH problems (U.S. Department of Health and Human Service [USDHHS], 1999). Research-based child treatments demonstrate that child therapies work for a wide-range of emotional/behavioral problems, with the average treated youth doing better posttreatment compared to 75% of youth who did not receive treatment (Casey & Berman, 1985; Weisz, Huey, & Weersing, 1998; Weisz & Weiss, 1987; Weisz, Weiss, Han, Granger, & Morton, 1995). There is little doubt that research-based therapies are efficacious for children, including those from ethnically diverse backgrounds (Huey & Polo, 2008). However, as many as 80% of U.S. youth in need of MH care do not receive MH services (Kataoka, Zhang, & Wells, 2002). McKay & Bannon, Jr., (2004) point out that unfortunately, these rates of child unmet MH need are identical to those reported in the mid-1980s by the Office of Technology Assessment (1986), indicating that unmet MH need remains unchanged despite significant advances in developing evidence-based treatments for children. Further constraining the reach of MH care are findings that among families who initiate child mental health services (MHS), over 50% fail to complete treatment (Kazdin, 1996; Kazdin, Holland, & Crowley, 1997; Yeh, McCabe, Hough, DuPuis, & Hazen, 2003). In fact, some data suggests that the majority of families who enter care attend only one or two sessions (Ambruster & Fallon, 1994). Thus, unmet MH need for U.S. youth continues to be a serious concern due to problems with access and attrition.

Children from ethnic minority groups and vulnerable populations (e.g., children of single mothers, socially and economically disadvantaged children) demonstrate higher rates of unmet MH need, and are thus of particular concern (Kazdin, 2003). When assessing factors related to

unmet MH need, factors related to socioeconomic status (SES) are often confounded with ethnic minority status, thus making it difficult to determine if ethnicity alone is related to disparities in unmet MH need (Cauce et al., 2002). However, careful studies that control for multiple factors demonstrate that racial/ethnic disparities remain after such factors as problem severity, functioning, insurance coverage, and SES are accounted for (Garland et al., 2005). Another source of confusion is inconsistent findings for service use rates for certain racial/ethnic groups, which is largely due to how service use disparities are operationalized. For example, African American youth have demonstrated overrepresentation in the MH sector (compared to their representation in the local population; Bui & Takeuchi, 1992) and studies have supported both under- and over- utilization of services (compared to non-Hispanic White youth; see USDHHS, 2001). However, when MH need is measured directly, ethnic minority youth are consistently less likely than non-Hispanic White youth to receive services when they have clinically significant psychopathology symptoms and associated functional impairment (Flisher et al., 1997; Kataoka, Zhang, & Wells, 2002; Yeh, McCabe, Hough, Dupuis, & Hazen, 2003). There is recent evidence that these racial/ethnic disparities depend on problem-type, with ethnic-minority youth more likely to be linked to care for externalizing behavior problems, but not for internalizing behavior problems (Gudiño, Martinez, & Lau, 2012; Martinez, Gudiño, & Lau, 2013).

Thus, consistent evidence shows that African American, Latino, and Asian American youth demonstrate higher levels of unmet MH need compared to non-Hispanic White youth. For example, in a study of U.S. and Puerto Rico youth, African Americans had higher rates of unmet need compared to Caucasian children in the previous 6 months (Flisher et al., 1997). The Patterns of Care study with a large sample of youth involved in public sectors of care found that African American youth demonstrated significantly higher rates of unmet need (47.7%)

compared to non-Hispanic White youth (30.7%; Yeh et al., 2003). In this same study, Latino youth also had significantly elevated rates of unmet need (47.2%). A general population based study found that 88% of Latino youth had unmet MH needs compared to a rate of 75% for all U.S. youth, and Latino youth had higher unmet need than non-Hispanic White youth even after accounting for socioeconomic and insurance status (Kataoka et al., 2002). Studies including Asian/Pacific Islander youth are few, but the Patterns of Care study found that Asian/Pacific Islander youth had the highest rates of unmet need (71.8%) compared to all other racial/ethnic groups (Yeh et al., 2003). These results demonstrate a consistent and concerning pattern of racial disparities in youth MH care.

Chapter II. Barriers to Child MH care

Evidenced-based treatments - identified through randomized controlled trials comparing active treatment with no treatment, placebo, or treatment as usual – appear to be efficacious for ethnic minority youth (Huey & Polo, 2008). Although the evidenced-based treatment literature demonstrates that child therapies work, MH services that fail to reach those children in need cannot be said to be effective (Hoagwood, 2001). Many studies have attempted to provide insight into barriers that families encounter during the help-seeking process and after initiating services. Owens et al. (2002) categorized these barriers into 1) structural barriers, which include lack of availability of providers, long waiting lists, lack of insurance, inability to pay for services, transportation problems, inconvenient services, 2) barriers related to perceptions about MH problems, which include inability to identify children's need for MHS, denial of the severity of a MH problem, belief that the problem can be handled without treatment, and 3) barriers related to perceptions about MHS, which include lack of trust in or negative experience with MH providers, stigma related to receiving help, and lack of knowledge about treatments and what

they are for (Flisher et al., 1997; Kazdin et al., 1997; McKay, Stoewe, McCadam, & Gonzales, 1998, Nock, Ferriter, & Holmberg, 2007). It should be noted that some of these barriers are not yet clearly understood, as some have shown inconsistent relationships to service use (e.g. low SES; Cauce et al., 2002).

Chapter III. School-based MH services to Address Structural Barriers

To reduce the impact of barriers that ethnic minority families face when accessing needed MH services for their children, it is important to provide services in community settings where diverse populations feel comfortable (Pumariega, Rogers, & Rothe, 2005; Miranda et al., 2003). Schools are a logical site in which to base children's MHS (Atkins, 2003), as they can address key practical barriers to families accessing needed services (Flaherty, Weist, & Warner, 1996; Weist, 1997; Garrison et al., 1999). School-based MHS (SBMHS) offer the advantage of having contact with children during school hours and are close to home for families, thus increasing access to care (Atkins, 2003). In fact, schools are commonly regarded as the de facto providers of MHS for youth (Burns, Schoenwald, Burchard, Faw, & Santos, 1995; Farmer, Burns, Phillips, Angold, & Costello, 2003). As many as 70-80% of children who receive MHS receive them in schools, providing the only form of treatment for many children with MH need (Burns et al., 1995; Rones & Hoagwood, 2000).

Although SBMHS offer several advantages to overcoming practical barriers to accessing child MHS, the quality and types of services offered have been questioned (Rones & Hoagwood, 2000). SBMHS are often fragmented and focus variably on improving academic or career skills and decreasing disruptive behavior in the classroom (Adelman & Taylor, 2003). There appears to be an overreliance on individual counseling in most school-based programs (Weist, 1997), and schools may be reluctant to involve parents in services when they can conveniently access

children for treatment sessions without being accompanied by parents (Cerio, 1997). When schools do attempt to engage families in SBMHS, many parents do not enroll in services, or the programs have high attrition rates (McCurdy & Daro, 2001).

Reliance on individual child counseling in SBMHS is troubling, as evidenced-based treatments, especially for disruptive behavior and externalizing disorders, require active parent participation in sessions and family implementation of techniques between sessions in order for positive outcomes to occur (Nock & Kazdin, 2005). Evidenced-based treatments for disruptive behavior include parent management training, which demonstrate that parents are the key agents of change (Eyberg, Nelson, & Boggs, 2008; Farmer, Compton, Burns, & Robertson, 2002) In fact, individual counseling for disruptive behavior is generally not indicated (Weisz & Jensen, 1999) and may actually exacerbate problems (Farmer et al., 2003; Hunter, 2003; Ringeisen, Henderson, & Hoagwood, 2003). Instead, school-based programs that include consultation and collaboration with parents and teachers can be effective approaches to improving children's MH (Greenfield & Suzuki, 1998; Lowie, Lever, Ambrose, Tager, & Hill, 2003; McKay, Atkins, Hawkins, Brown, & Lynn, 2003; Weiss, Harris, Catron, & Han, 2003). Although the research on involving families in SBMHS is limited, there is evidence that MH counselors who are aware of barriers faced by parents can increase family involvement (Edwards, 2002; Fox, Dunlap, & Powell, 2002; Rones & Hoagwood, 2000).

Chapter IV. Cultural Barriers to Child MH care

While barriers may prevent many families from accessing or completing treatment, some research suggests that many of these barriers disproportionately affect ethnic minority families (Cheung & Snowden, 1990; Takeuchi et al., 1993; Trevino et al., 1991). Furthermore, there is evidence that unmet MH needs in ethnic minority families remain even after accounting for a

variety of structural barriers (Garland et al., 2005; Scheffler & Miller, 1991; Padgett et al., 1994). This suggests that cultural differences in beliefs about youth MH problems and MH treatment play a major role in the underutilization of care among ethnic minorities (Cauce et al., 2002; Cheung & Snowden, 1990; McKay, Sue, 1994; U.S.DHHS, 2001; Yeh et al., 2005). Cauce et al. (2002) provides an organizational and conceptual framework for understanding how culture impacts various junctions along the decision-making process for ethnic minority families to seek help for child MH problems. Cauce et al. argues that this process begins with 1) the recognition of child MH needs, defined as epidemiological need or subjective perceived need, then moves to 2) the decision to seek help, which is most likely to occur when a MH problem is recognized as undesirable and deemed not to go away on its own, and ends with 3) service selection, defined as decisions about where or to whom children and families turn after identifying MH need and committing to seek help. Although Cauce's model ends with service selection, which may include informal or formal avenues of support, these cultural processes may continue to impact care after ethnic minority families enter formal MH services and may be responsible for disproportionate early attrition from care.

Culture & Problem Recognition

Problem recognition and identification of child MH needs is the first step to entry into MH services (Cauce et al., 2002). In child therapy, children rarely consider themselves in need of services and it is the parent that is chiefly responsible for identifying child MH needs and initiating treatment (Nock & Kazdin, 2005). Parents often serve as gatekeepers to child MH care and the degree of distress that parents experience in response to child MH problems often determines whether treatment will follow (Weisz, et al., 1988). Families who experience personal or practical difficulties dealing with the their child's MH problems are more likely to

access MHS than families who do not experience this strain; one study found that the strongest predictor of families entering into services is the presence of parental perceived burden or caregiver strain (Angold et al; 1998). Similarly, another study found that parental beliefs that their child would improve without professional intervention was associated with lower entry into services (Owens et al., 2002). Thus, the parents' perception of their child's MH problems influences whether parents seek help for those problems (Angold et al., 1998; Burns et al., 1995; Farmer, Burns, Angold, & Costello, 1997; Pescosolido, 1992).

Ethnic minority families may be less likely to recognize what would be construed by service providers to be bona fide MH needs in their children. For example, African American parents were less likely than non-Hispanic White parents to describe their child's ADHD symptoms using medical or MH labels (Bussing, Schoenberg, Rogers, Zima, & Angus, 1998). Thus, ethnic minority parents may be less likely to construe children's behavior as indicative of MH need. There is considerable evidence of ethnic differences in parental beliefs about the etiology of child's MH problems (McMiller & Weisz, 1996; Weisz, McCarty, Eastman, Suwanlert, & Chaiyasit, 1997; Yeh et al., 2005). For example, McCabe (2002) found that Mexican American parents were more likely to view their child's emotional and behavioral problems as a matter of ineffective parenting (thus requiring more strict discipline) rather than a MH problem needing to be addressed with psychotherapy. While this belief may not be untrue, per se, this attribution overlooks the possibility of multiple contributing factors and the potential benefits of MH treatments. Yeh et al. (2004) found that compared to non-Hispanic Whites, African American and Asian/Pacific Islander parents held etiological beliefs about their child's problems that were more sociological in nature and less consistent with biological and psychosocial explanations. Parental beliefs about children's problems are found to partially

explain racial/ethnic disparities in the utilization of school-based (Yeh, et al., 2004) and specialty MH services (Yeh et al., 2005). Ethnic minority parents are more likely to endorse etiological factors other than biopsychosocial factors, and these alternative causal attributions mediate racial differences in likelihood of subsequent entry into youth MH services.

Thus, problem recognition and causal attributions concerning child problems in ethnic minority families represent significant barriers to engaging families in treatment. The impact that child MH problems pose on the family and recognition of these child MH needs is a key to families entering services (Costello et al., 1996; Farmer et al., 1997).These findings reveal specific opportunities for intervention development and service re-design to reduce racial disparities in service use.

Culture & Decisions to Seek Help

Once a MH problem is recognized as abnormal, undesirable, and/or needing intervention to improve, cultural factors play a key role in whether families actually seek help (Cauce et al., 2002). Evidence suggests that ethnic minority families may hold cultural values that can dissuade parents from seeking help for their child's MH problems. For example, while MH stigma is a problem across populations, the literature suggests that shame and stigma are central barriers for Asian American families who view mental illness as highly stigmatizing and the need for help from sources outside one's family is regarded as shameful and a threat to "face" and family status (Zane & Yeh, 2002; Cheung & Snowden, 1990; Liao, Rounds, & Klein, 2005). Asian American family member stigma attitudes are the main predictor of delayed help-seeking even when the ill relative has serious mental illness (Okazaki, 2000). Asian Americans are much less likely to discuss their MH problems with friends/relatives or to consult with a MH professional (Zhang, Snowden, & Sue, 1998), instead making every attempt to deal with the

child's problems within the family (Lin, Inui, Kleinman, & Womack, 1992). Similarly, Latino families have been described as valuing stoicism and preferring to handle problems within the family, which may lead to not seeking outside sources of help from professionals (Alvidrez, 1999; Martinez, 1993; Rosello & Bernal, 1996). One qualitative study with Mexican American families found that when asked why Latino families were less likely to bring children in for therapy, parents emphasized the strong stigma associated with seeking formal help and a tendency to "keep problems within the family" (McCabe, 2002). Similarly, African American families strive to overcome MH problems through self-reliance and determination (Snowden, 1998) and African American youths are encouraged by adults to use willpower to overcome adversity or to "tough out" certain difficult situations (Poulin et al., 1997). These cultural values and beliefs encourage many minority individuals to deal with problems on their own or within the immediate family, and lead to a lesser likelihood of seeking outside help.

Culture and the Types of Service Selected

Once a problem is recognized as undesirable and the decision to seek help of some type is made, cultural factors may act as barriers for ethnic minority families to seek entry into formal MHS (Cauce et al., 2002; Chun et al., 1996; Gallo, Marino, Ford, & Anthony, 1995) For example, a qualitative study with Mexican American parents of children with MH problems found that over half of parents bringing their child in for formal treatment experienced disapproval from another family member, often a parent or a spouse who felt that the problem was not a MH related, treatment would not work, or that seeking treatment meant that the parent had failed (McCabe, 2002). This same study found that parents believed that Latinos were less likely to bring children in for therapy because of the strong stigma associated with mental health treatments, as well as a lack of knowledge about where to find treatment, and lack of information

about what treatments are and how they work. When ethnic minority families do seek help, they often prefer alternative sources of help that are more consistent with their cultural values and beliefs. For example, in a study of families who eventually came into contact with a MH provider to address their child's MH needs, African American and Latino parents were less likely than Caucasian parents to contact MH professionals during initial help-seeking, and instead sought help from family and community contacts (McMiller & Weisz, 1996). Other studies have found that ethnic minority families often seek informal sources of care such as help from family, friends, clergy, and traditional healers over formal sources of care (Harrison et al., 2004; Snowden, 2001; Peifer, Hu, & Vega, 2000). When ethnic minority families do decide to seek formal health services, they are twice as likely than White families to seek treatment in general health care settings as opposed to specialty MH settings (Cooper-Patrick et al., 1999).

Thus, decisions to seek formal or informal sources of help may be related to stigma associated with MHS, or alternatively a lack of MH literacy - defined as lack of knowledge about MH problems (which aid their recognition, management or prevention) and appropriate professional help available for those problems (Jorm, 2000). Many have speculated that etiological beliefs about child MH problems may be related to service use decisions for those problems (Cheung & Snowden, 1990; Leong, Wagner, & Tata, 1995; Ruiz, 1995; U.S. DHHS, 2001). For example, if parents believe that their child's emotional/behavioral problems are the result of a biological issue, then they may be more likely to seek medical/psychiatric services that may provide medication, whereas parents who believe that their children's problems are due to spiritual issues may then seek a religious leader for guidance (see Yeh et al., 2005). Understanding and addressing these parental beliefs are critical once families initiate formal MHS, as discrepancies in beliefs between parents and provider may lead to differential treatment

expectations and goals, which in turn may negatively affect parental engagement processes in treatment.

Chapter V. Barriers to Engaging Families in Child MH Services

Barriers related to problem recognition, the decision to seek help, and the types of service selected may continue to play a strong role once families initiate formal MHS, thus impacting the treatment engagement process. Among families that seek outpatient MH treatment, 40 to 60 percent discontinue services before the completion of treatment (Kazdin, Holland, & Crowley, 1997). Moreover, these families typically do not use outpatient services for very long; one study showed that most children who enter outpatient treatment attend for only one or two sessions (Armbuster & Fallon, 1994). Families that dropout and terminate prematurely do not receive the maximum benefits services offer, and may continue to experience significant levels of impairment (Kazdin, Holland, & Crowley, 1994). Even among families who continue, levels of engagement are variable with some families showing poor or inconsistent attendance and low levels of adherence or participation when they are present, thus negatively impacting care (Kazdin, 1993; Nock & Kazdin, 2005). To facilitate the engagement of parents in child therapy, an understanding of the role of parental perceptions of the treatment process is key (Morrisey-Kane & Prinz, 1999; Nock, Ferriter, & Holmberg, 2007).

Parental beliefs about the credibility of treatment (i.e., how believable, convincing and logical a given treatment is) and expectations about treatment (e.g., improvements that a client believes will be achieved through treatment) are significant predictors of engaging families in child MHS (Nock, Ferriter, & Holmberg, 2007). Parents are likely to end services prematurely when they have a mismatch of expectations with the therapist in terms of how long treatment will last, how quickly their child will begin to improve, and how much they and their children

need to be involved in the treatment process (Flisher et al; 1997; McCabe et al., 1999; Morrissey-Kane & Prinz, 1999; Nock & Kazdin, 2005). In one study, parent perceptions of treatment relevance for their child's problems was found to be the factor that best discriminated dropouts from completers (Morrisey-Kane & Prinz, 1999). Nock, Ferriter, and Holmberg (2007) found that treatment credibility and expectancies were significantly related to motivation for treatment as well as subsequent treatment adherence. Additionally, family perceptions of aspects of the therapeutic relationship and the degree to which the families are involved in service planning have also emerged as important issues impacting engagement (Garcia & Weisz, 2002; Koren et al., 1997; McCabe et al., 1999).

Ethnic minority families experience significant barriers to successful engagement in child treatment, and are thus less likely to stay in treatment beyond the first session and more likely to discontinue treatment prematurely compared to White families (Huey, 1998; Kazdin, 1993; Kazdin, Stolar, & Marciano, 1995; McCabe, 2002; Morrisey-Kane & Prinz, 1999). Evidence suggests that one explanation for higher rates of attrition among ethnic minorities are differing treatment expectations and perceptions of treatment relevance, which may in turn influence a parent's decision to remain in services and to become successfully engaged in care (Armbruster & Fallon, 1994; Kazdin et al., 1993). For example, among Latino parents of youth in psychotherapy, those who believed that services would be effective were less likely to drop out (Huey, 1998). McCabe (2002) found that of the majority of Mexican American parents bringing their child in for therapy experienced disapproval from another family member, often a parent or spouse who felt that the child's behavior did not represent a MH problem and thus treatment would not work. Furthermore, Mexican American parents were more likely to drop out of treatment when they endorsed one of the following beliefs: that they should be able to overcome

their child's problems on their own, that the problems should be handled with strict discipline, and that recovery would be quick. These findings suggest that to successfully engage ethnic minority families in treatment, an assessment of parents' beliefs about child MH problems and expectations about treatment should conducted so that misconceptions can be addressed at the outset of therapy. Thorough therapy orientation procedures are necessary so that families will have accurate information to guide their expectations and increase the perceived credibility of treatment (McCabe, 2005).

Chapter VI. Parental Engagement Approaches for Child MH Services

With most evidenced-based treatments focused on reduction of problematic behavior and improvement in functioning, as well as displaying effectiveness in community-based settings, few protocols for increasing parental engagement in child MHS have been developed and evaluated (Nock & Ferriter, 2005). Within the engagement literature, family engagement in child MHS has been investigated in two specific steps: initial attendance and ongoing engagement (McKay, Stoewe, McCadam, & Gonzales, 1998). Ongoing engagement in services has been defined by such things as treatment attendance, adherence, satisfaction, and therapist-client alliance (Nock & Kazdin, 2005). A review of engagement intervention approaches is provided in Tables 1 and 2. These engagement interventions have demonstrated increased attendance at initial intake (Szapocznik et al.,1988; McKay et al., 1996) and throughout treatment sessions (Chacko et al., 2009; McKay, McKay, Nudelman, McCadam, & Gonzalez, 1996; McKay et al., 1998; Nock & Kazdin, 2005; Szykula, 1984; Prinz & Miller, 1994), greater treatment motivation and adherence (Nock & Kazdin, 2005), and greater homework compliance and parent satisfaction (Chacko et al., 2009).

The engagement interventions reviewed in Table 1 have demonstrated increased family

engagement in child MH services relative to control conditions. Most approaches emphasize a problem-solving component to address practical barriers to treatment participation (Chacko et al., 2009; McKay, McCadam, & Gonzales 1996; Nock and Kazdin, 2005; Sykula, 1984; Szapocznik et al., 1988). Several interventions are based on motivational interviewing strategies (Miller & Rollnick 1991), which assume an active resistance to care model and thus address treatment resistance and motivational barriers (Dishion & Kavanaugh, 2000; Nock & Kazdin, 2005; Szapocznik et al. 1988). On a related note, some protocols ensure that concerns related to previous negative experiences in care are discussed (McKay et al, 1996; Dishion & Cavanaugh, 2000). While several approaches do address treatment expectations in some form (Chacko et al. 2009; McKay et al.1996; Nock & Kazdin, 2005; Prinz & Miller, 1994; Sykula, 1984), few address parents' attributions about their child's problems, or provide information on problem etiology or the underlying theoretical rationale for treatment. Thus, there appears to be a relative emphasis on motivational and practical barriers in contrast to psychoeducational strategies to provide information on child MH problems and the importance of treatment as a method of engaging families in care.

Furthermore, identifying engagement strategies for ethnic minority families is of particular importance (Miranda et al., 2005), as ethnic minority families have evidenced higher rates of unmet MH need and increased barriers to care. While the engagement approaches reviewed have included a large proportion of African American families, Latino and Asian American families have largely been neglected. As African American families may hold high levels of mistrust and stigma due to past negative and coercive experiences with the MH care system and other associated public sectors like child protective services and juvenile justice (Whaley, 2001; McKay, 1996), addressing resistance to care may be particularly indicated for

engaging African American families. In addition, in services for alcohol and drug problems, motivational enhancement engagement practices are highly relevant and effective for addressing active resistance to care for addictions (Dunn et al., 2001). This was effectively applied in Szapocznik et al's (1988) engagement intervention for families of Latino adolescents referred for drug use. However, engagement strategies that go beyond addressing practical barriers and lack of motivation for treatment are particularly indicated for families with low levels of MH literacy such as immigrant Latino and Asian American families. For these populations, engagement strategies could also focus on generating an understanding of child MH problems and associated rationale and credibility for evidence-based treatment approaches, as ethnic minority families have demonstrated misconceptions of child MH problems that appear to contribute to observed racial disparities in use of youth MH services (Yeh et al., 2005).

Chapter VII. Psychoeducation and Engagement

Psychoeducation is an evidence-based practice that emphasizes the presentation of factual information about child MH problems and treatments (Lukens & McFarlane, 2004) and may be a powerful tool for addressing cultural barriers to engaging families, particularly ethnic minority families with low levels of MH literacy. Psychoeducation facilitates comprehension of complex information about child MH problems and the appropriate avenues of care (Miklowitz & Goldstein, 1997), and provides optimistic messages about the treatability of child MH problems (Lukens & McFarlane, 2004). The parents are considered partners with the treatment provider on the premise that the more knowledgeable the caregivers are, the more positive outcomes will occur (Lukens & McFarlane, 2004). As parental misconceptions about child MH problems, expectation for treatment, and the credibility of treatment have been related to treatment engagement, in that incongruent or unrealistic expectations lead to poor engagement (Morrisey-

Kane & Prinz, 1999, Nock, Ferriter, Holmberg, 2007), preparing families for treatment using psychoeducation strategies can help alter misconceptions, thereby increasing engagement in treatment. Table 2 lists psychoeducational practices employed in published engagement interventions.

Because of the flexibility of the model, psychoeducation has emerged as a promising engagement tool in both clinical trials and community settings for a wide variety of child MH problems (Lukens & McFarlane, 2004). For example, psychoeducational strategies have been demonstrated to result in increased knowledge about children's MH problems, improved family interactions, and increased use of appropriate services compared to controls in families of children with mood disorders (Fristad, Goldberg-Arnold, and Gavazzi, 2003; Fristad, 2006), increased attendance in child MHS (Becker et al., in review), parental satisfaction with treatment in families of children with ADHD (Lopez et al., 2005), higher levels of treatment adherence and satisfaction in youth with bipolar disorder (Pavuluri et al, 2004), increased knowledge and modification of dysfunctional beliefs about child MH problems and treatment in parents of adolescents with depressive disorder (Brent et al, 1993), and greater parental satisfaction with treatment compared to controls in families of adolescents with depressive disorder (Sanford et al., 2006).

Thus, psychoeducational strategies may uniquely increase family involvement in child MH treatment over and above the use of other engagement strategies, and may be a powerful tool for addressing cultural barriers in Cauce's (2002) conceptual framework for understanding how culture impacts MH care (see Figure 1). Targeting these barriers may be especially important for children in SBMHS, as parents many times are not the referring agent and thus may not understand why services are needed. Specifically, psychoeducation can target problem

recognition barriers by increasing parent's understanding of child MH problems and addressing misperceptions of child MH needs. This may lead to decisions to seek help and follow through with SBMH referrals by recognizing child MH needs as undesirable and not likely to go away on their own. Psychoeducation can then target appropriate service selection, where rationale for SBMHS treatment can be provided, along with problem-solving barriers to engagement and addressing expectations and describing the course of treatment.

Table 1. General strategies employed in published engagement interventions

Engagement Protocol	Protocol Description and Purpose	Address Practical Barriers	Motivational Interviewing Approach	Expectations /Goals for Tx	Past Negative Experiences	Collaborative /Working Alliance
Comprehensive Referral Pursuit and Maintenance (CRMP; Szykula, 1984)	Engagement procedure to ensure that family referrals to a community-based clinic attended the initial intake session. During initial phone contact to schedule an intake session, the clinic staff inquired on expectations and goals for treatment to ensure that families felt comfortable attending the intake session. After initiating services, potential practical barriers to treatment participation were addressed and problem-solved throughout treatment	✓		✓		
Strategic structural-systems engagement (SSSE; Szapocznik et al., 1988)	A family-focused engagement intervention for families of adolescents with substance abuse problems. Delivered via initial telephone contact and throughout the treatment process, the engagement protocol targeted resistance to treatment by establishing a working alliance with the caregiver and developing strategies that helped the family attend the sessions.	✓	✓			
Enhance Family Treatment (EFT; Prinz & Miller, 1994)	Enhanced engagement procedure to standard family treatment designed to promote discussions of parental expectations, feelings, and issues related treatment. At intake, EFT solicited parents' feelings about seeking treatment, prepared for and normalized possible parental reactions during therapy, probed for general concerns, and set up a framework of openness between therapist and parents. Later sessions included regular discussions about personal family concerns and other feelings throughout therapy.			✓		✓
Telephone Engagement Intervention, plus first session engagement (McKay, McCadam, & Gonzales, 1996)	Phone call aimed to clarify the need for child MH care, increase the caregiver's investment and efficacy in relation to help seeking, identify attitudes about and previous experiences with MH care, and develop problem-solving strategies to overcome concrete obstacles. Later protocol included above phone call plus first session engagement that focused on the need to clarify the roles and helping process for the client, the importance of establishing a collaborative working relationship with the client, a focus on immediate practical concerns, and addressing barriers to help seeking	✓		✓	✓	✓
Family Check-Up Intervention (FCU; Dishion & Kavanaugh, 2000)	The FCU is part of a multilevel intervention program - the Adolescent Transitions Program, which supports parents' accurate appraisal of their child's risk status and provides parenting resources for reducing risk and promoting adjustment. The FCU is a 3-session intervention with an initial interview, comprehensive assessment, and a family feedback session. The FCU uses motivational skills to address concerns, encourage maintenance of current positive practices, change of disruptive practices, and exploration of potential intervention services.		✓		✓	
Participation Enhancement Intervention (PEI; Nock & Kazdin, 2005)	Brief engagement strategy to increase parents' motivation to participate in treatment and increase attendance and adherence to treatment. Based on motivational enhancement techniques, the PEI (delivered by therapists in three brief 5–15 min doses during the first few therapy sessions) provided information about the importance of attendance and adherence, elicited motivational statement about attending and adhering, and identified and problem-solved potential barriers to treatment participation.	✓	✓			
Strategies to Enhance Positive Parenting (STEPP; Chacko et al., 2009)	Enhanced engagement procedure to traditional behavior parent training for single mothers of children with ADHD. The STEPP intervention included an enhanced intake and treatment procedure to address possible practical barriers to treatment participation, maternal cognitions regarding expectations for treatment, and attributions regarding their child's behavior.	✓		✓		

Table 2. Psychoeducational practices employed in published engagement interventions

Engagement Protocol	Addressing Causes of MH problems	Correcting/ Altering Beliefs about Child MH Problems	Providing Rationale/ Credibility for Treatment	Discussing Expectations/ Goals for Treatment	Describing Course of Treatment
Comprehensive Referral Pursuit and Maintenance (CRMP; Szykula, 1984)				✓	
Strategic structural-systems engagement (SSSE; Szapocznik et al., 1988)					
Enhance Family Treatment (EFT; Prinz & Miller, 1994)				✓	
Telephone Engagement Intervention, plus first session engagement (McKay, McCadam, & Gonzales, 1996)			✓	✓	
Family Check-Up Intervention (FCU; Dishion & Kavanaugh, 2000)		✓	✓		
Participation Enhancement Intervention (PEI; Nock & Kazdin, 2005)			✓		
Strategies to Enhance Positive Parenting (STEPP; Chacko et al., 2009)		✓		✓	

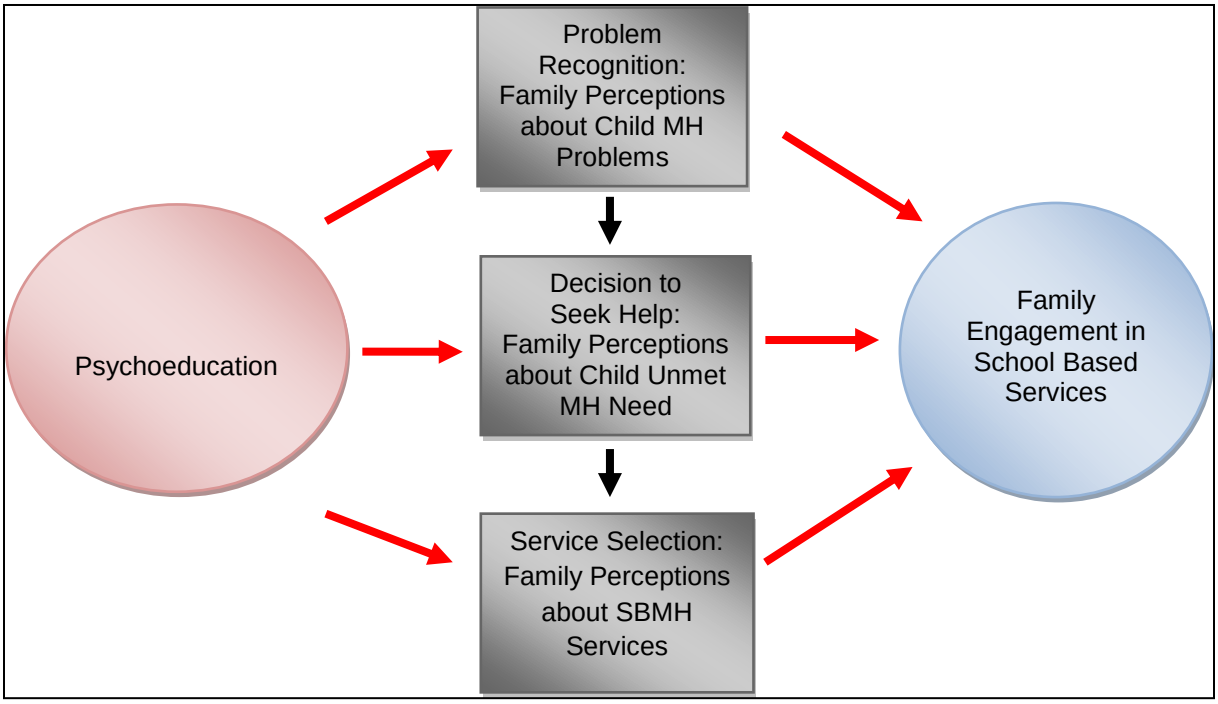


Figure 1**.** Psychoeducation and barriers to engagement

The Dissertation

The current dissertation has the following overall aims: 1) examine the unique effect of psychoeducation, over and above therapists' use of other engagement strategies, on promoting parental engagement in child MHS, and 2) understand parents' experiences in SBMHS, including their perceptions of barriers to parent participation in their child's services and their reports of therapists' use of psychoeducation practices. To accomplish these overall aims, the dissertation was carried out in two separate studies, with each overall aim investigated in each study. Study 1 examined whether there was a unique effect of therapists' use of psychoeducational strategies on promoting parental engagement among an ethnically diverse sample of families that received child MHS in community clinics. To investigate this aim, an observational coding system was developed to examine therapists' use of psychoeducation and other engagement strategies in recorded therapy sessions, and measures of parental engagement were obtained via parent-report and attendance records. Study 2 involved the collection of quantitative data via administrative records available in SBMHS and qualitative data via semi-structured interviews with parents of children that received SBMHS. The interviews assessed parent perspectives on barriers to parent participation in their child's services and whether and how therapists employed psychoeducation to promote parental participation in SBMHS.

Study 1

The central aim of Study 1 was to examine the unique effect of therapists' use of psychoeducational strategies, over and above the use of other engagement strategies, on promoting parental engagement among an ethnically diverse sample of families of children with disruptive behavior disorders that received community-based child MHS in Hawaii and

Massachusetts. Families were randomized to receive one of two different types of treatment: a) an evidenced-based treatment approach (modular manual treatment; MMT) or usual care treatment (UC). The secondary aim of Study 1 was to investigate differences in MMT vs. UC therapists' use of psychoeducation and other engagement strategies in promoting parental engagement. To investigate these aims, an observational coding system was developed to code recorded treatment sessions for psychoeducational and other engagement strategies employed by therapists. Parental engagement in child MHS was assessed via parent-report and attendance records. We proposed the following hypotheses: H1) there will be a unique effect of therapist use of psychoeducation on promoting parental engagement, while controlling for therapists' use of other engagement practices, H2) there will be more observable therapist use and intensity of psychoeducation and other engagement practices in MMT vs. UC, H3) there will be higher levels of parental engagement in MMT vs. UC, and H4) higher levels of parental engagement in MMT vs. UC will be mediated by therapists' use of psychoeducation strategies, while controlling for use of other engagement strategies. See Figure 2 for Study 1 model and hypotheses.

Methods

Data Source

Study 1 utilized data from the Child System and Treatment Enhancement Projects' (STEPs; MacArthur Network) Clinic Treatment Project (CTP), a multi-site, randomized treatment and effectiveness trial that investigated children assigned to be treated with evidenced-based practices or usual care procedures in community clinic settings in Hawaii and Massachusetts. The overall trial included 184 children ages 7 to 14 and their parents who were seeking treatment in community clinic settings for problems related to anxiety, depression and/or disruptive behavior. Youth were randomly assigned to be treated with the usual treatment

procedures (usual care, or UC) in their clinics or with evidence-based practices deployed in two forms: a) standard manual treatment (SMT), using full treatment manuals, one at a time, exactly as they have been tested in clinical trials, and b) modular manual treatment (MMT) in which therapists learn the component practices of the standard manuals but individualize the use of the components for each child using a guiding clinical algorithm. Unlike the SMT approach, the MMT approach allows the duration and sequencing of techniques to be individualized in an effort to fit the child's needs and allows the clinician to draw techniques from outside the target disorder domain when needed.

The study included 84 therapists who worked in 10 different outpatient clinical service organizations in Massachusetts and Hawaii, providing treatment in clinic office and school settings. Therapists in the same clinic who consented to participate were randomly assigned to provide evidenced-based practices or UC procedures for children who were recruited into the study. Of these therapists, 80% were women; 56% were white, 23% were Asian American, 6% were African American, and 6% were Pacific Islander. The mean age was 40.6 years, and the mean number of years of clinical experience was 7.6; 40% were social workers, 24% were psychologists, and 36% were classified as“other” (eg, licensed mental health counselor). Therapists reported the following orientations: cognitive behavioral (38%), eclectic (23%), psychodynamic (15%), behavioral (8%), family systems (8%), and other (8%. There were no significant differences across conditions on any of the therapist characteristics.

Clinicians randomly assigned to SMT or MMT conditions received training in the specific treatment procedures plus weekly case consultation from project supervisors familiar with the protocols to assist the clinicians in applying the treatment procedures to children in their caseload. Therapists in the MMT condition used MATCH (Chorpita & Weisz, 2005), a

collection of modules designed to correspond to evidenced-based treatment procedures for anxiety, depression, and disruptive behavior. With MATCH, the therapist focuses on the initial problem area identified as most important. The flowchart for the problem area selected (e.g., depression) specifies a default sequence of modules. If interference arises (e.g., if a comorbid condition or stressor impedes use of the default sequence), the sequence is altered, with other modules used systematically to address the interference. Clinicians randomly assigned to UC agreed to use the treatment procedures that they used regularly and believed to be effective. Although clinicians assigned to UC may have had access to the manuals or materials used by clinicians in the standard or modular manualized conditions, actual implementation of the evidence-based treatments required extensive clinician supervision, coaching, and rehearsal, which was not provided to clinicians across treatment condition boundaries. Clinicians randomly assigned to the SMT or MMT conditions received 2 days of training on treatment for each problem area, for a total of 6 days. Subsequently, both SMT and MMT-assigned clinicians received weekly consultations on study cases from project supervisors; these supervisors were informed by participating in consultant-guided discussions of measurement feedback on client progress and practice history. Clinicians randomly assigned to UC received the usual supervision procedures in their settings, with no intervention from project personnel, to ensure that usual care would not be altered.

Participant inclusion criteria in the CTP intervention trial were as follows: a) primary diagnoses of an anxiety disorder, depressive disorder, or disruptive behavior disorder, or parent- or child reported disturbances of anxiety, depression, or disruptive behavior that did not meet criteria for clinical diagnosis; b) significant elevation ($T > 64$) on at least one of the Internalizing or Externalizing narrowband scales of the Child Behavior Checklist (CBCL) or Youth Self

Report (YSR); c) 7–13 years of age at the time of initial assessment; and d) primary language of English for parent and child. The assessments were performed in MH clinics and school-based behavioral health settings in cities and suburban areas of two U.S. states by trained members of the investigator team. Informants for the caregiver interviews were mothers (biological, adoptive, or step-mothers; *n* = 153; 85.5%), grandparents (*n* = 15; 8.4%), fathers (*n* = 9; 5.0%), uncle (*n* = 1; 0.6%), and great-great aunt (*n* = 1; 0.6%). Grade level ranged from 1 to 9, mean age was 10.64 years (SD = 1.80; range = 7.15–13.97), and 127 of the 184 participants were boys (69.0%). The sample included Non-Hispanic White (n = 81; 44.0%), multiethnic (n = 58; 31.5%), African American (n = 19; 10.3%), Hispanic or Latino (n = 12; 6.5%), Asian American (n = 7; 3.8%), Pacific Islander (n = 4; 2.2%), and other (n = 3; 1.6%) self-identified youth. Modal education level for parents was a high school diploma or equivalent. Household income was assessed with a checklist of ranges that spanned $20,000 each. The median income was in the $20,000 – $39,000 range (56.0% of the sample fell within or below this category) and supported 3.80 family members on average (SD = 1.43).

Participants

The current study subsample included participants that were treated in the MMT or UC arms (n = 135), received treatment for disruptive behavior within these arms (n = 66), had at least one treatment session after study randomization (n = 59), and had at least one available session recording in early treatment (i.e., first three treatment sessions; n = 46). Of these 46 cases, n=25 and n=21 cases were treated in the MMT and UC arms, respectively. See Table 3 for subsample descriptives. Parents were involved in early treatment sessions for 10 out of 21 UC cases (47.6%) and for 23 out of 25 MMT cases (92%). There were a total of 105 available session recordings out of 138 possible session recordings (76.1% recordings available) in early

treatment for these 46 cases (*M* = 2.28 recordings, *SD* = .83). Of these 105 session recordings, 64 included sessions with parents (61.0%). We included children that were treated for disruptive behavior, as this child treatment evidence-base demonstrates that active parent participation within and between sessions is indicated and is integral to the delivery of first-line interventions (e.g., parent management training), more so than anxiety and depression child treatments. Treatment within MMT and UC arms were assessed, as these treatments offer flexibility in the dose (amount and intensity) of psychoeducation and engagement practices compared to the SMT arm, which requires strict adherence to specific session-by-session content outlined in the treatment manual and therefore limits flexibility in practices employed by therapists.

Measures

Observational Coding of Psychoeducation and Engagement Practices use by Therapists.

An observational coding system was developed to code session recordings from the early phase of treatment (first three treatment sessions) to measure therapists' use of psychoeducational and other engagement strategies. The coding system was developed to align with the structure of the Therapy Process Observational Coding System – Strategies Scale (TPOCS-S; McLeod & Weisz, 2010) to characterize psychoeducation and engagement practices common in the literature on evidenced-based practice with children and families. As the MMT protocol includes psychoeducation and engagement content from the child therapy evidenced-base, some of the codes were derived from the MMT protocol. The coding system follows the structure of the TPOCS in that it includes both microanalytic and extensiveness scales. The microanalytic scale is intended to track the occurrence and frequency of therapists' use of specific psychoeducation and engagement practices over the course of a session. That is, occurrence indicates whether the strategy was observed during a session. This extensiveness

scale is designed to capture the extent to which the therapist conducts activities and/or discussions towards each psychoeducation and engagement strategy. That is, the extensiveness scale is intended to provide a rating of the intensity to which therapists use psychoeducation and engagement strategies within a treatment session. Intensity measures how actively and thoroughly a strategy was pursued throughout the session. Thus, intensity reflects both the time spent on the strategy and the thoroughness with which it was pursued. A *high intensity* rating reflects a high degree of effort or force that the therapist places in delivering an engagement strategy. A *low intensity* rating reflects reflect a cursory and/or incomplete application of the treatment strategy with limited follow-through. Extensiveness was rated at the end of the session for each observed strategy on a Likert scale of 1 to 7. See Appendix C for psychoeducation and engagement coding guidelines.

Strategies for each scale are based on psychoeducational and engagement practices used in the evidence-based practices literature base and reviewed in the Introduction. The psychoeducation scale consists of the following five strategies used by the therapist: 1) describing child behavior problems, 2) discussing causes of child's misbehavior, 3) describing goals of treatment program, 4) providing rationale for treatment, and 5) providing strategies for managing misbehavior. The engagement scale consist of the following six strategies used by the therapist: 1) collaborative goal setting, 2) validating and affirming parent's commitment to treatment, 3) checking in about past experiences and addressing concerns in treatment, 4) managing expectations and what can work, 5) defining roles in treatment process, and 6) addressing and problem-solving practical barriers to treatment. Due to the low base rate of individual engagement strategies, the engagement strategies were summed up to create a composite score of overall engagement strategies used by the therapist in a session.

Psychoeducation and engagement composites were derived by summing the individual strategies for psychoeducation and engagement. Thus, the psychoeducation composite was comprised of 5 individual psychoeducation strategies (composite total out of 35), and the engagement composite was comprised of 6 individual engagement strategies (composite total out of 42). Each psychoeducation and engagement strategy has 2-3 exemplars to aid in coding. For example, exemplars for discussing causes of child's misbehavior include: a) therapist discusses general factors that may contribute to misbehavior in children, b) therapist elicits from parent specific factors that may contribute to child's misbehavior, and c) therapist reflects/summarizes factors that may contribute to child's misbehavior (see Appendix C for psychoeducation and engagement coding guidelines).

Scoring Strategy. The observational coding scoring strategy is based on observational coding research (Hogue et al., 1996; McLeod & Weisz, 2005; McLeod & Weisz, 2010) and can be carried out to yield quantitative data that is non-subjective and specific with regard to how therapists carry out therapeutic strategies (Hogue et al., 1996). The scoring strategy involves microanalytic scales for raters to code the occurrence of specific psychoeducation or other engagement components during a given time segment (defined as five minute time periods) with an entire treatment session. Thus, the microanalytic scale can yield occurrence and observed frequency of use of each therapy practice. Extensiveness ratings were developed to measure the intensity to which therapists use psychoeducation and other engagement strategies within a treatment session. Intensity measures how actively and thoroughly a strategy was pursued throughout the session. Thus, intensity reflects both the time spent on the strategy and the thoroughness with which it was pursued. Extensiveness was rated for each observed strategy on a Likert scale of 1 to 7. Specific definitions for each point on the scale relevant to each strategy

are provided. See Appendix C for microanalytic and extensiveness rating scoring sheets. The psychoeducation and other engagement strategies used by the therapist were coded only if the strategies were directed at the parents in the session. *Coders.* The coding team consisted of the author and four undergraduate research assistants under the supervision of a clinical psychologist. Four coders were trained to assist the primary coder for the duration of the coding period. Training of coders included didactic training on the coding manual, review of specific session segments, practice scoring of sessions, and weekly coding meetings to discuss questions and inconsistencies. Interrater reliability was calculated across all coders for each of the items using intraclass correlations (ICCs). Coders were approved for coding after their ratings achieved acceptable interrater reliability (ICC $\geq$ .60; Cicchetti, 1994). Session recordings were randomly assigned to coders, and weekly coding meetings were held throughout the duration of coding to prevent rater drift.

Pilot Coding phase. The pilot coding phase was conducted to aid in the development of items for the coding system as well as train coders to establish adequate pre-study interrater reliability. A random sample of session tapes from early treatment sessions in the UC and MMT arms were coded. Based on the coding manual, the primary coder and four undergraduate student coders independently coded five therapy sessions. Items that demonstrated poor agreement during the pilot phase were refined or dropped. During the piloting phase, coders provided feedback on item content and definitions, which were used to refine the coding system items. After the piloting phase was completed, a final version of the coding manual was produced and utilized throughout the current study (see Appendix C for coding guidelines).

Inter-Rater Reliability. Of the 64 parent-attended sessions coded in the current study, 15 (23.4%) were randomly selected for double-coding to examine inter-rater reliability. ICCs below

.40 reflect “poor” agreement, .40 to .59 reflect “fair” agreement, .60 to .74 reflect “good” agreement, and .75 and above reflect “excellent” agreement (Cicchetti, 1994). The mean ICC for the psychoeducation extensiveness ratings was .77, and the mean ICC for the psychoeducation microanalytic occurrence codes was .75. The ICCs for the psychoeducation and engagement extensiveness scale composites (total scores) was .85 and .66, respectively. The ICCs for the psychoeducation and engagement microanalytic scale composites (any occurrence) was .96 and .64, respectively. Thus, all scales demonstrate acceptable reliability (ICC > .60). See Table 4 for ICC for all codes.

Parental Engagement Measures

Therapeutic Alliance. The quality of the parents’ working alliance with their child’s therapists was assessed via the Therapeutic Alliance Scale for Children (TASC; Shirk & Saiz, 1992). The 9-item scale comes in a parent-report form (parents reporting on their relationship with the child’s therapist). The parent measure has shown good internal consistency in a sample of 47 parents of clinic-referred youth (α =.92), and good 7-14-day test-retest reliability (r=.82) in a sample of 25 parents of clinic-referred youth. In the current sample, the parent-therapist alliance scale demonstrated good internal consistency (α = .84). Sample items included: “I looked forward to meeting with my child’s therapist, I liked spending time with my child’s therapist, and I feel like my child’s therapist was on my side and tried to help me.” Response items were on a 4-point Likert scale: “1-Not like me, 2-A little like me, 3-Mostly like me, and 4-Very much like me.”

Satisfaction with Services. The Parent and Child Satisfaction Scales (PCSS; Hawley, Weersing, & Weisz, 1998) consists of an 8-item parent-report on their satisfaction with their

child's services. The parent measure has shown good internal consistency in a sample of 47 parents of clinic-referred youth (α =.85), and good 7-14-day test-retest reliability (r=.83) in a sample of 25 parents of clinic-referred youth. In the current sample, the PCSS demonstrated good internal consistency (α = .91). Sample items included: "How would you rate the quality of services your child received, Did you get the kind of service you wanted for your child, How satisfied are you with the amount of help your child received?" Response items were on a 4-point Likert scale (e.g., 1-Quite dissatisfied, 2-Indifferent or mildy dissatisfied, 3-Mostly satisfied, 4-Very satisfied).

Session Attendance. Sessions attended by the parent in early treatment (session 1-3), after early treatment (after session 3 through to the end of the treatment episode), and throughout the course of treatment were documented. Therapists' use of psychoeducation and other engagement strategies measured in early treatment was used as a predictor of parent attendance after session 3. Parent attendance after session 3 was used as the key outcome variable, as including early treatment sessions would result in counting early attendance sessions toward the outcome variable that is being predicted. To examine consistency in treatment attendance (overall attendance regardless of whether the parent attended), we examined session density, which was the number of treatment sessions attended over the number of weeks of treatment. As typical treatment attendance requires 1 session per week, session density captures the consistency in weekly treatment attendance over the course of treatment, with higher scores approaching 1.0 reflecting closer to weekly attendance.

Results

Hypothesis 1: There will be a unique effect of therapist use of psychoeducation on promoting parental engagement, while controlling for therapists' use of other engagement strategies

Table 5 shows the bivariate correlations among all study variables of interest. Therapists' overall use of psychoeducation as well as therapist use of other engagement strategies were significantly associated with parent attendance throughout treatment and parent attendance after session 3. Psychoeducation and other engagement strategies were unrelated to parent-therapist alliance and parents' satisfaction with their child's services. As such, subsequent analyses focused on parent attendance throughout treatment and beyond session 3 as the main parent engagement outcome of interest

Multiple regression analyses were run to determine the unique effect of therapists' use of psychoeducation on promoting parental engagement, while controlling for therapist use of other engagement practices. As predicted, psychoeducation was found to be uniquely associated with parent attendance throughout treatment ($B = .036$, $p < .01$), even after controlling for therapists' use of other engagement strategies. This significant pattern held when assessing parent attendance after session 3 ($B = .044$, $p < .01$), with therapist use of other engagement strategies having no significant independent association with parent attendance.

To determine which specific psychoeducation strategies promoted parental attendance, a series of multiple regression analyses were run to examine the effect of specific psychoeducation strategies on parental engagement, while controlling for therapist's use of other engagement strategies. *Discussing causes of child's behavior problems* and *describing goals of treatment program* were found to be significantly related to parent attendance throughout treatment and

after session 3, while controlling for therapists' use of other engagement strategies. See Table 6 for summary of regression models.

Hypothesis 2: There will be more observable therapist use and intensity of psychoeducation and engagement practices in MMT vs. UC early treatment sessions

Psychoeducation Strategies Observed in Early Parent-Attended Treatment Sessions

Table 7 shows the occurrence rates and average extensiveness ratings for therapist use of psychoeducation strategies in the session recordings in which a parent was present. For the MMT condition, the rate of occurrence of each psychoeduction strategy directed to parents was above 60% with the exception of *providing rationale for treatment* (27.7%). Average extensiveness ratings of the psychoeduction strategies in the MMT condition was M = 2.9, with *providing rationale for treatment* as the lowest average extensiveness rating (M = 1.8) and *providing strategies to manage misbehavior* as the highest average extensiveness rating (M = 3.4). The psychoeducation composite occurred in 95.7% of MMT sessions, with an average extensiveness rating of M = 14.4 (SD=5.3). For the UC condition, the rate of occurrence of each psychoeducation strategy was below 40%. Average extensiveness ratings of the psychoeducation strategies in the UC condition was M = 1.6, with all strategies having low intensity ratings (<2). The psychoeducation composite occurred in 52.9% of UC sessions, with an average extensiveness rating of M =7.9 (SD = 5.3).

Independent samples t-tests were conducted to examine differences in psychoeducation strategies delivered in parent sessions between the MMT and UC treatment conditions (see Table 8 and Figure 3). For these analyses, in order to obtain one score for each case, extensiveness ratings for early treatment sessions were averaged (i.e., average ratings for treatment sessions 1-3 for each case). As predicted, parents of children in the MMT group received significantly higher

extensiveness ratings for all psychoeducation strategies than parents of children in the UC condition (with the exception of *providing rationale for treatment).*

Engagement Strategies Observed in Early Parent-Attended Treatment Sessions

For early parent-attended treatment sessions, the engagement composite occurred in 87.0% of MMT sessions with an average extensiveness rating of $M = 13.4$ ($SD = 5.3$). For UC sessions, the engagement composite occurred in 58.8% of sessions, with an average extensiveness rating of $M = 9.2$ ($SD = 3.8$). Independent samples t-tests were conducted to examine differences in engagement strategies delivered to parents between the MMT and UC treatment conditions. As predicted, parents of children in the MMT group received significantly higher engagement composite extensiveness ratings ($M = 13.3$, $SD = 3.5$) than parents of children in the UC condition ($M = 8.2$, $SD = 2.3$; $t = -4.9$, $p < .001$).

Hypothesis 3: Parent engagement outcomes will be superior in MMT compared to UC

Parental attendance by treatment condition (MMT vs. UC)

Participants attended an average of $M = 14.59$ ($SD = 10.74$) sessions (range = 2 – 41) during the study period. Of the 105 coded early treatment sessions (i.e., sessions 1-3), parents attended 64 sessions (61.0%). As predicted, parent attendance varied significantly by treatment condition, with MMT parents attending more sessions than UC parents. For early treatment sessions, UC parents attended 17 out 53 sessions (32.1%), while MMT parents attended 47 out of 52 sessions (90.4%; $t = -7.56$, $p < .001$). Parent attendance beyond early treatment (i.e., after session 3) also varied significantly by treatment condition, with UC parents attending 28.0% of sessions and MMT parents attending 71.6% of sessions ($t = -3.6$, $p < .01$). Parent attendance over the entire course of treatment varied significantly by treatment condition, with UC parents

attending 30.9% of sessions and MMT parents attending 91.4% of sessions (t= -6.3, p < .001). However, session density (i.e., # of treatment sessions attended over the # of weeks of treatment) was not significantly different between conditions; MMT =.53 (*SD*=.19), UC = .53 (*SD*=.24) with families in each group attending a session on average about once every two weeks during the episode of care.

Parental Satisfaction and Alliance in Child MHS

There were no significant differences between MMT vs. UC conditions in parental-report measures of satisfaction with child MHS and parent-therapist alliance (See Table 9).

Hypothesis 4: The effect of treatment condition (MMT vs. UC) on parent attendance will be mediated by therapists' use of psychoeducation strategies, while controlling for use of engagement strategies.

The proposed mediational relationship was examined using the INDIRECT macro for SPSS (Preacher & Hayes 2008), which estimates the total, direct, and indirect effects of a predictor variable on an outcome variable through a proposed mediator variable (or multiple mediators), and allows controlling for the influence of other variables. Estimates of all paths are calculated using ordinary least squares regression. To test for significant mediation, the INDIRECT command utilizes bootstrapping - a nonparametric resampling procedure. Indirect effect estimates are calculate across 5000 bootstrap samples, along with 95% confidence intervals for the indirect effects. Bootstrapping is a preferred test for significant mediation (i.e., significant indirect effect) over the Sobel test, particularly for smaller samples, because it makes no sampling distributional assumptions of the indirect effect. When evaluating multiple mediators in one model, the INDIRECT command also calculates bootstrap tests of contrasts between the indirect effects.

Figure 4 depicts findings of the mediation model. This mediation model used the psychoeducation composite as the hypothesized mediator and controlled for therapists' use of other engagement strategies. The effect of treatment condition (MMT vs UC) on pychoeducation was significant (B = 4.56, p < .01). The direct effect of psychoeducation on parent attendance was not significant, (B = .03, p = .08). However, this path is not required to be significant to test for mediation using the Preacher & Hayes (2008) method. The total effect of treatment condition on parent attendance was significant, with higher parent attendance in MMT vs. UC (B = .40, p < .05). However, the direct effect of treatment condition on parent attendance was not significant (B = .25, p = .17). In other words, the effect of treatment condition on parent attendance was no longer significant when controlling for psychoeducation, suggesting the presence of mediation. To formally test for mediation (i.e. a significant indirect effect of treatment condition on parent attendance via psychoeducation), the bootstrap confidence intervals were assessed, and revealed no significant indirect effect (Bootstrap mean of indirect effect B = .15, Bootstrap 95% CI = -.02, .40).

The INDIRECT command allows testing for multiple mediators in one model, and therefore the individual psychoeducation strategies were entered as multiple mediators, while still controlling for therapists' use of other engagement strategies (see Figure 5 for multiple mediator model). There was a significant effect of treatment condition on *describing child behavior problems* (B = 1.15, p < .05) and *discussing causes of child's misbehavior* (B = 1.61, p < .01), but no significant effect on *describing goals of treatment, providing rationale for treatment, and providing strategies to manage misbehavior.* The direct effect of these mediators on parent attendance was only significant for *discussing causes of child's misbehavior* (B = .12, p < .05). The total effect of treatment condition on parent attendance was significant, with higher

parent attendance in MMT vs. UC (B = .40, p < .05). However, the direct effect of treatment condition on parent attendance was not significant (B = .22, p = .24). In other words, the effect of treatment condition on parent attendance was no longer significant when controlling for multiple psychoeducation mediators, suggesting the presence of mediation. To formally test for mediation (i.e. significant indirect effects of treatment condition on parent attendance via individual psychoeducation mediators), the bootstrap confidence intervals were assessed, and revealed a significant indirect effect for *discussing causes of child's misbehavior* (Bootstrap mean of indirect effect B = .19, Bootstrap 95% CI = .001, .52). None of the specific contrasts between the various indirect effects were significant.

Discussion

The current study sought to examine the extent to which therapists employed psychoeducation and other engagement strategies, consistent with evidenced-based practices, within a randomized controlled trial of treatment for children with disruptive behavior. This study provides detailed data on the variability of psychoeducation and other engagement strategies employed by therapists in a modular evidenced-based treatment (MMT) and in UC. Psychotherapeutic strategies were observed in child MHS delivered to parents of children with disruptive behavior problems, which are the most common presenting problems in community-based MHS (Garland et al., 2001). Evidenced-based practices for disruptive behavior problems require active parent participation within and between sessions in which parents are taught to change their own parenting behavior and/or to support changes their children are making (Eyberg et al. 2008; Garland et al. 2008). Parent involvement in children's MH treatment has consistently been associated with improved child outcomes (Dowell and Ogles 2010; Karver et al. 2006), with children showing significantly more improvement when parents are actively

involved compared to individual child treatment (Dowell and Ogles 2010).

We hypothesized that therapists' use of psychoeducation strategies in early treatment would uniquely promote parental engagement in child treatment for disruptive behavior problems in ways that would support first line interventions for these problems. We anticipated that psychoeducation could promote parental involvement in treatment, even after accounting for other engagement strategies employed by the therapist. This was partially supported by the study findings, as psychoeducation independently predicted parent attendance beyond the initial treatment phase. However therapist use of psychoeduation was unrelated to other indicators of parent engagement (i.e, parent-therapist alliance and satisfaction). Although psychoeducation was associated with a greater proportion of sessions attended by parents and caregivers, it was not associated with parents' feelings of having a collaborative relationship with their child's therapist or satisfaction with their child's services.

In assessing the role of specific psychoeducation strategies, therapists' use of practices including *discussing causes of child's behavior problems* and *describing goals of treatment program* were found to significantly predict parent attendance, while controlling for therapists' use of other engagement strategies. These findings align with observational studies of predictors of parent involvment in child therapy. For example, parents' expectations about treatment and parent-youth agreement on the focus of treatment have been associated with improved family attendance (Brookman-Frazee et al., 2008; Nock & Kazdin, 2001). Preparing and orienting parents to their child's treatment using psychoeducation strategies can help address parental misconceptions about child MH problems and unrealistic treatment expectations, thereby increasing parent involvement in services. Indeed, a recent study suggests that the engagement interventions that outperformed other study groups (i.e., a comparison engagement intervention,

waitlist, no-treatment, or other control group) on indicators of family engagement utilize psychoeducation as a core element, and that psychoeducation specifically relates to enhanced treatment attendance, treatment adherence, and cognitive preparation (Becker et al., in review).

It was important in the current study to determine whether therapist use of psychoeducation strategies could predict parent engagement outcomes within the treatment conditions under study in the present examination. Because psychoeducation was tacitly included in the materials that the therapist could implement in the MMT condition, it was important to determine that our index of observed psychoeducation was not merely a proxy for adherence to the MMT protocol. As such, it was particularly important to establish whether the association between psychoeducation and parent engagement could be observed within the UC arm. In the UC condition, therapists' overall use of psychoeducation in early treatment was significantly associated with parent attendance beyond session 3, while overall use of engagement strategies were unrelated to parent attendance.

As hypothesized, there was more observable therapist use and intensity of psychoeducation and other engagement practices in MMT vs. UC early treatment sessions. Overall and specific psychoeducation strategies occurred in the majority of early treatment MMT sessions, but infrequently in UC sessions. When psychoeducation strategies were employed by UC therapists, they were delivered at a much lower intensity relative to MMT therapists, and thus not consistent with expectations of evidenced-based treatment approaches. . Psychoeducation may be characterized as a more directive treatment approach (Lukens & McFarlane, 2004), and more directive approaches have been associated with greater improvement in specific behavioral outcomes (Schoenwald et al., 2000). Research on adult psychotherapy finds that directive therapeutic approaches are not observed as frequently in UC

compared to evidenced-based treatment models (Malik et al., 2003). Therapists in UC clinics generally have positive attitudes about psychotherapeutic techniques that may be conceptualized as directive (Brookman-Frazee, Garland, Taylor, & Zoffness, 2009), and they employ psychoeducation with high frequency (81% of parent sessions) in the treatment of child disruptive behavior problems (Garland et al., 2010). However, UC therapists very rarely employ psychoeducation strategies (13% of parent sessions) with sufficient intensity (i.e. intensity ratings $\leq$ 4 on a likert scale of 1 to 6, indicating lack of high intenisty) to promote a well-developed understanding of causes of disruptive behavior, treatment rationale and expectations and roles of therapy (Garland et al., 2010).

Similarly, other engagement strategies occurred in the majority of early treatment MMT sessions, but infrequently in UC sessions. When engagement strategies were employed by UC therapists, they were delivered at a much lower intensity than MMT therapists. Although hypothesized, this result is surprising when one considers that UC therapists often spend much time using eclectic strategies to engage clients, often at the expense of delivering evidenced-based, cognitive and behavioral strategies (McLeod & Weisz, 2005). It is important to note that the engagement strategies that were observationally coded corresponded to practices found in evidenced-based interventions that utilize enhanced engagement strategies. These practices included collaborative goal setting, validating and affirming parents commitment to treatment, addressing past negative treatment experiences and concerns, managing expectations for treatment process, defining roles in treatment, and problem-solving barriers to care. UC therapists may spend a great deal of time on certain things such as joining empathically with parents to engage and build rapport, in ways that do not necessarily position the parent to be an active agent in the child's treatment. Additionally, UC therapists may place an emphasis on

engagement, but may direct most of their attention on engaging their child clients in their intervention rather than the parents. This is supported by the significantly higher proportion of child-only sessions in UC relative to MMT.

Levels of parent engagement in treatment for child disruptive behavior was characterized across treatment arms, and it was hypothesized that parents assigned to receive MMT would demonstrate higher engagement in services than parents in UC. This hypothesis was partially supported. As predicted, parents in the MMT condition attended a much higher proportion of sessions than parents in the UC condition; however, there were no differences in parent ratings of the parent-therapist alliance and parents' satisfaction with services between MMT vs. UC conditions. That is, parents' feelings of having a collaborative relationship with their child's therapist and their satisfaction with their child's services were similar across MMT and UC conditions.

The findings of no significant differences in parent-rated alliance and satisfaction may be due to a lack of sensitivity in these measures to detect differences by treatment condition because of a a ceiling effect and demand characteristics (i.e. consumers wanting to provide positive feedback), as ratings of alliance and satisfaction were generally high (average alliance rating M = 3.5 out of 4, average satisfaction rating M = 3.5 out of 4). Parents across conditions reported such things as liking their child's therapist, that they agreed with their child's thearapist on what to work on, and that they were satisfied with the services their child received. Studies support that parents often express high satisfaction with services, regardless of whether those services result in behavioral improvement in their children (Garland, Aarons, Hawley, & Hough, 2003). While consumer demand characteristics may have contributed to high ratings of alliance and satisfaction, it should be noted that these measures were collected by independent assessors and

were not shared with clients' therapists. It should be highlighted that therapists' use of psychoeducation did not interfere with parent feelings of having a working, collaborative relationship with their child's therapist or their satisfaction with services. Importantly, pychoeducation impacts parent attendance, which is essential to implementing first line interventions for child disruptive behavior. Qualitative data from a study of parents of children served in the public mental health sector suggest that within-session, reliance on directive therapeutic practices may be strong predictors of parent attendance (Baker-Ericzén, Jenkins, & Haine-Schlagel, 2011). This finding that parent-rated measures of alliance and satisfaction were no different between UC and MMT may help dispel some of the concerns that community therapists have expressed that the use of evidenced-based treatments or manualized therapy may interfere with the development of therapeutic alliance and contribute to poorer engagement of families (Nelson, Steele, & Mize, 2006).

Finally, it was hypothesized that effect of treatment condition (MMT vs. UC) on parent attendance would be mediated by therapists' use of psychoeducation strategies, while controlling for use of other engagement strategies. This was partially supported by study findings. While treatment condition significantly predicted parent attendance (with higher parent attendance in MMT vs. UC), the direct effect of treatment condition on parent attendance was no longer significant when accounting for overall psychoeducation strategies. However, the indirect effect of treatment condition on parent attendance via psychoeducation did not reach statistical significance, thus indicating no significant mediation. There was evidence that therapist use of specific psychoeducation strategies mediated the relationship between treatment condition and parent attendance. Analyses revealed that *discussing causes of child's misbehavior* with parents in early sessions significantly predicted parent attendance beyond the early phase of treatment. A

formal test for mediation revealed a significant indirect effect of treatment condition on parent attendance via *discussing causes of child's misbehavior*, thus supporting the presence of mediation.

The psychoeducational strategy of *discussing causes of child's misbehavior* may have accounted for differences in parent attendance between treatment conditions due to increasing parents' understanding of factors associated with child misbehavior. Therapist behaviors for this strategy include highlighting the role of parent characteristics in contributing to child misbehavior as well as other factors that they believe are relevant to misbehavior in their own children. Parents who hold biopsychosocial etiological beliefs about causes of child problems are more likely to utilize MHS to address those problems (Yeh et al., 2005). *Discussing causes of child's misbehavior* may address parents' misperceptions about causes of misbehavior and highlight causes of misbehavior that can be targeted in evidence based treatments for child disruptive behavior that leverage parent participation. As parental misconceptions about child MH problems and unrealistic expectations for treatment have been related to poor engagement (Morrisey-Kane & Prinz, 1999, Nock, Ferriter, Holmberg, 2007), preparing and orienting families for treatment by discussing parent and other relevant factors may increase parents' motivation for active involvement.

The results of the current study should be interpreted in light of some study limitations. First, although we utilized multiple measures of parental engagement, we did not examine the quality of parent's engagement in session (e.g., listening attentively, being receptive to new ideas, asking questions when appropriate, actively contributing to discussions and activities, etc.). Second, engagement in services could have also been captured by assessing premature termination from treatment. However, we did not assess for premature termination, as there were

heterogeneous reasons for early termination, which may not have been elected by the family (e.g., therapist leaving agency). Third, session recordings were not available for all early treatment sessions due to missing data, but there were no differences in missing recordings in MMT vs. UC. It is conceivable that some psychoeducation and engagement strategies occurred in sessions that were not recorded, and thus not captured in early treatment sessions adding error to our analysis. Fourth, the small sample size did not permit the examination of moderators of treatment attendance, such as racial/ethnic background. Given that ethnic minority families demonstrate poorer engagement in services, psychoeducation may be a particularly powerful tool for addressing cultural barriers, such as misconceptions about child MH problems and expectations for treatment. Despite these limitations, the current study has important merits that warrant consideration. The development of a reliable observational coding system to examine in-session use of psychotherapeutic strategies employed by therapists (as opposed to therapist self-report), inclusion of a relatively diverse group of patients and providers who are generally representative of other samples from community-based MH settings, assessing multiple indicators of parental engagement, and use of randomized sample of children in an evidenced-based treatment model and usual care are notable strengths of the current study.

Conclusion

Consistent with the existing literature, we found great variability in treatment session attendance among children and families receiving care in community-based MHS. The findings of low occurrence and extensiveness of psychoeducation and other engagement strategies employed by UC therapists reflect a cursory and/or incomplete application of the psychotherapeutic strategy with limited follow-through. These findings are consistent with research on community early intervention services that indicate that there are gaps between

research-based practices and those that are provided in the community (Stahmer 2007; Stahmer et al. 2005). While the observational measure used in the current study is not a measure of fidelity to a particular treatment, the low occurrence and intensity suggests that evidenced-based psychoeducation and engagement strategies are not being delivered in UC as thoroughly as would likely be present in an evidenced-based treatment model. Taken together, these findings replicate results from similar observational coding studies that show psychotherapeutic strategies conceptually consistent with evidence-based practices for children with disruptive behavior are delivered with some frequency in UC clinics, but are not delivered very intensively (Garland et al., 2010; Brookman-Frazee, Taylor, and Garland, 2010).

There is a substantial amount of research on client characteristic that predict treatment attendance. Understanding more about how specific within-session practices may influence parent attendance could elucidate the therapist's role in promoting client attendance, particularly for ethnic minority families that have evidenced higher rates of unmet MH need and increased barriers to care. These results support the need for training community therapist on psychoeducation strategies to enhance parent attendance, such as providing psychoeducation on the therapy process to parents prior to the start of treatment. Identifying engagement strategies for ethnic minority families is of particular importance (Miranda et al., 2005), as parental misconceptions about child MH problems, expectations for treatment, and the credibility of treatment have been related to treatment engagement, in that incongruent or unrealistic expectations lead to poor engagement (Morrisey-Kane & Prinz, 1999, Nock, Ferriter, Holmberg, 2007). Thus, preparing and orienting families for treatment using psychoeducational strategies can help alter misconceptions, thereby increasing engagement in services.

Appendix B: Tables and Figures

Table 3. Sample descriptives by treatment condition

	MMT Condition n=25		UC Condition n=21		Total Sample N=46	
	N (%)	*M (SD)*	*N (%)*	*M (SD)*	*N (%)*	*M (SD)*
Youth Gender						
Female	4(16.0)		7(33.3)		11(23.9)	
Youth Age		9.6(2.0)		10.4(1.7)		10.0(1.9)
Youth Race/Ethnicity						
Non-Hispanic White	12(50)		7(33.3)		19(42.2)	
Africa American	3(12.5)		4(19.0)		7(15.6)	
Latino	2(8.3)		1 (4.8)		3(6.7%)	
Mixed	6(25)		8(38.1)		14(31.1%)	
Other	1(4.2)		1(4.8)		2(4.4)	

Note. One participant had missing data on race/ethnicity

Table 4. ICC of psychoeducation strategies, psychoeducation composite, and engagement composite

Psychoeducation Strategies	Occurrence	Extensiveness
Describing Child Behavior Problems	.46	.76
Discussing Causes of Child's Misbehavior	.93	.83
Describing Goals of Tx program	.73	.68
Providing rationale for Tx	.63	.71
Providing Strategies for Managing Misbehavior	.99	.87
Psychoeducation Composite	.96	.85
Engagement Composite	.64	.66

Table 5. Bivariate correlations of all study variables

Variable	**1**	**2**	**3**	**4**	**5**	**6**	**7**
1. Psychoeducation Composite	-						
2. Engagement Composite	.70*	-					
3. Parent-Therapist Alliance	-.14	-.09	-				
4. Parent Satisfaction	-.08	-.10	.66*	-			
5. Session Density	-.12	.02	.07	.19	-		
6. Parent Attendance	.67*	.63*	-.17	-.23	-.31*	-	
7. Parent Attendance > 3	.50*	.35*	.08	-.09	-.45*	.77*	-

*Note: *p*<.05. Bivariate correlations were also run within each treatment condition to examine whether associations were similar across UC and MMT arms. In the UC condition, therapists' overall use of psychoeducation as well as therapist use of engagement strategies were significantly associated with parent attendance throughout treatment, but only psychoeducation was significantly associated with parent attendance beyond session 3. However, in the MMT condition, neither therapists' use of psychoeducation nor engagement strategies were related to parent attendance throughout treatment or beyond session 3.

Table 6. The effect of psychoeducation on parental attendance, controlling for other engagement strategies

Psychoeducation Strategies	Parent Attendance throughout treatment		Parent Attendance after session 3	
	B (*SE*)	*t*	*B* (*SE*)	*t*
Model 1: Describing child behavior problems	.06 (.04)	1.55	.06 (.05)	1.23
Model 2: Discussing causes of child's misbehavior	.09 (.03)	2.88**	.10 (.04)	2.53*
Model 3: Describing goals of treatment	.10 (.05)	2.14*	.13 (.06)	2.13*
Model 4: Providing rational for treatment	.02 (.08)	.25	.06 (.10)	.61
Model 5: Providing strategies to manage misbehavior	.05 (.04)	1.14	.06 (.05)	1.17
Model 6: Psychoeducation Composite	.04 (.01)	2.87**	.04 (.02)	2.68*

Note: *p<.05, **p<.01. All models control for therapists' use of other engagement strategies. Analyses were also run within the UC condition, which revealed that psychoeducation was uniquely associated with parent attendance throughout treatment (B = .130, p < .05) and parent attendance after session 3 (B =.152, p <.01). Therapist use of engagement strategies had no significant effect on parent attendance variables in the UC condition. The specific psychoeducation strategies of *discussing causes of child's behavior problems* and *describing goals of treatment program* were found to be significantly related to parent attendance throughout treatment and after session 3.

Table 7. Occurrence and extensiveness of psychoeducation strategies in early parent-attended treatment sessions

Psychoeducation Strategies	MMT (n=47)		UC (n=17)	
	% of sessions strategy observed	Extensive *M* (*SD*)	% of sessions strategy observed	Extensive *M* (*SD*)
Describing child behavior problems	66.0	2.9 (2.0)	29.4	1.5 (1.0)
Discussing causes of child's misbehavior	61.7	3.2 (2.3)	35.3	1.7 (1.3)
Describing goals of treatment	70.2	3.0 (1.7)	29.4	1.8 (1.6)
Providing rational for treatment	27.7	1.8 (1.5)	5.9	1.2 (1.0)
Providing strategies to manage misbehavior	61.7	3.4 (2.4)	23.5	1.7 (1.5)
Psychoeducation Composite	95.7	14.4 (4.7)	52.9	7.9 (4.5)

Table 8. Average psychoeducation extensiveness ratings in early parent-attended sessions between MMT vs. UC cases

Psychoeducation Strategies	MMT n=23	UC n=10	*t*(31)
Describing child behavior problems	3.0 (1.7)	1.3 (.7)	-3.9*
Discussing causes of child's misbehavior	3.4 (1.8)	1.7 (1.3)	-3.2*
Describing goals of treatment	2.8 (1.3)	1.6 (.8)	-3.3*
Providing rational for treatment	1.6 (.9)	1.1 (.4)	-1.9
Providing strategies to manage misbehavior	3.3 (1.6)	1.4 (1.1)	-4.2*
Psychoeducation Composite	14.1 (4.0)	7.1 (3.0)	-5.6*

Note. *$p<.05$

Table 9. Parental engagement outcome measures by treatment condition

Engagement Outcomes	MMT n=25	UC n=21	*t*(44)
Parent Attendance All[a]	.92 (.20)	.31 (.41)	-6.3*
Parent Attendance > Session 3[a]	.72 (.41)	.28 (.41)	-3.6*
Session Density	.53 (.19)	.53 (.24)	.06
Alliance	31.71 (4.90)	32.70 (3.73)	.73
Satisfaction	28.27 (3.83)	28.05 (2.63)	.75

Note. **p*<.05. [a] = proportion of sessions attended by parent.

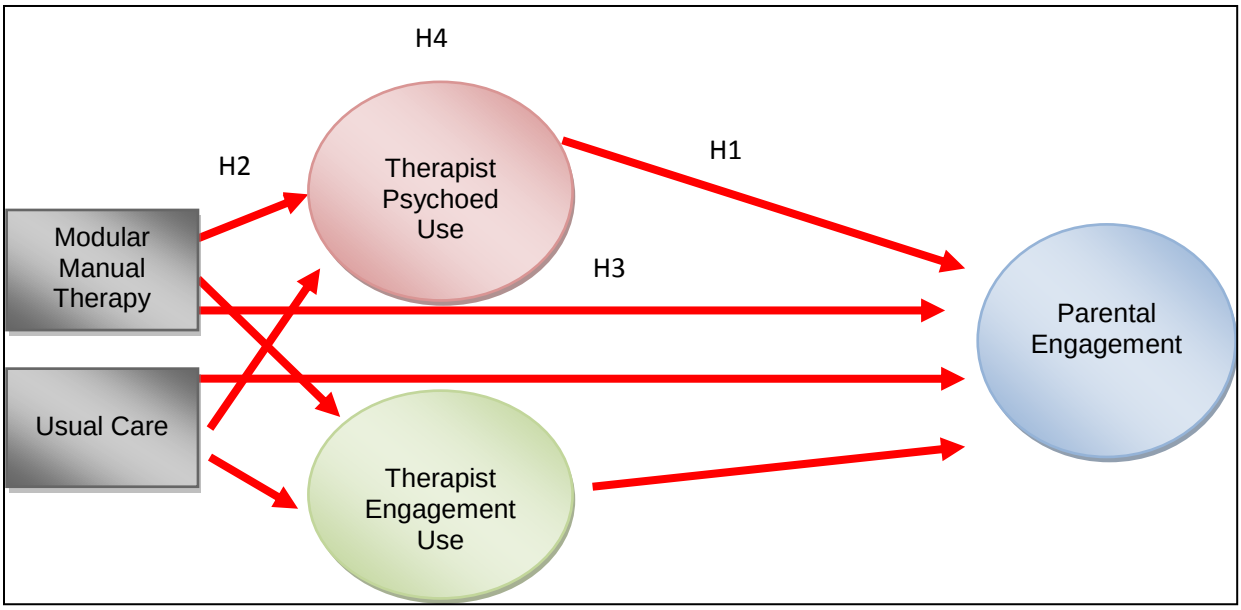
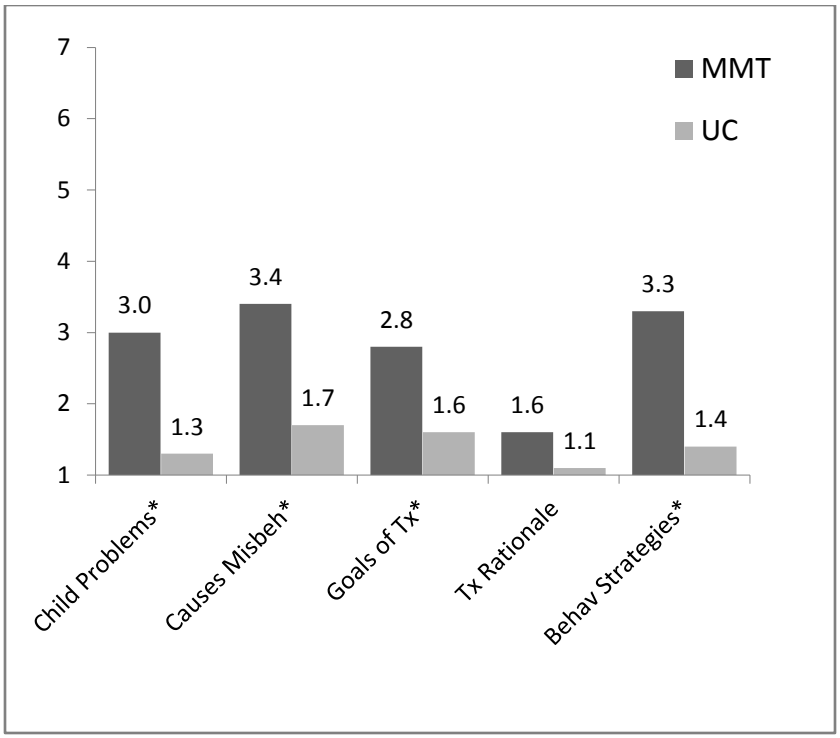


Figure 2. Study 1 Model



Note. *$p<.05$

Figure 3. Average psychoeducation extensiveness ratings in early parent-attended sessions by condition

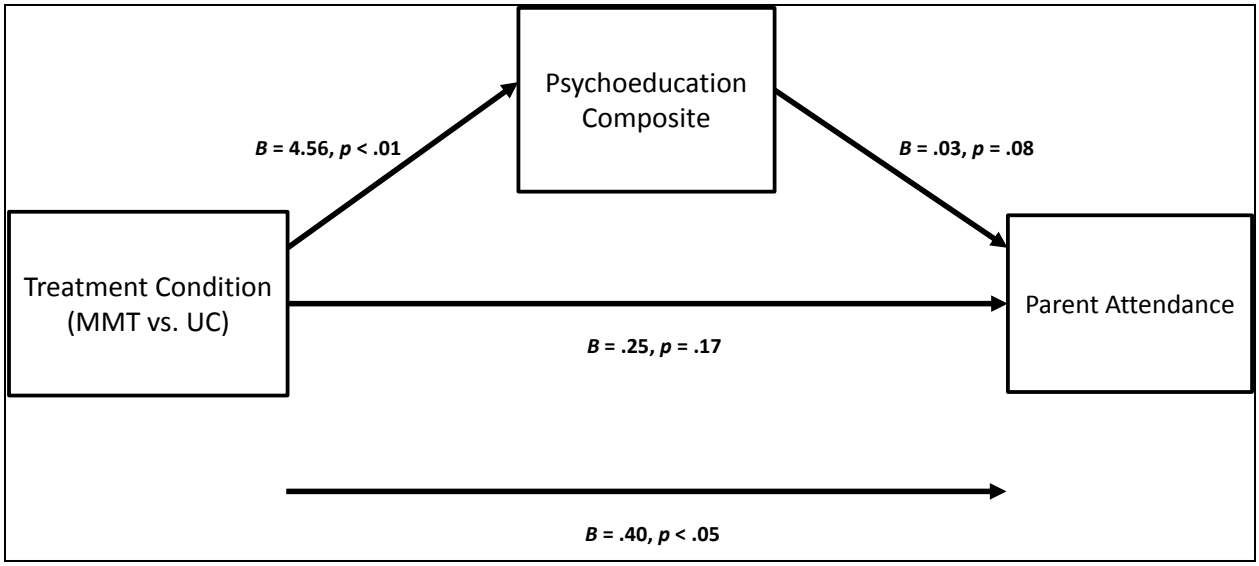


Figure 4. Mediation model, controlling for therapists' use of engagement strategies

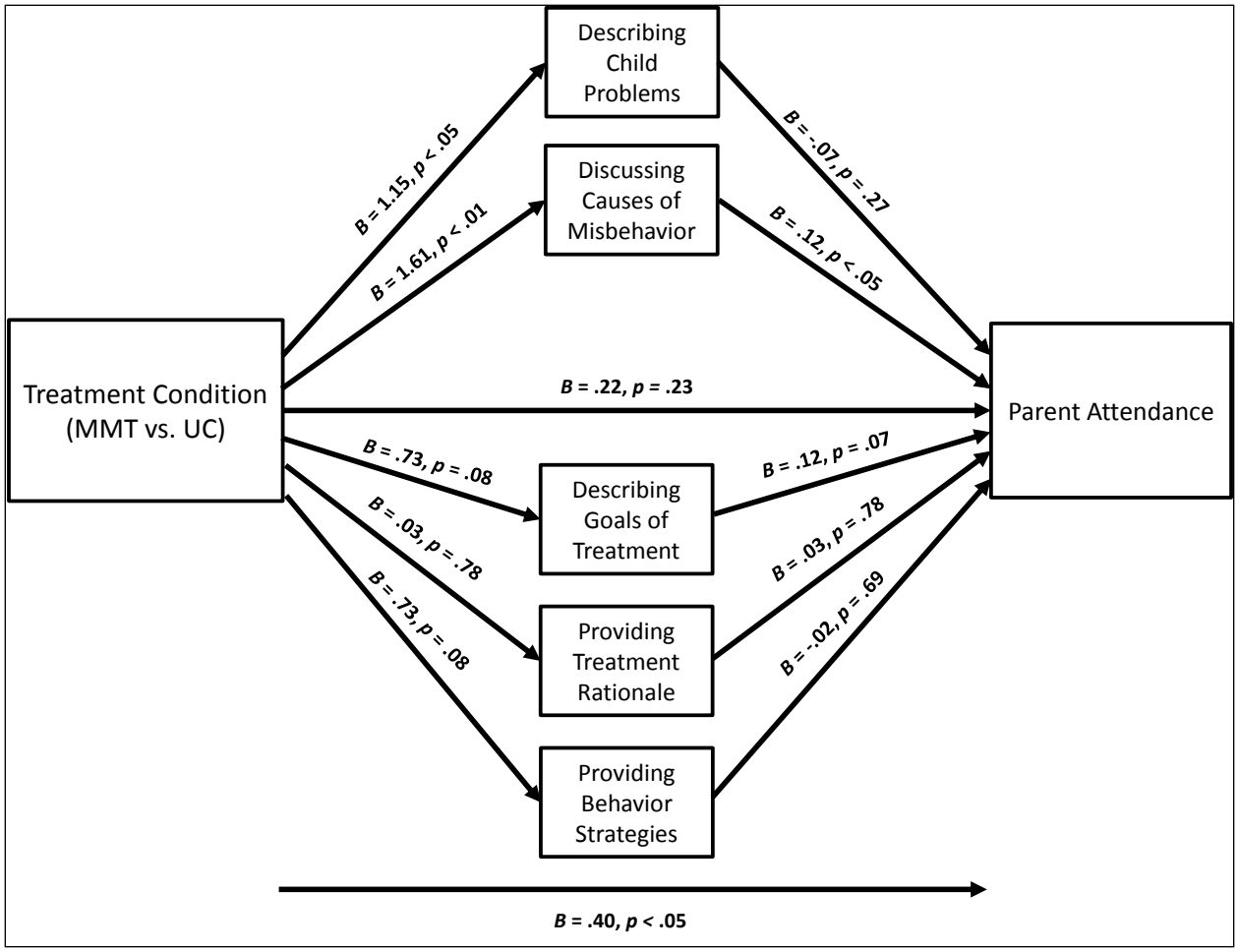


Figure 5. Multiple mediation model, controlling for therapists' use of engagement strategies

PSYCHOEDUCATION CODING GUIDELINES

DESCRIBING CHILD BEHAVIOR PROBLEMS: Extent to which therapist describes child behavior problems in general, behavior problems specific to the child, and provides informational handouts on child behavior problems

MICROANALYTIC RATING

This item is designed to capture the frequency with which the therapist describes child behavior problems

EXEMPLARS

The following are examples of items that the therapist should perform to reach the goal of describing child behavior problems:

- Therapist describes child behavior problems in general (e.g., symptoms, diagnoses, impairment)
- Therapist describes behavior problems specific to the child (e.g., symptoms, diagnoses, impairment)
- Therapist provides informational handouts on child behavior problems

EXTENSIVENESS RATING

This extensiveness item is designed to capture the extent/intensity to which the therapist conducts activities/discussions towards the goal of describing child behavior problems

Intensity is the amount of effort or the force the therapist places in the behavior when it occurs

Score	Example
1	Therapist does not conduct any activities listed under exemplars
2	Therapist conducts **1** of the activities listed under exemplars with low intensity
3	Therapist conducts **2** of the activities listed under exemplars with low intensity
4	Therapist conducts **3** of the activities listed under exemplars with low intensity
5	Therapist conducts **1** of the activities listed under exemplars with high intensity
6	Therapist conducts **2** of the activities listed under exemplars with high intensity
7	Therapist conducts **all 3** of the activities listed under exemplars with high intensity

DISCUSSING CAUSES OF CHILD'S BEHAVIOR PROBLEMS: Extent to which therapist discusses general factors that may contribute to child misbehavior, elicits specific factors from parent, and reflects/summarizes contributing factors

MICROANALYTIC RATING

This item is designed to capture the frequency with which the therapist discusses causes of child's behavior problems

EXEMPLARS

The following are examples of items that the therapist should perform to reach the goal of discussing causes of child's behavior problems:

- Therapist discusses general factors that may contribute to misbehavior in children
- Therapist elicits from parent specific factors that may contribute to child's misbehavior
- Therapist reflects/summarizes factors that may contribute to child's misbehavior

EXTENSIVENESS RATING

This extensiveness item is designed to capture the extent/intensity to which the therapist conducts activities/discussions towards the goal of discussing causes of child's behavior problems

Intensity is the amount of effort or the force the therapist places in the behavior when it occurs

Score	Example
1	Therapist does not conduct any activities listed under exemplars
2	Therapist conducts **1** of the activities listed under exemplars with low intensity
3	Therapist conducts **2** of the activities listed under exemplars with low intensity
4	Therapist conducts **3** of the activities listed under exemplars with low intensity
5	Therapist conducts **1** of the activities listed under exemplars with high intensity
6	Therapist conducts **2** of the activities listed under exemplars with high intensity
7	Therapist conducts **all 3** of the activities listed under exemplars with high intensity

DESCRIBING GOALS OF TREATMENT PROGRAM: Extent to which therapist describes what will occur during treatment sessions and describes specific treatment goals or changes that can occur for parent and child

MICROANALYTIC RATING

This item is designed to capture the frequency with which the therapist describes goals of treatment program

EXEMPLARS

The following are examples of items that the therapist should perform to reach the goal of describing goals of treatment program:

- Therapist describes what will occur during treatment sessions
- Therapist describes specific treatment goals or changes that can occur for parent and child

EXTENSIVENESS RATING

This extensiveness item is designed to capture the extent/intensity to which the therapist conducts activities/discussions towards the goals of describing goal of treatment program

Intensity is the amount of effort or the force the therapist places in the behavior when it occurs

Score	Example
1	Therapist does not conduct any activities listed under exemplars
2	Therapist conducts **1** of the activities listed under exemplars with low intensity
3-4	Therapist conducts **2** of the activities listed under exemplars with low intensity
5	Therapist conducts **1** of the activities listed under exemplars with high intensity
6-7	Therapist conducts **all 2** of the activities listed under exemplars with high intensity

PROVIDING RATIONALE FOR TREATMENT: Extent to which therapist provides evidence of efficacy of treatment, discusses consequences of untreated behavior problems, and provides informational handouts about treatments for problems.

MICROANALYTIC RATING

This item is designed to capture the frequency with which the therapist provides rationale for treatment

EXEMPLARS

The following are examples of items that the therapist should perform to reach the goal of providing rationale for treatment:

- Therapist provides evidence of efficacy of treatment
- Therapist provides evidence of consequences of untreated behavior problems
- Therapist provides handouts about treatment for behavior

EXTENSIVENESS RATING

This extensiveness item is designed to capture the extent to which the therapist conducts activities/discussions towards the goal of providing rationale for treatment

Intensity is the amount of effort or the force the therapist places in the behavior when it occurs

Score	Example
1	Therapist does not conduct any activities listed under exemplars
2	Therapist conducts **1** of the activities listed under exemplars with low intensity
3	Therapist conducts **2** of the activities listed under exemplars with low intensity
4	Therapist conducts **3** of the activities listed under exemplars with low intensity
5	Therapist conducts **1** of the activities listed under exemplars with high intensity
6	Therapist conducts **2** of the activities listed under exemplars with high intensity
7	Therapist conducts **all 3** of the activities listed under exemplars with high intensity

PROVIDING STRATEGIES FOR MANAGING MISBEHAVIOR: Extent to which therapist provides strategies to manage child's misbehavior and provides rationale for strategies.

MICROANALYTIC RATING

This item is designed to capture the frequency with which the therapist provides strategies for managing misbehavior

EXEMPLARS

The following are examples of items that the therapist should perform to reach the goal of providing strategies for managing misbehavior:

- Therapist provides strategies to manage child's misbehavior
- Therapist provides rationale for strategies

EXTENSIVENESS RATING

This extensiveness item is designed to capture the extent to which the therapist conducts activities/discussions towards the goal of providing strategies for managing behavior

Intensity is the amount of effort or the force the therapist places in the behavior when it occurs

Score	Example
1	Therapist does not conduct any activities listed under exemplars
2	Therapist conducts **1** of the activities listed under exemplars with low intensity
3-4	Therapist conducts **2** of the activities listed under exemplars with low intensity
5	Therapist conducts **1** of the activities listed under exemplars with high intensity
6-7	Therapist conducts **all 2** of the activities listed under exemplars with high intensity

MICROANALYTIC SUBSCALE – PSYCHOEDUCATION

Instructions: Using the grid below, please indicate whether each specific psychoeducation component occurs during a given time segment (defined as five minute time periods). If a psychoeducation component occurs during a time segment place a check mark in the space provided in the grid corresponding to the correct item. Only record one checkmark per time period, even if the item occurs more than once in the 5-minute interval.

Microanalytic Items	T1	T2	T3	T4	T5	T6	T7	T8	T9	T10
Describing Child Behavior Problems										
a. Therapist describes child behavior problems in general (e.g., symptoms, diagnoses, impairment)										
b. Therapist describes behavior problems specific to the child (e.g., symptoms, diagnoses, impairment)										
c. Therapist provides handout on child behavior problems										
Discussing Causes of Child's Misbehavior										
a. Therapist discusses general factors that may contribute to misbehavior in children										
b. Therapist elicits from parent specific factors that may contribute to child's misbehavior										
c. Therapist reflects/summarizes factors that may contribute to child's misbehavior										
Describing Goals of Tx program										
a. Therapist describes what will occur during tx sessions										
b. Therapist describes specific tx goals or changes that can occur for parent and child										
Providing rationale for Tx										
a. Therapist provides evidence of efficacy of tx										
b. Therapist provides evidence of consequences of untreated behavior problems										
c. Therapist provides handouts about tx for behavior problems										
Providing Strategies for Managing Misbehavior										
a. Therapist provides strategies to manage child's misbehavior										
b. Therapist provides rationale for strategies										

EXTENSIVENESS SCALE – PSYCHOEDUCATION

Instructions: Listed below are the psychoeducation components that occurred during the session. Using the Likert scale provided below, please indicate the degree to which each component is present in the session you are viewing. Place the appropriate number from the Likert scale in the space provided next to each item.

Score	Example
1	Therapist does not conduct any activities listed under exemplars
2	Therapist conducts **1** of the activities listed under exemplars with low intensity
3	Therapist conducts **2** of the activities listed under exemplars with low intensity
4	Therapist conducts **3** of the activities listed under exemplars with low intensity
5	Therapist conducts **1** of the activities listed under exemplars with high intensity
6	Therapist conducts **2** of the activities listed under exemplars with high intensity
7	Therapist conducts **all 3** of the activities listed under exemplars with high intensity

_____**Describing Child Behavior Problems:** Extent to which therapist describes child behavior problems in general, behavior problems specific to the child, and provides informational handouts on child behavior problems

_____**Discussing Causes of Child's Behavior Problems:** Extent to which therapist discusses general factors that may contribute to child misbehavior, elicits specific factors from parent, and reflects/summarizes contributing factors.

_____**Describing Goals of Treatment Program:** Extent to which therapist describes what will occur during tx sessions and describes specific tx goals or changes that can occur for parent and child.

_____**Providing Rationale for Treatment:** Extent to which therapist provides evidence of efficacy of tx, discusses consequences of untreated behavior problems, and provides informational handouts about tx for problems.

_____**Providing Strategies for Managing Misbehavior:** Extent to which therapist provides strategies to manage child's misbehavior and provides rationale for strategies.

ENGAGEMENT CODING GUIDELINES

COLLABORATIVE GOAL SETTING: Extent to which therapist elicits main challenges going on with child or family, elicits goals or changes parent would like to see occur in child, and reviews/clarifies main challenges or goals

MICROANALYTIC RATING

This item is designed to capture the frequency with which the therapist participates in collaborative goal setting

EXEMPLARS

The following are examples of items that the therapist should perform to reach the goal of collaborative goal setting:

- Therapist elicits from parent main challenges going on with child or family
- Therapist elicits from parent goals or changes parent would like to see occur in child during treatment
- Therapist reviews and/or clarifies main challenges or goals that parent stated

EXTENSIVENESS RATING

This extensiveness item is designed to capture the extent/intensity to which the therapist conducts activities/discussions towards the goal of collaborative goal setting

Intensity is the amount of effort or the force the therapist places in the behavior when it occurs

Score	Example
1	Therapist does not conduct any activities listed under exemplars
2	Therapist conducts **1** of the activities listed under exemplars with low intensity
3	Therapist conducts **2** of the activities listed under exemplars with low intensity
4	Therapist conducts **3** of the activities listed under exemplars with low intensity
5	Therapist conducts **1** of the activities listed under exemplars with high intensity
6	Therapist conducts **2** of the activities listed under exemplars with high intensity
7	Therapist conducts **all 3** of the activities listed under exemplars with high intensity

VALIDATING AND AFFIRMING PARENT'S COMMITMENT TO TREATMENT: Extent to which therapist validates parent as caring adult, emphasizes that parent is expert on child, and reminds parent of his/her invaluable role in treatment process

MICROANALYTIC RATING

This item is designed to capture the frequency with which the therapist validates and affirms parent's commitment to treatment.

EXEMPLARS

The following are examples of items that the therapist should perform to reach the goal of validating and affirming parent's commitment to treatment:

- Therapist validates parent as caring adult
- Therapist emphasizes that parent is expert on child
- Therapist reminds parent of his/her invaluable role in treatment process

EXTENSIVENESS RATING

This extensiveness item is designed to capture the extent/intensity to which the therapist conducts activities/discussions towards the goal of validating and affirming parent's commitment to treatment

Intensity is the amount of effort or the force the therapist places in the behavior when it occurs

Score	Example
1	Therapist does not conduct any activities listed under exemplars
2	Therapist conducts **1** of the activities listed under exemplars with low intensity
3	Therapist conducts **2** of the activities listed under exemplars with low intensity
4	Therapist conducts **3** of the activities listed under exemplars with low intensity
5	Therapist conducts **1** of the activities listed under exemplars with high intensity
6	Therapist conducts **2** of the activities listed under exemplars with high intensity
7	Therapist conducts **all 3** of the activities listed under exemplars with high intensity

CHECKING IN ABOUT PAST EXPERIENCES AND ADDRESSING CONCERNS WITH TREATMENT: Extent to which therapist elicits from parent what has worked well/positive experiences and not worked well/negative experiences in treatment, and elicits concerns parent has with current treatment

MICROANALYTIC RATING

This item is designed to capture the frequency with which the therapist checks in about past experiences and addresses concerns with treatment

EXEMPLARS

The following are examples of items that the therapist should perform to reach the goal of checking in about past experiences and addressing concerns with treatment:

- Therapist elicits from parent what has worked well and/or positive experiences with treatment
- Therapist elicits from parent what has not worked well and/or negative experiences with treatment
- Therapist elicits any concerns parent has with current treatment

EXTENSIVENESS RATING

This extensiveness item is designed to capture the extent/intensity to which the therapist conducts activities/discussions towards the goals of checking in about past experiences and addressing concerns with treatment

Intensity is the amount of effort or the force the therapist places in the behavior when it occurs

Score	Example
1	Therapist does not conduct any activities listed under exemplars
2	Therapist conducts **1** of the activities listed under exemplars with low intensity
3	Therapist conducts **2** of the activities listed under exemplars with low intensity
4	Therapist conducts **3** of the activities listed under exemplars with low intensity
5	Therapist conducts **1** of the activities listed under exemplars with high intensity
6	Therapist conducts **2** of the activities listed under exemplars with high intensity
7	Therapist conducts **all 3** of the activities listed under exemplars with high intensity

MANAGING EXPECTATIONS AND WHAT CAN WORK: Extent to which therapist describes what will or will not occur in treatment process, and emphasizes working with parent to provide strategies to manage child's behavior

MICROANALYTIC RATING

This item is designed to capture the frequency with which the therapist manages expectations and describes what can work in treatment

EXEMPLARS

The following are examples of items that the therapist should perform to reach the goal of managing expectations and what can work:

- Therapist describes what will or will not occur in treatment process
- Therapist emphasizes working with parent to provide strategies to manage child's behavior

EXTENSIVENESS RATING

This extensiveness item is designed to capture the extent to which the therapist conducts activities/discussions towards the goal of managing expectations and what can work

Intensity is the amount of effort or the force the therapist places in the behavior when it occurs

Score	Example
1	Therapist does not conduct any activities listed under exemplars
2	Therapist conducts **1** of the activities listed under exemplars with low intensity
3-4	Therapist conducts **2** of the activities listed under exemplars with low intensity
5	Therapist conducts **1** of the activities listed under exemplars with high intensity
6-7	Therapist conducts **all 2** of the activities listed under exemplars with high intensity

DEFINING ROLES IN TREATMENT: Extent to which therapist describes parent, child, and therapist role in treatment and reinforces participation

MICROANALYTIC RATING

This item is designed to capture the frequency with which the therapist defines roles in treatment

EXEMPLARS

The following are examples of items that the therapist should perform to reach the goal of defining roles in treatment:

- Therapist describes parent's role in treatment and reinforces participation
- Therapist describes child's role in treatment
- Therapist describes his/her role in treatment

EXTENSIVENESS RATING

This extensiveness item is designed to capture the extent to which the therapist conducts activities/discussions towards the goal of defining roles in treatment

Intensity is the amount of effort or the force the therapist places in the behavior when it occurs

Score	Example
1	Therapist does not conduct any activities listed under exemplars
2	Therapist conducts **1** of the activities listed under exemplars with low intensity
3	Therapist conducts **2** of the activities listed under exemplars with low intensity
4	Therapist conducts **3** of the activities listed under exemplars with low intensity
5	Therapist conducts **1** of the activities listed under exemplars with high intensity
6	Therapist conducts **2** of the activities listed under exemplars with high intensity
7	Therapist conducts **all 3** of the activities listed under exemplars with high intensity

ADDRESSING AND PROBLEM SOLVING PRACTICAL BARRIERS TO TREATMENT: Extent to which therapist elicits from parent potential barriers to parent/child participation, and helps problem-solve barriers

MICROANALYTIC RATING

This item is designed to capture the frequency with which the therapist addresses and problem solves practical barriers to treatment

EXEMPLARS

The following are examples of items that the therapist should perform to reach the goal of addressing and problem solving practical barriers to treatment:

- Therapist elicits from parent potential barriers to parent/child participation in treatment
- Therapist helps problem-solve barriers

EXTENSIVENESS RATING

This extensiveness item is designed to capture the extent to which the therapist conducts activities/discussions towards the goal of addressing and problem solving practical barriers to treatment

Intensity is the amount of effort or the force the therapist places in the behavior when it occurs

Score	Example
1	Therapist does not conduct any activities listed under exemplars
2	Therapist conducts **1** of the activities listed under exemplars with low intensity
3-4	Therapist conducts **2** of the activities listed under exemplars with low intensity
5	Therapist conducts **1** of the activities listed under exemplars with high intensity
6-7	Therapist conducts **all 2** of the activities listed under exemplars with high intensity

MICROANALYTIC SUBSCALE – ENGAGEMENT

Instructions: Using the grid below, please indicate whether each specific engagement component occurs during a given time segment (defined as five minute time periods). If an engagement component occurs during a time segment place a check mark in the space provided in the grid corresponding to the correct item. Only record one checkmark per time period, even if the item occurs more than once in the 5-minute interval.

Microanalytic Items	**T1**	**T2**	**T3**	**T4**	**T5**	**T6**	**T7**	**T8**	**T9**	**T10**
Collaborative Goal Setting										
a. Therapist elicits from parent main challenges going on with child or family										
b. Therapist elicits from parent goals or changes parent would like to see occur in child during tx										
c. Therapist reviews and/or clarifies main challenges or goals that parent stated										
Validating and Affirming Parent's Commitment to Tx										
a. Therapist validates parent as caring adult										
b. Therapist emphasizes that parent is expert on child and thus knows child better than anyone										
c. Therapist reminds parent of his/her invaluable role in tx process and will rely on parent's involvement										
Checking in about Past Experiences and Addressing Concerns in Tx										
a. Therapist elicits from parent what has worked well in past and/or positive experiences with tx										
b. Therapist elicits from parent what has not worked in past and/or negative experiences with tx										
c.Therapist elicits any concerns parent has with current tx										
Managing Expectations and What Can Work										
a. Therapist describes what will or will not occur in tx process										
b. Therapist emphasizes working with parent to provide strategies to manage child's behavior										
Defining Roles in Tx Process										
a. Therapist describes parent's role in tx and reinforces participation										
b. Therapist describes child's role in tx										
c. Therapist describes his/her role in tx										
Addressing and problem-solving practical barriers to Tx										
a. Therapist elicits from parent potential barriers to parent/child participation in tx										
b. Therapist helps problem-solve barriers										

EXTENSIVENESS SCALE – ENGAGEMENT

Instructions: Listed below are the engagement components that occurred during the session. Using the Likert scale provided below, please indicate the degree to which each component is present in the session you are viewing. Place the appropriate number from the Likert scale in the space provided next to each item.

Score	Example
1	Therapist does not conduct any activities listed under exemplars
2	Therapist conducts **1** of the activities listed under exemplars with low intensity
3	Therapist conducts **2** of the activities listed under exemplars with low intensity
4	Therapist conducts **3** of the activities listed under exemplars with low intensity
5	Therapist conducts **1** of the activities listed under exemplars with high intensity
6	Therapist conducts **2** of the activities listed under exemplars with high intensity
7	Therapist conducts **all 3** of the activities listed under exemplars with high intensity

_____ **Collaborative Goal Setting:** Extent to which therapist elicits main challenges going on with child or family, elicits goals or changes parent would like to see occur in child, and reviews/clarifies main challenges or goals.

_____ **Validating and Affirming Parent's Commitment to Tx:** Extent to which therapist validates parent as caring adult, emphasizes that parent is expert on child, and reminds parent of his/her invaluable role in tx process.

_____**Checking in about Past Experiences and Addressing Concerns in Tx:** Extent to which therapist elicits what has worked well/positive experiences and not worked well/negative experiences in tx, and elicits concerns parent has with current tx.

_____ **Managing Expectations and What Can Work:** Extent to which therapist describes what will or will not occur in tx, and emphasizes working with parent to provide strategies to manage child's behavior.

_____ **Defining Roles in Tx Process:** Extent to which therapist describes parent's role in tx and reinforces participation, describes child's role in tx, and describes his/her role in tx.

_____ **Addressing and problem-solving practical barriers to Tx:** Extent to which therapist elicits from parent potential barriers to parent/child participation, and helps problem-solve barriers.

Study 2

The central aim of study 2 was to employ a mixed methods approach to investigate parent participation in SBMHS. A mixed methods approach allows the examination of quantitative data on parent involvement, and importantly, an assessment of consumer perspectives and contextual influences impacting care, thus providing a better understanding of the problem than either approach alone (Palinkas, Horwitz, Chamberlain, Hurlburt, & Landsverk, 2011). To investigate this main aim, 1) an analysis of quantitative data available by a SBMH program in the greater Los Angeles area was utilized to examine parent participationin their child's SBMHS, and 2) the collection of qualitative data via semi-structured interviews with parents of children who received SBMHS in the past academic year was utilized to better understand parent perspectives on barriers to treatment participation, parents' reports of therapist use of psychoeducation practices in SBMHS provided in the community, and parent's impressions of how psychoeducation strategies would be received by parents in SBMHS. Using this mixed methods approach, we investigated the following research questions. First, to what extent are parents actively involved in their children's SBMHS? This question was assessed first using quantitative analyses of SBMHS utilization in a local SBMH program. Second, to the extent that levels of parent participation in child treatment is limited, what are the barriers to parent participation in their child's SBMHS? Third, to what extent are therapists using psychoeducation practices in treatment of children in SBMHS. This was assessed indirectly through parents interview responses about what information their therapist provided about aspects of their child's MH problems and treatment. Fourth, what are parents attitudes toward therapists' use of psychoeducation practices in SBMHS?

Methods

Quantitative Study Participants

Participants were families that received therapy services in a SBMH program in an urban public school district in the greater Los Angeles area serving primarily immigrant, low-income families. Of the approximately 18,000 students enrolled, 40% are Hispanic and 52% are Asian American (predominantly Chinese). The district has 13 elementary schools (K-8) and 4 high schools. The SBMHprogram is funded by a Safe Schools/Healthy Students grant to provide comprehensive prevention and intervention services to reduce campus violence, student behavioral and substance-related problems, and to increase the reach of SBMHS. This SBMH program has generated the infrastructure to assess and meet student MH needs through a surveillance and referral system. Contracts are in place with over 20 community partner MH agencies to provide SMBHS on all campuses in this public school district and at nearby community clinics. That is, the SBMHS are not provided by school-employed personnel, but rather by MH providers from community partner MH agencies that offer on-site, school-based services. Most SBMH programs have similar, formal arrangements with community-based MH agencies that offer school-based services (Foster et al., 2005). Families who are Medicaid eligible can be served by providers in local public community MH agencies. Uninsured or underinsured youth receive SBMHS though contracts with nearby universities with clinical psychology training programs delivered by trainees supervised by licensed professionals. Most SBMH programs have intern-level and professional MH providers (National Association of School Psychologists, 2006). See Table 10 for SBMH provider characteristics.

Administrative data were obtained from this SBMH program. SBMHS referrals are made by school staff, parents, and students themselves, and a School Site Team (SST) triages

and assigns each referral to an appropriate provider. Next, the SST contacts the family, and prepares the family for subsequent contact with the service provider. The provider then contacts the student's caregiver to offer and coordinate care. Data from this SBMH program referral tracking system was used to determine whether students were referred to care during 2010-2011 year, and whether students attended an initial session.

Qualitative Study Participants

A sample of 10 Latino and 10 Chinese American parents whose children received SBMHS in this SBMH program were recruited for the current study. Eligibility for study participation included the following: 1) child was referred for SBMHS in the academic year 2011-12, 2) parent consented to services for child, 3) child received SBMHS (i.e., not exclusively group treatment), 4) child was enrolled in Kindergarten – 8th grade, 5) and child race/ethnicity is Latino or Chinese American. A random sample of 50 Latino and 30 Chinese parents that met the above eligibility criteria were contacted. Out of the 80 eligible cases drawn for recruitment, 20 parents agreed to participate, one parent declined participation, 44 could not be reached after repeated attempts using the contact information on record, and 15 expressed interest in the study but were not able to be scheduled (these may be considered passive declines to participate in the study).

Individual interviews were conducted with 10 Latino parents (six in English, four in Spanish) and 10 Chinese parents (six in Cantonese, three in Mandarin, and one in English). Parent interviews were completed by a biological parent (mothers = 18, fathers = 2). Children that received services ranged in age from 7 – 14 (M = 10.1, SD = 2.5), and grade ranged from 1st – 8th grade. Children were receiving SBMHS for a variety of presenting problems, including externalizing and internalizing disorders. Twelve children received services from a licensed

professional, and eight children received services from an unlicensed intern. The location in which treatment was provided was mostly at the child's school only (n = 12), although some received additional services at home and community clinics (n=8).

Parent Semi-structured Interview Procedure

The semi-structured parent interviews were conducted by two graduate students and an undergraduate research assistant. One graduate student is fluent in English and Spanish, and completed the Latino parent interviews. The other graduate student and research assistant are fluent in English and Chinese (Mandarin and Cantonese), and completed the Chinese parent interviews. Participants signed an informed consent approved by the UCLA Institutional Review Board prior to any research procedures conducted. The interviews lasted approximately 60 minutes, and were conducted at a location convenient for the parents (e.g., parent home, nearby library or coffee shop). Interviews were audio-recorded, transcribed in the language conducted, and translated into English by two undergraduate research assistants fluent in the languages in which the interviews were conducted.

The semi-structured interview (see Appendix D for interview guide) consisted of 25 open- and close-ended questions, with several follow up questions contingent upon participant responses. These questions probed for the following areas: a) whether parents were invited to attend sessions and their participation throughout treatment, b) barriers that were encountered to treatment participation and whether service providers were responsive in addressing barriers, c) parents expectations of their involvement in treatment and whether they had an active role in treatment, d) whether parents felt informed of their child's problems, the treatment provided, and their expected role, and e) parent's satisfaction with the treatment their child received. After the interview was completed, parents were asked to fill out a 17-item questionnaire on their

satisfaction with their child's services, parent-therapist alliance, and psychoeducation received in services (responses were provided on a 7-point likert scale).

Qualitative Coding of Parent Interviews

To capture the richness and potential diversity of parents' experiences in their child's SBMHS, the current study used qualitative interviews coded for a priori and emergent themes using a coding, consensus, and comparison methodology (Willms et al. 1990) that followed an iterative approach rooted in grounded theory (Glaser and Strauss 1967). Qualitative coding is particularly appropriate for gathering participants' in-depth, subjective experiences (Marshall and Rossman 2006). Four interviews (20%) were independently coded by the principal investigator and two research assistants to capture a priori themes and elicit emergent themes (i.e., themes surfacing from the interview text) within the interviews. Responses were assigned codes by considering the frequency of and salience with which (i.e., importance or emphasis) a parent discussed a particular theme. Segments of the texts, ranging from sentences to paragraphs, were assigned specific codes that enabled members of the research team to consolidate interview data into analyzable units. Disagreements in coding were resolved through discussion among research team members, and the coding of themes was modified accordingly based on these discussions. The codes were then applied to a new set of four interviews, and codes that displayed low frequency were either dropped (four codes dropped) or combined with other overlapping codes (six individual codes collapsed into three codes) . Reliability of coding was assessed, and after achieving acceptable ICC for each code, the final codebook was applied to the remaining 12 interviews.

Inter-rater Reliability

Of the 20 parent interviews coded in the current study, six (30%) were selected for

double-coding to assess inter-rater reliability. ICCs for each code are presented below in Table 11. ICCs below .40 reflect "poor" agreement, .40 to .59 reflect "fair" agreement, .60 to .74 reflect "good" agreement, and .75 and above reflect "excellent" agreement (Cicchetti, 1994). Average ICC for each theme ranged from .79 - .80, thus demonstrating good reliability.

Results

Quantitative Results on Parent Engagement

Descriptive analysis of a referral tracking system revealed that during 2010-2011, 1423 students in K-12 were referred for therapy services in a local SBMHprogram. Of those referred, 813 (57.1%) were K-8 students, including 558 (68.6%) Latino children and 128 (15.7%) Chinese American children. Of these 686 K-8 Latino and Chinese American student referrals, 554 (80.7%) of caregivers consented to services for their children. Ultimately, 425 students (76.7% of those whose caregivers consented to treatment, 62.0% of those referred) attended an initial session. The current analysis focused on this sample of families of students who received at least one SBMH session. This sample included families of 341 (80.2%) Latino children and 84 (19.8%) Chinese American children, 305 (71.7%) of whom reported that English was their primary language at home. Of these 425 students, the mean number of individual (i.e., child only) sessions was 10.93 (*SD* = 10.03), collateral parent (i.e., parent only) sessions was 1.58 (*SD* = 3.72) and family (i.e., parent and child) sessions was 0.77 (*SD* = 1.97). Of these 425 cases, 244 (57.4%) involved only child individual sessions with no parental attendance, 181 cases (42.6%) included at least one parent-attended session, and 143 cases (33.6%) had parental attendance beyond one session.

Logistic regression analyses were employed to identify predictors of parent attendance in SBMHS. Results revealed that Chinese American parents were less likely to attend at least one

treatment session compared to Latino parents (*OR* = .51, $p < .01$), and non-English speaking parents were less likely to attend at least one treatment session compared to English speaking parents (*OR* = .52, $p < .01$; see table 12)

Qualitative results on parent engagement

The final themes that emerged throughout the coding of parent interviews included the following: 1) parents experience barriers to parent participation in their child's services (e.g., therapist availability/schedule, confidentiality/privacy concerns, stigma, and language/cultural barriers), 2) the structure of SBMHS impedes parent participation (e.g., parents not asked to attend sessions, parents attempt to initiate contact, parents not informed of their role in their child's services, parents not included as active participants, 3) parents receive limited amount of psychoeducation about their child's MH problems and treatment (e.g., parents are not informed of child's behavior problems, parents do not have an understanding of what occurs, parents are not informed of child's tx plan and progress, parents' understanding of therapy is playing games, parents not informed of rationale/benefits of therapy, and 4) parents are motivated to be actively involved in their child's treatment (e.g., parents want a better understanding of their child's problems, parents would have preferred to have an active role in their child's treatment). The themes are presented in Table 11, along with the frequency with which parents raised each theme and the percentage of respondents who raised a particular theme. Data from the interviews are presented by theme, and passages from the interview transcripts are included to provide additional contextual information.

Barriers to parent participation in their child's SBMHS

In the current sample, 45% of parents expressed that the schedule and availability of the therapist at school was a barrier to parent participation. As one parent stated, *"Well the*

timing…it was only certain days that they were available or certain days that they would come in or sometimes school would have different events or functions and just, the timing was off, you know." Another parent reported, *"I am not saying that the therapy services are not good, but just we don't have time to go. We have to work. If the therapy sessions can be at the time when we are free, that would be great."* Most children attended sessions at their school during school hours, which reduces key logistical barriers to families accessing needed services, thus increasing access to care. However, many working parents may have difficulty attending sessions during school hours, and therefore parental attendance is compromised although access to children is facilitated.

More than a third (35%) of parents also expressed that confidentiality/privacy at school was a concern, which may lead to feelings of shame and stigma concerning children being seen as in need of mental health treatment. As one parent stated, *"Maybe for some parents, they would feel shame that their children receive this kind of counseling services because their children is always called out by someone. So maybe if the therapy happens at home, then it would prevent that kind of concern."* Similarly, another parent stated, *"Meeting at home or other place other than school will avoid the situation of my son gossiped by peers."*

Thirty percent of parents also expressed language/cultural barriers to participation in services, particularly language barriers. For example, one parent noted, *"Yes, it would be better if the counselor speaks Chinese. So I can get to know how the process of the therapy was and the therapist can tell me the strategies about how to help my son."* Another parent stated, *"If the counselor speaks the same language as me, then we would be able to communicate with each other. Now, I just asked the therapist randomly what I can do, you know, if the therapist speaks the same language, he/she can teach me step by step about how the process should be. I think it*

would be better."

Structure of parent involvement in SBMHS.

More than half (55%) of parents indicated that aside from an initial meeting to consent for services, they were not asked to attend treatment sessions. As one parent stated in response to whether she attended any sessions, *"No, because I didn't know about it…I didn't know that parents were required to attend the therapy sessions."* Another parent indicated that she never had any contact with the therapist, *"…The therapist didn't tell me anything. In fact, I had not met with the therapist. We had not talked to each other."* In fact, 35% of parents expressed that they initiated contact with therapists to gather information about their child and how they can help. As one parent stated, *"It was more me initiating…If there was anything, it's just feedback on the questions that I've been asking them."* Another parent reported, *"Usually, I called her, then I left a message, then the counselor called me back."*

Thirty percent of the sample expressed confusion about their role in their child's therapy services, with most indicating they were not informed of their potential role. As one parent noted, *"I don't know what my role should be",* while another parent stated, *"The therapist didn't tell me anything about what my role should be."* Parents reported that they were not included as active participants in their child's SBMHS. One parent expressed frustration about not being included, *"The truth is that when they tell us that they are going to give him therapy…in reality, they put us to the side. They say the role is between the boy, the student, and the counselor. We can't do anything."* Another parent indicated, *"Sometimes, I think, you know, what we have in Hong Kong is different. The counselor in Hong Kong will call you actively, they will tell me about how things are going on with my son, and so on. But here, they do not do that."*

Information parents receive about their child's problems and treatment

Half of the parents (50%) in the sample reported that they had not been informed of their child's diagnosis or target problems. As one parent stated, *"We never received information about what his problem is or anything… In reality we only wait for them to tell us what problem there is but he has never told us, he has never told us anything."* Another parent reported, *"No, she didn't discuss anything about the result with me. I hope that the therapist can tell me, and discuss the result with the parents."* Likewise, half of the parents in the study parents stated that they were uninformed about what occurred in their child's therapy. For example, one parent expressed, *"Actually, I don't know what the therapy is about…I don't know. I really don't know. I only remember that they asked me if I agree to let my son receive the therapy services, and then I said okay. But they didn't give me any information about it. They didn't tell me anything, and my son didn't tell me anything about it too."* Another parent stated, *"The therapist didn't tell me about anything or what was going on in the therapy… I asked the therapist about what the plan was, and how will she talk to him. Then the therapist said 'I know how to talk to him, but I cannot tell you.' Therefore, I didn't ask the therapist about the details."*

Similarly, one out of two parents in the sample reported that they were not informed of their child's treatment goals and progress. As one parent stated, *"…I think the therapist should let the parent know the progress of the child. At least let us know if the child gets improved. If there is no improvement, it might because of the parent's problem. The therapist should notify the parent, and ask the parent to make some adjustment."* Another parent noted. *"She [the therapist] is okay, but she didn't tell me about the progress….I want to know when he will be okay. I don't know how long the therapy would last."*

Five parents (25%) reported that their child's therapy consisted of the therapist observing or playing games with the child. As one parent stated, *"They would just say…we really can't*

help her so much, we're just trying to observe what she's going through or you know, give her just little things to either to play…certain games that they would do to see how kids would react to that." Another parent indicated that she met with therapist, but the time spent with her child was only playing, *"[The therapist] talked to me for about half an hour and then played games with my son for half an hour."*

In the current sample, 25% of parents indicated that were not informed of the rationale and/or benefits of therapy, and therefore expressed skepticism about effectiveness. *"The reason why I don't trust the therapy is that I don't think it is helpful and I don't think playing games with my son could change his temper and make him to be better…She didn't say anything about how it is going to be helpful."* Another parent expressed, *"A lot of that was a little bit too in depth for them to really, you know, for them to really assist her in that kind of way…I do understand also that they only have certain amount and some of them are interns, so it's not like they're, you know, officially licensed to practice or anything."*

Parents' motivation for involvement in child's SBMHS

A quarter of the parents interviewed expressed wanting a better understanding of their child's target problems and what they can do to help. For example, one parent stated, *"I expected to get more information from the therapist about what I could do to help my child."* Another parent noted, *"I hope that I can know more about how is the psychology about my child, how to communicate with them."* A large majority (70%) of parents reported that they would have liked to have had an active role in their child's therapy. As one parent noted, *"I wouldn't say that [therapy was helpful]. I guess what I was looking for in this therapy is to, again, assist us on skills on how to communicate with one another better…"* Another parent expressed wanting to take an active role, but that the structure of therapy did not allow it, *"Yes, I want to get*

involved…There is not enough time for the parents to talk to the counselor…It would be better to have three people together, and have more time for three people - parent, child, and counselor - to be together." Another parent stated, *"In my opinion, it is good if the parent can get involved 100% in the treatment process…The therapist should notify the parent, and ask the parent to make some adjustments…We need to help them to make judgments. Someone should help them instead of letting them deal with it themselves…I think it is very important to let the parent know what is going on, and let the parent know what they should do to help….I really need to know how my son is doing at school, and how his progress is, and what I should do to help."*

In some instances, parents being uninformed of their child's problems and treatment may have shaped beliefs that parents should not be involved at all, as 35% of parent believed that parental involvement would impact treatment negatively. As one parent stated, *"...I think I am useless during the therapy sessions"*, while another parent expressed, *"No, I don't think the parent could help."* In fact, some parents expressed that parental involvement may make matters worse. For example, one parent noted, *"The counselor told me that, if I sit there, the child would not talk as much as always…because sometimes, if you sit there, the child will not talk as much as usual…"* Similarly, another parent stated, *"…if I'm there, she'll either shut down or…if it was a quarrel between me and her or disagreement then that would be not very good, you know, for me to be in that session with her."*

Qualititative study themes that emerged from the parent interviews were examined by parent ethnicity (Latino vs. Chinese American) and by home language (English vs. non-English speakers). Results revealed that Chinese American parents and non-English speakers identified a number of engagement concerns at a significantly higher frequency than that of Latino parents (see Table 13).

Quantitative Survey Data

Parents were administered a short survey after completing the interview. Several items inquired about information parents' received about their child MH problems and services, and responses were provided on a 7-point likert scale (1-Never to 7-Always). On average, parents reported having a good understanding of why their child was referred for therapy services (M = 6.2, SD = 1.7). However, parents reported that they occasionally to sometimes felt that their child's therapist provided them with enough information about their child's behavior problems (M = 3.8, SD = 1.7). In response to whether their child's therapist gave them a good understanding of their role in their child's therapy, parents on average reported sometimes (M = 4.0, SD = 1.8). Lastly, parents reported that they occasionally to sometimes felt that their child's therapist provided them with a good understanding about what would be occurring in their child's therapy (M = 3.9, SD = 2.1).

Discussion

The current study employed a mixed methods approach to investigate parent participation in SBMHS, parent perspectives on barriers to treatment participation, parents' reports of therapist use of psychoeducation practices in SBMHS, and parent's impressions of how psychoeducational strategies may affect parent participation in SBMHS. Data from administrative records were collected from a SBMH program in an urban public school district in the greater Los Angeles area, and parents of children that received SBMHS in this program were interviewed.

It was hypothesized that parents of children that received SBMHS would report barriers to participation in their child's services. Indeed, nearly half of parents expressed that the

schedule and availability of the therapist at school was a barrier, and more than a third of parents expressed that confidentiality/privacy at school was a concern. Additionally, nearly a third of parents identified cultural barriers (e.g. language access, beliefs and expectations of parenting and therapy, etc), while one in five parents expressed that stigma about therapy was a concern. While barriers may prevent many families from accessing services, some have speculated that many of these barriers disproportionately affect ethnic minority families (Cheung & Snowden, 1990; Takeuchi et al., 1993; Trevino et al., 1991), and that barriers remain after accounting for structural barriers (Garland et al., 2005), suggesting the presence of cultural barriers (Cauce et al., 2002; Yeh et al., 2005). For example, stigma about child MH problems has been found to be associated with lower parental education (Mukolo, Heflinger, & Wallston, 2010). MH stigma is a problem across populations, but the literature suggests that shame and stigma are central barriers for Asian American families who view mental illness as highly stigmatizing and the need for help from sources outside one's family as shameful (Zane & Yeh, 2002; Cheung & Snowden, 1990; Liao, Rounds, & Klein, 2005). Thus, although SBMHS offer several advantages to overcoming practical barriers to accessing children, practical barriers and barriers related to beliefs about MHS remain for parents.

Parental participation in SBMHS was examined via administrative records and with parent interviews. As predicted, parental participation in SBMHS was quite low. Administrative data in a local SBMH program revealed that of those 425 children whose parents consented for services, more than half the parents (57.4%) did not attend a single session, and only a third of parent attended more than one session. Treatment consisted mostly of individual child sessions, with minimal parent attendance (only an average of 1.6 parent sessions and an average of .7 family sessions for all treatment sessions). Chinese American parents were less likely to attend at

least one treatment session compared to Latino parents, and non-English speaking parents were less likely to attend at least one treatment session compared to English speaking parents. Similarly, the qualitative interviews revealed low parent participation in child SBMHS. More than half of parents reported that aside from an initial meeting to consent for services, they were not asked to attend treatment sessions, and more than a third indicated that they were initiating contact. Nearly a third of parents indicated that they were not informed of their potential role, and over a third expressed that they were not included as active participants in their child's services. In most school-based programs, although children are receiving much needed services, there is an overreliance on individual child counseling (Weist, 1997), and schools may be reluctant to expend the extra effort needed to involve parents in services (Cerio, 1997). Reliance on individual child counseling in SBMHS is troubling, as evidenced-based treatments, especially for externalizing disorders, require active parent participation in sessions and family implementation of techniques between sessions in order for positive outcomes to occur (Nock & Kazdin, 2005).

We examined the extent to which parents reported that therapists used psychoeducation practices in treatment. In our interviews we asked parents to relate what their child's therapist told them about aspects of their child's presenting problems, treatment plan and activities in therapy. From parent responses we could infer that parents were frequently uninformed about many of these topics. Half of parents reported that they had not been informed of their child's diagnosis or target problems, what occurred in their child's therapy, and of their child's treatment goals and progress. A quarter of parents reported that therapy appeared to consist of the therapist observing or playing games with their child, and reported not being informed of the rationale and/or benefits of therapy. Under these conditions, 40% of parents in the interview sample

expressed skepticism about the therapist's ability to help their child. Parental beliefs about the credibility of treatment and expectations about treatment are significant predictors of engaging families in child MH services (Nock, Ferriter, & Holmberg, 2007).

The literature suggest that recognition of problems in children is a critical first step in receipt of care (Cauce, 2002), as parents' perception of their child's problems influences engagement in services (Angold et al., 1998; Burns et al., 1995; Farmer, Burns, Angold, & Costello, 1997; Pescosolido, 1992). Decisions to seek help may be related to a lack of MH literacy (i.e., lack of knowledge about MH problems and appropriate avenues for care), as many have speculated that beliefs about child MH problems may be related to service use decisions for those problems (Cheung & Snowden, 1990; Yeh et al., 2005). Understanding and addressing these parental beliefs and expectation via psychoeducation strategies is critical once families initiate services, as discrepancies in beliefs between parents and providers may lead to poorer engagement in services.

Parents' motivation for having an active role in their child's SBMHS was also assessed. Parents' appeared motivated to be involved in their child's services. The majority of parents (70%) reported that they would have liked to have had an active role in their child's therapy, and a quarter of the parents expressed wanting a better understanding of their child's target problems. Most research on barriers to care has focused on parent or family characteristics that are related to unmet MH need or poor engagement. These finding suggest that parents are motivated to be actively involved in their child's care and are interested in receiving information about their child's problems, yet the structure of SBMHS does not place an emphasis on including parents the various aspect of the treatment process. In some instances, parents being uninformed of their child's problems and treatment may have shaped beliefs that parents should not be involved at

all, as over a third of parent believed that parental involvement would impact treatment negatively.

The results of the current study should be interpreted in light of some study limitations. First, parent perspectives were assessed within a specific SBMH program, which may not be generalizable to other SBMH programs, particularly programs that exclusively provide services by school-employed personnel. However, most SBMH program have a similar structure of having SBMHS provided my community partner MH agencies (Foster et al, 2005). Second, parents participating in the study consented to services and participated in an interview for the research project, and thus the sample does not represent all families referred for SBMHS. Thus, our sample may be biased in favor of families who are open to involvement as they have already demonstrated an initial commitment to treatment and volunteered to participate in a research interview. Third, parents that were interviewed were primarily mothers. The extent to which fathers are disengaged in SBMHS should be examined in future studies. Despite the limitations, this study has several methodological strengths. This study used mixed methods and data sources to examine the extent of the problem of parental participation in SBMHS and to unearth possible explanations for the identified problem. Through integrating the quantitative and qualitative data, findings were triangulated, as there was consistency in findings of low parent participation in care.

Conclusion

This line of research highlights the utility of understanding parent perspectives from the outset in order promote parent participation in SBMHS. These findings suggest that to successfully engage ethnic minority families in treatment, an assessment of parents' beliefs and expectations about treatment should be done so that parent misconceptions can be addressed at

the outset of therapy. Thorough therapy orientation procedures are necessary so that families will have accurate information to guide their expectations and increase the perceived credibility of treatment (McCabe, 2005).

These results may inform the development of a psychoeducation-based engagement intervention at entry into care to target knowledge/belief barriers to parent participation in treatment. Psychoeducation strategies can increase parent engagement in child MHS, and may be a powerful tool for reducing barriers for ethnic minority families entering services. Psychoeducation strategies that target problem recognition barriers may be particularly important for families entering SBMHS, as many times parents are not the referring agent and thus may lack an understanding of child MH problems and the relevance of treatment. Addressing misperceptions about child MH needs may strengthen decisions to seek help and follow through with SBMH referrals. Treatment expectations and rationale for SBMHS can addressed, along with problem-solving barriers to successfully engagement families in care. Future research will include developing a psychoeducation-based engagement intervention for families entering SBMHS, and assess whether it promotes parent attendance compared to families that did not receive the procedure.

Appendix D: Tables and Figures

Table 10. SBMH provider characteristics and proportion of youth served

	Youth Served *N (%)*
Provider	
Alliant	222 (52.2)
Community MH Agencies	203 (47.8)
Training	
Student/Intern	272 (64)
Professional	153 (36)
Location	
School only	364 (85.6)
School and Agency/Home	61 (14.4)

Table 11. Themes, ICC, and occurrence

Themes	ICC	Freq	% of parents
Barriers to parent participation in child's therapy	.79[a]		
Availability/schedule of therapist	.92	26	45%
Confidentiality/Privacy	.73	9	35%
Stigma	.76	7	20%
Language/Cultural Barriers	.73	13	30%
Structure of parent involvement in child's therapy	.80 [a]		
Parents not asked to attend sessions	.97	19	55%
Parents initiate contact	.81	16	35%
Parents not informed of their role in child's therapy	.44	8	30%
Parents not included as active participants	.98	14	40%
Information parents receive about child's problems and tx	.78 [a]		
Parents not informed of child's behavior problems	.62	13	50%
Parents do not have understanding of what occurs	.88	23	50%
Parents not informed of child's tx plan and progress	.65	22	50%
Parents understanding of therapy is playing games	1.0	6	25%
Parents not informed of rationale/benefits of therapy	.60	7	25%
Parents skeptical of therapists' ability to help their child	.95	21	40%
Parent motivation for involvement in child's therapy	.79 [a]		
Parents want better understanding of child's problems	.60	10	25%
Parents would have preferred to have an active role	.87	42	70%
Parents involvement may impact treatment negatively	.91	9	35%

Note. [a] = average ICC for theme

Table 12. Predictors of parents attending at least one session

Variables	*OR*	*CI*
Child Age	.95	.88 – 1.03
Child Gender (Female vs. Male)	1.11	.74 – 1.65
Ethnicity (CA vs. LA)	.51**	.31 – .83
Home Language (non-English vs. English)	.52**	.34 – .80

Note. **p<.01

Table 13. Frequency of themes by race/ethnicity and home language

Themes	LA	CA	$\chi^2(1)$	Eng	Non-Eng	$\chi^2(1)$
n	10	10		7	13	
Barriers to parent participation in child's therapy						
Availability/schedule of therapist	12	14	.15	12	14	.15
Confidentiality/Privacy	3	6	1.0	2	7	2.78
Stigma	2	5	1.29	2	5	1.29
Language/Cultural Barriers	0	13	13*	0	13	13*
Structure of parent involvement in child's therapy						
Parents not asked to attend sessions	3	16	8.9*	2	17	11.84*
Parents initiate contact	8	8	0	5	11	2.25
Parents not informed of their role in child's therapy	2	6	2	2	6	2
Parents not included as active participants	5	9	1.14	1	13	10.29*
Information parents receive about child's problems and tx						
Parents not informed of child's behavior problems	6	7	.08	4	9	1.92
Parents do not have understanding of what occurs	3	19	11.64*	3	19	11.64*
Parents not informed of child's tx plan and progress	8	19	4.48*	8	19	4.48*
Parents understanding of therapy is playing games	2	4	.67	2	4	.67
Parents not informed of rationale/benefits of therapy	0	7	7*	0	7	7*
Parents skeptical of therapists' ability to help their child	6	15	3.86*	6	15	3.86*
Parent motivation for involvement in child's therapy						
Parents want better understanding of child's problems	3	7	1.6	5	5	0
Parents would have preferred to have an active role	11	31	9.52*	5	37	24.38*
Parents involvement may impact treatment negatively	1	8	5.44*	1	8	5.44*

Note. * $p<.05$

Appendix E: Qualitative Parent Interview Guide

Parent Interview

Introduction of Interview:

Thank you for meeting with me today. My name is _____ and I will be interviewing you on your experience with the therapy services your child received at school. We would like to understand what your involvement was in these services and what information was provided to you throughout your child's therapy. I will be recording this interview to ensure that the discussion is recorded accurately. This interview will take about an hour. Please let me know if you need any breaks throughout this interview.

Confidentiality:

Your responses to this interview will be kept confidential. We will not share or use your name or any other identifying information in reports or other materials. We hope you'll feel free to speak openly and honestly. However, complete confidentiality cannot be guaranteed.

The main exception to confidentiality involves information we learn about child or elder abuse. If you tell us information that leads us to worry that a child or elder is being harmed, we are required by law to report that information to the authorities.

Compensation:

You will receive a $25 gift certificate for you participation in this interview.

Participant Consent:

The informed consent to participate will be our record that you have agreed to participate in this interview. Do you have any questions about this interview or about the consent form before we begin? If not, please sign and date the form.

As I mentioned before, we would like to understand what your experience was like in the therapy services your child received at school and what your involvement was in these services.

1. Why was your child referred for therapy at school?

a. Who made the referral?

2. Do you think your child needed or could benefit from these services?

3. Do you remember how many sessions your child had for this therapy?

4. Did the therapist invite you to attend any sessions?

5. What did the therapist say about what your role or involvement should be in your child's therapy?

6. What did you expect your involvement would be in your child's therapy?

7. What do you think a parent's role should be, if any, in therapy services at school? **(If unclear or no response, ask a-d below)**

a. Checking in with therapist about child's progress?
b. Attending sessions regularly?
c. Setting treatment goals?
d. Talking to your child about how therapy is going?

8. Did you attend any sessions or meetings? **(If Yes, ask a-d below)**

a. Did you attend the first meeting where you gave consent for your child's therapy?
b. Did you attend other sessions?
c. Did you have phone meetings with your child's therapist?
d. How many sessions in total do you remember attending?

We understand that many times parents are not involved in their child's therapy at school, or that there may be difficulties parents have with attending therapy sessions at school.

9. Did you experience any difficulties in meeting with your child's therapist at school? **(If Yes, ask a below)**

a. What was the most difficult challenge?

10. Did you discuss these difficulties with your child's therapist? **(If Yes, ask a below)**

a. Did the therapist try to help you figure out how to address these difficulties?

11. What are ways in which your child's therapist could have made it easier for you to attend sessions?

(If unclear or no response, ask a-d below)

a. Scheduling sessions after school?
b. Providing childcare?
c. Meeting at a closer location to where you live or at your home?
d. Meeting in a more private location?

I'd like to now ask you about the things your child worked on in therapy and what information was provided to you throughout your child's therapy at school.

12. What did the therapist tell you when you were first contacted about your child being referred for therapy services?

13. Did the therapist tell you what would be occurring in your child's therapy (i.e., what the treatment plan would be)?

14. Did the therapist tell you the ways in which therapy could be helpful for you and your child?

15. Did you discuss with the therapist what you would like to happen in your child' therapy (i.e., discussing your child's treatment goals with the therapist)?

16. What information was provided to you by the therapist about your child's behavior problems?

17. Did you fill out any forms regarding your child's behavior? ***(If Yes, ask a below)***

a. Did the therapist discuss the results with you?

18. Did you receive any handouts about behavior problems in children?

19. Did your child's therapist discuss factors that may have contributed to your child's

difficulties?

20. Did the therapist discuss what your role would be in your child's therapy services?

Now that therapy has been completed, I'd like you to take a look back your experience with your child's therapy services. I'd like to ask you questions about your thoughts about the therapy your child received.

21. Do you feel like you have an understanding of why your child was referred for treatment (i.e., What your child's difficulties may be)?

22. Do you think the therapy your child received at school was helpful for you and your child? **(If unclear about how child's therapy could help the parent, ask a below)**

a. How much did you learn about what you can do as a parent to help with your child's difficulties?

23. Overall, how satisfied were you with the therapy your child received at school?

24. If your child were to need help again, would you go back to those services at school?

25. Looking back at the therapy your child received at school, how much would you have like to have been involved? ***(If unclear or no response, ask a-c below)***

a. Attending sessions?
b. Meeting with therapist
c. Setting goals for therapy?

The following questions describe some of the different ways you might have thought or felt about

your child's therapist. Please rate each question below on a seven point scale:

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

If the statement describes the way you always feel (or think) circle the number 7; if it never applies to you, circle the number 1. Use the numbers in between to describe the variations between these extremes.

1. My child's therapist and I agreed about the things I needed to do in therapy to help improve my child's situation.

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

2. What I did in therapy gave me new ways of looking at my child's difficulties.

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

3. I believe my child's therapist liked me.

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

4. My child's therapist did not understand what I wanted to accomplish in my child's therapy.

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

5. I was confident in my child's therapist's ability to help my child.

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

6. My child's therapist and I worked towards mutually agreed upon goals.

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

7. I feel that my child's therapist appreciated me.

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

8. My child's therapist and I agreed on what was important for my child to work on.

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

9. My child's therapist and I trusted one another.

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

10. My child's therapist and I had different ideas on what my child's problems were.

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

11. My child's therapist and I established a good understanding of the kind of changes that would be good for my child.

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

12. I believe the way we worked with my child's problems were correct.

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

13. My child's therapist provided me with enough information about my child's behavior

problems.

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

14. My child's therapist gave me a good understanding about my role in my child's therapy.

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

15. My child's therapist provided me with a good understanding about what would be occurring in my child's therapy.

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

16. I have a good understanding of why my child was referred for therapy services.

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

17. I feel like the therapy my child received at school was helpful for me and my child.

1	2	3	4	5	6	7
Never	**Rarely**	**Occasionally**	**Sometimes**	**Often**	**Very Often**	**Always**

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