Published in final edited form as:

J Behav Health Serv Res. 2013 July ; 40(3): 247–262. doi:10.1007/s11414-013-9330-6.

Improving Implementation of Mental Health Services for Trauma in Multicultural Elementary Schools: Stakeholder Perspectives on Parent and Educator Engagement

Audra Langley, Ph.D.,

UCLA Semel Institute for Neuroscience & Human Behavior, 760 Westwood Plaza, Rm 67-447, Los Angeles, CA 90095, alangley@mednet.ucla.edu, 310.825.3131, 310.206.9365

Catherine DeCarlo Santiago, Ph.D.,

Assistant Professor, Clinical Psychology, Loyola University Chicago, Department of Psychology, 1032 W. Sheridan Road, Chicago, IL 60660, csantiago4@luc.edu, 773.508.2712

Adriana Rodríguez, M.S., and

Virginia Commonwealth University, Department of Psychology, White House, 806 W. Franklin St., Richmond, VA 23284-2018, rodrigueza2@vcu.edu, 714.334.1629

Jennifer Zelaya, B.A.

1138 Diamond Ave #A, South Pasadena, CA 91030, Zelaya.jen@gmail.com

Abstract

Although more schools are offering mental health programs, few studies have involved the school community in research to improve their successful implementation. In this community partnered study, focus groups were conducted with school staff and parents to explore issues related to community engagement and feasibility of a mental health intervention for elementary school students exposed to trauma. Four educator focus groups, including 23 participants, and 2 parent focus groups, consisting of 9 Spanish-speaking and 7 English-speaking parents were conducted. Participants discussed facilitators and barriers to successful implementation of the program. Participants identified the importance of pre-implementation parent education, raising awareness of the impact of student mental health among educators, maintaining ongoing communication during the intervention, and addressing logistical concerns. Participants described clear considerations for parent and educator engagement both at the pre implementation phase and during implementation of the program. Implications for next steps of this community partnered approach are described.

Keywords

child; school; implementation; trauma; stakeholder

Correspondence to: Audra Langley.

CORRESPONDING AUTHOR AND REPRINT REQUESTS: Audra Langley, Ph.D. 760 Westwood Plaza, Rm 67-447 Los Angeles, CA 90095; (310) 825-3131; alangley@mednet.ucla.edu.

Conflicts of Interests: The authors declare no conflicts of interest.

Improving Implementation of Mental Health Services for Trauma in Multicultural Elementary Schools: Stakeholder Perspectives on Parent and Educator Engagement

Childhood Trauma Prevalence, Impact, and Treatment

Exposure to traumatic events and interpersonal violence is a growing concern,^{1–3} with estimates that 20 to 50% of American children are victims of trauma within their families, at school, and in their communities.⁴ Recent studies suggest that 40% of 8–11 year old elementary school children reported having their life threatened⁵ and 68% of adolescents have experienced at least one potentially traumatic experience in their lifetime⁶ ranging from physical abuse, sexual abuse, and exposure to domestic or community violence. Moreover, children in vulnerable populations such as low-income urban youth and immigrant children have often been exposed to multiple traumatic events and secondary adversities.^{7–9}

Studies have documented the broad range of negative sequelae of trauma exposure for children, including posttraumatic stress disorder (PTSD,^{10–11} anxiety,^{12–13} and depression^{10,14}). Further, trauma exposure is related to impairment in school functioning and more school absences;^{15–16} decreased rates of high school graduation;¹⁷ and aggressive and delinquent behavior.¹⁸ Although not every child exposed to a traumatic event goes on to develop a psychological problem, there is little doubt that these experiences are harmful for many children.

To mitigate the long-term effects of violence exposure, effective psychosocial interventions for trauma-related symptoms in youth, such as Trauma Focused-Cognitive Behavioral Therapy (TF-CBT)¹⁹ and Cognitive Behavioral Intervention for Trauma in Schools (CBITS)²⁰ have been developed. Despite a clear imperative to identify and broadly disseminate effective psychosocial treatments for traumatized children and their families,²¹ few youth, especially low-income minority youth, receive early interventions to prevent negative developmental outcomes from exposure to trauma.²²

Schools, Access, and Mental Health Disparities

Despite effective cognitive-behavioral interventions, many children are left untreated. Currently, only about 20% of children in need of mental health services are accessing these services.^{23–24} Consistent with the Surgeon General's *National Action Agenda* for child mental health services, it is crucial to bring more evidence-based treatments into naturalistic settings such as schools to reduce mental health disparities and increase access to services.²⁵ Of those children currently accessing mental health services, three-fourths of them receive care through the education sector.²⁶ In a recent study, students in post-hurricane New Orleans were screened for trauma-related symptoms and randomized to clinic-based TF-CBT or school-based CBITS. Despite major efforts to engage families and overcome logistical obstacles, only 12% of those assigned to TF-CBT completed treatment, compared to 93% of those assigned to CBITS.²⁷ Clearly, quality school-based programs have the potential to reduce barriers to accessing services and impact many students in need of intervention.

School-based services may be particularly important for underserved ethnic minority youth who traditionally are less likely to receive such services, despite increased risk for violence exposure and mental health problems due to risk factors including poverty^{28–30} and community fiscal factors.³¹ Latino children, in particular, are at risk for not receiving mental healthcare,²⁴ due to disproportionate numbers without health insurance, parental preferences and help-seeking patterns, and an unrecognized need for services.^{32–35} Delivering mental

health services through the school system can address key financial and structural barriers that often prevent low SES and ethnic minority children from receiving needed services.³⁶

Implementation Facilitators and Barriers

Although school-based services can increase access to quality mental healthcare for children, the implementation of those services is also crucial for positive child outcomes. Successful treatment of children depends both on effective interventions and effective implementation strategies.³⁷ Without successful implementation, even a highly effective intervention will result in inconsistent use and poor outcomes.³⁸ Given the multiple layers of systems involved in a school setting, a critical area of focus for school-based mental health services is the development of engagement strategies across the multiple stakeholder levels, including district and school administrators, mental health service providers, educators, parents and families, and students.³⁹ In fact, Langley and colleagues⁴⁰ found buy-in from parents, administrators, and teachers to be among the top implementation barriers for clinicians trained to implement a school-based intervention for trauma (CBITS). Without a multifaceted approach, organizational change needed for successful implementation and sustainability will not occur.³⁸

Mental Health Engagement Strategies in the School Setting

Both teacher and parent engagement are important for successful implementation in schools. Community-partnered research has highlighted the importance of gaining buy-in from teachers.⁴¹ Without such buy-in, logistical issues such as pulling students from class become larger barriers to implementation success.⁴¹ Though parent engagement in education and mental health services has proven challenging, it is recognized as key to successful programs.⁴² Parental perceptions of discrimination,⁴³ parental perceptions of teacher outreach, and parent language⁴⁴ are frequently identified as barriers.

Mental health services engagement strategies that include exploration of parental concerns and beliefs about treatment, adjustment of logistical barriers, and highlighting parental strengths, have demonstrated significant reductions in no-show rate for first appointments in clinic settings.⁴⁵ Relational engagement, utilizing existing or building relationships among parents and school staff to foster involvement, increases engagement of immigrant families.⁴⁶ Further, working toward collaborative relationships among students, parents and school personnel benefits both the school and families^{46, 47} and may further facilitate effective implementation of a school-based intervention.

Current Study

Few have studied the role of engagement of educators and parents in mental health service implementation in school settings. Through a community-participatory partnered research (CPPR) approach aimed at adapting and implementing an intervention for multicultural elementary school students exposed to traumatic events, the current study builds on previous work by exploring and outlining key engagement factors relevant to successful implementation. The research partnership included an iterative process to develop both the content and implementation plan for the Bounce Back Program based on input from multiple levels of stakeholders.

The Bounce Back Program was developed as an extension for younger elementary school students of Cognitive Behavioral Intervention for Trauma in Schools (CBITS), a school-based group intervention found to be effective in treating post-traumatic stress disorder (PTSD) and depression in middle school youth exposed to a broad range of traumatic events.^{5,48} From its inception, CBITS was developed with equal partnership between school district clinicians and community members, administrators, and clinician researchers.

Likewise, the Bounce Back program followed the same CPPR model in elementary schools, including the focus groups described in the current study.

Specifically, this focus group study was conducted to gain perspective from parents and school stakeholders on: (a) issues related to improving parent consent and engagement in parent psychoeducation sessions, (b) factors related to effective implementation of mental health services in multicultural elementary schools, and (c) perceived need and attitudes toward mental health services.

Method

Participants

Focus group participants were recruited through an existing community-partnership with four Title I elementary schools in Southern California. Four staff focus groups consisted of elementary school educators, administrators, and program staff. Across the four schools, school staff focus groups included 23 participants (6 teachers, 6 school mental health clinicians, 3 principals, 5 school-community liaisons, and 3 on-site school-based childcare providers). Two focus groups were also conducted with parents from the four elementary schools, which consisted of nine Spanish-speaking parent participants in one group (100% female; 100% Latina) and seven English-speaking parent participants (86% female; 43% African American, 43% Caucasian, 14% Latino) in the other. Parents were ethnically and socioeconomically representative of the district's diverse demographics.

Procedures

The principal from each elementary school was asked to nominate a senior administrator, a school counselor/psychologist, up to two teachers, and a school safety officer or after school childcare provider to attend the staff focus group. The school principal and school-based mental health clinicians from each of the four schools were asked to nominate 1–2 English speaking parents and 1–2 Spanish speaking parents to participate in the parent focus groups. A licensed clinical psychologist (AL) led the six focus groups, which consisted of 5–9 participants per group and one member of the research team who observed (AR). A semi-structured focus group guide was used, which covered the following topics: (a) perceived mental health service need, (b) engaging parents and educators, (c) implementation issues, and (d) developmental and cultural appropriateness of the content and format of the school mental health program under development. All participants received \$50 for their time. This study was conducted in compliance with the UCLA Institutional Review Board.

Data Analysis

All focus groups were audiotaped, transcribed, and reviewed by members of the research team (AL, AR) who were also present during focus groups. Content analyses were used to explore emerging themes relevant to the implementation process. Two research team members reviewed transcriptions and process notes from the moderators and came to consensus on emerging themes. A qualitative data analysis software program was utilized, ATLAS.ti_{tm} 5.1, for preliminary coding of the focus group transcripts for major domains of inquiry based on the focus group topics. Subsequently, the research team discussed the content of each domain and refined the coding scheme by expanding, collapsing, or eliminating codes until there was consensus. Additional coding was done based on the range of responses within each domain.

Results

Parent Engagement

Pre-Implementation Parent Engagement Considerations—Pre-Implementation is defined here as the period prior to program roll out that may include engagement of stakeholders/consumers, recruitment, awareness raising, understanding organizational logistics, etc. From the perspective of both parents and school staff members, the following common themes emerged for pre-implementation: (a) the importance of presenting information and describing the program in ways that are clear, reduce stigma, and focus on strengths, (b) the need to address barriers associated with consent and confidentiality, and (c) using existing relationships in the school to reach out to parents.

Presentation of program and information: Parents and educators discussed the importance of presenting information in a way that is clear and strength-based. Parents urged providers to "*keep it simple*" and clear and liked the idea of having the curriculum for the program available. For example, staff agreed that educating on trauma and stress may further facilitate engagement with families, "*The psychoeducation piece-- I think that component is huge*" such as explaining how experiencing stressful and traumatic events may "*impact students: the learning, the attendance, test scores.*"

Parents echoed educator recommendations to keep the language accessible and positive. They recommended that emphasis be placed upon "*the program's goal to work on the child's strengths.*" Similarly, staff felt that the content and goals should be aimed at resilience and coping and specifically suggested framing as coping skills for success. They also brought up the fact that students "*need some sort of stigma free way of communicating to peers what kind of group that they're in. Skill-building...think solution oriented.*"

Several parents also noted that there would be more resistance to participate if the language feels too threatening or stigmatizing. Staff emphasized the importance of reducing stigma with particular attention to cultural differences among Latino families. For example, cultural differences in attitudes about mental health: "*We're talking about parents that grew up thinking: 'I never had mental health resources at school and I turned out okay, so why do we need this?'*" Staff noted various strategies that might reduce barriers and increase engagement, such as discussing trauma in the context of "stress" as that would likely be easier for parents to understand and likewise, allow them to more comfortably discuss the topic. Specifically, a Latino staff member offered that "*if they [parents] hear 'trauma' or 'mental health' especially in the Latino community, they're going to be like, 'oh that's only for cookoo people,'*" and many staff members agreed that any mental health terminology can feel very threatening, "*even the word 'social work,'*" brings to mind somebody capable of taking their children away.

Consent and confidentiality: Parents and staff outlined a number of potential barriers related to consent and confidentiality including translation/language of materials and limits to confidentiality. Parents underscored that any program material, including consent documents would need to be translated for non-English speaking parents and that careful thought about appropriate translation is critical.

In exploring ways to improve informed consent, parents conveyed the importance of providing various means of communicating information and dispelling concerns early on. They encouraged concrete and understandable information about the program be sent home to parents, but also offered through meetings about the program at school. In addition, parents recommended that an opportunity to meet with families individually and privately may aid in reducing threat of stigma. Parents in the Spanish speaking focus group agreed

that gaining consent from the child's father would be important, as he is often times the decision maker in the family. Along with consent, both parents and school staff members recognized the importance of mental health confidentiality on several levels. Staff members noted that parents need to be informed that school-based mental health records are separate from the child's school record. As one staff member voiced, "*[parents are often concerned] because it [mental health service] is offered in a school setting that it will stay with the child for the rest of their time there, potentially 'labeling' them with the school.*" However, they also expressed concern about the children's ability to keep sensitive information shared in a group confidential.

Relational Engagement: Parents and staff both noted the importance of utilizing existing relationships to best engage families. That is, make use of school liaisons that have an existing relationship with parents to further facilitate engagement in a school mental health program and describe why it may benefit the child. Staff added that existing school organizations that parents trust can be key in creating engagement and spreading the word to other parents. Moreover, parents urged that school-based mental health clinicians make an effort to be "visible" within the school community and connect and build relationships with parents. For example, having the mental health clinician visible during drop off and pick up times, greeting people as they pass through the hallways, mingling with families during school events, and having him or her write up short notes to the families in the school's regular newsletters would enable families to view this person as part of the school community. A teacher complimented her school's principal on her weekly commentaries in the school newsletter and how helpful it would be for her to include program background, buy in, and implementation material.

Parent Engagement Considerations During Implementation—Implementation is defined here as the period of initial, active, or full program implementation. Both parents and staff emphasized the importance of parent involvement during the intervention and offered various suggestions for approaching and engaging parents during implementation.

Parent participation in treatment: Most participants expressed the importance of including collateral parent sessions as the children are involved in groups. Staff believed that including parents to the extent possible during the intervention is critical for children at this developmental level, who may require assistance with homework or important concepts. They urged, "*Discussing mental health with parents and common misconceptions*" and having at least "*three parent sessions for the groups, so that parents also get that psychoeducation piece and understand what their child is going through.*" Parents agreed that "*teaching the parent about what is going on, so that they can further support their child once the program is over*" is key. This would allow parents to continue to reinforce their child's skills and recovery at home, both during and after the group intervention is complete "*because after the ten weeks you[clinician] are going to be gone.*" Parents also expressed that regular communication about what the children are learning week to week could be helpful. Finally, parents offered suggestions to provide some external motivation for parents to attend sessions.

Educator Engagement

Pre-Implementation Educator Engagement Considerations—Related to educator engagement during the pre-implementation stage, school staff members raised two main themes: trust in the longevity and sustainability of the program and needing education about the impact of adverse events on students.

Sustainability and trust: Several educators discussed the importance of having a sense of program sustainability and partnership in gaining and maintaining teacher buy-in. Other comments highlighted the need to believe that the program works and will be there for a while. Despite fears about sustainability, staff noted that teachers could be powerful partners in making the program successful if they believed in the program and its sustainability.

Awareness: Some educators felt that many teachers recognize that their students are encountering these issues. In addition, they voiced that buy-in from these teachers could be achieved without much education, "*Because it's so hard for these students to focus in class, because they're so worried about whatever trauma or whatever event is going on.*" For educators without as much awareness, staff recommended teacher education around how stressful, adverse, or traumatic events may impact classroom performance and potentially hinder students in the learning process. This would provide teachers with information about how to be more understanding of their students and also allow them to be more open to children being involved in a school-based mental health program.

Educator Engagement Considerations During Implementation—Related to educator engagement during the implementation stage of the mental health intervention, school staff members raised two main themes: (1) need for ongoing communication between school therapist and teacher about intervention content and (2) need for teacher convenience (e.g., minimal class disruption).

Ongoing Communication: One teacher noted: "*I don't let anyone go unless I know what they're doing because when my kids leave, I like to know how they're growing.*" Other teachers spoke to the difficulty in letting students out of class and emphasized the importance of providing educators with information about the general content of the program and updates on their students' progress for credence of the program.

In another group, an educator offered a potential solution, "*Maybe once the program starts, at the end of the week, the teachers who have students participating in the group can get a little email that says: 'this week we taught them this and worked on this; if you want to support them you can do this or something they can do, like walk by that child and say 'count from one to ten backwards and take a deep breath.'*" Many school staff members reiterated this sentiment of helping teachers feel included and integrated into the program.

Logistical considerations for school setting implementation: School staff had numerous ideas about how to make the program fit within the school setting and be the least disruptive to education. Most teachers felt that it would be most beneficial to hold sessions consistently at the same time each week with advance notice of the full program schedule. As elucidated by one teacher: "*If I knew ahead of time I would make a note of that or ask the mom to review the lesson or figure out some partner thing...something.*"

Although school staff agreed that 60-minute group sessions were sensible, they highlighted that teachers may be concerned about this amount of time away from the classroom. Further, educators commented on the fact that children targeted for a mental health intervention may also be pulled out for other services. In terms of the best time of the day to pull students out of class for a group, some of the educators thought that the end of the day may be "less academic" in some elementary schools. In thinking about fitting the program into an elementary setting comprised of multicultural families, school staff also acknowledged that language may be an issue for younger students from non-English speaking homes. Finally, they felt it would be beneficial to build off of existing school programs to the extent possible.

Discussion

Studies examining implementation in school-based settings are needed to improve effective implementation and services for children. While it is clear that school-based services can dramatically increase the number of children who receive needed mental healthcare,²⁷ improving child mental health also depends on effective implementation of programs.³⁷ Despite the plethora of effective evidence-based interventions for various childhood disorders (e.g.⁴⁹), the literature on evidence-based interventions neglects to consider school contextual factors that may affect implementation.⁵⁰ Further, the competing pressures of the education system and federal/state performance standards have implications for the implementation of mental health interventions in the school setting as well.⁵⁰ For example, mental health interventions can easily be perceived as a burden in a school setting. It is therefore imperative to understand the school context and relevant perspectives for effective implementation. Some have posited that engagement and buy-in across multiple stakeholders is an important approach (e.g.³⁹).

This study is a key step toward understanding perspectives from various stakeholders to increase engagement with the aim of facilitating successful program implementation. Overall, findings suggest that parents and school staff perceived parent and educator engagement as important themes for implementation in a school setting both prior to and during implementation. Specifically, parents and school staff considered information presentation as key to successful engagement in the pre-implementation stages. For example, presenting information in ways that reduce stigma and build trust by utilizing existing school relationships may foster parent consent and engagement in the program. Likewise, school staff noted the importance of building awareness of the impact of trauma on students. Parents suggested including information on how stress can impact students' functioning and learning presented in understandable language that is free of mental health jargon. Accurate and thoughtful translation was also highlighted as critical for engaging non-English speaking families. Successful interventions with culturally diverse families include a focus on resilience as a key component of engagement and retention in the program^{45,51} and a lack of accurate translation is a frequently cited barrier for engaging Spanish-speaking families.⁴⁴

Further, within the school setting, issues of confidentiality are more salient for parents. Unlike in a clinic setting where school and mental health records are clearly separate, school-based services need to clarify confidentiality of mental health records. Parents expressed concerns that the program would appear on school records or that teachers might treat a student differently if they knew they were in the group. Although schools can ensure confidential and separate mental health records, students may be seen going to group and there are always limits to confidentiality in group settings. In addition, teachers noted the importance of having some limited information about what students are doing in their group in order to collaborate with clinicians, support students, and plan for missed class time. It is likely that parents may be open to this type of sharing when they understand what types of information will be kept private from the outset. School-based programs must plan for explanation of confidentiality and privacy as early as possible to prevent concerns becoming a barrier for parents. The results of this study suggest some confusion about what appears on school records and what are the legal obligations of care providers. When parents are provided with clear information regarding confidential records, including limits to confidentiality (e.g., abuse of a child or elder), the opportunity for a trusting relationship is retained. Presentation of the program in ways that reduce stigma, along with teacher support of the program may assuage concerns regarding the limits of complete privacy in a school setting.

Relationships between parents and school personnel emerged as key for engaging parents in the program and parent psychoeducation sessions. Parents emphasized the importance of utilizing existing relationships with the school to engage parents in the program. Likewise, parents noted the need to feel that the clinicians are well integrated in the school community through clinician presence at other school events and parent meetings. During the intervention, parents emphasized a desire to know what their children are learning in the group, so that they can support them at home and understand the skills. Emphasizing the importance of parent participation and accountability may reduce intervention attrition and enhance or maintain treatment gains. Consistent with prior research, relational engagement can be fostered both among parents and between parents and school staff to enhance willingness to participate in school programs.⁴⁶ For example, results of this study suggest that both parents who are already involved in school programs as well as trusted staff members can reach out and engage other families.

Like parents, school staff also emphasized the importance of building trust and collaborating with teachers around logistical issues. School staff emphasized the sustainability of the program as key for buy in. Staff did not want to invest in a program that would disappear once research was completed. A key to successful community partnership is engaging stakeholders in the project's process from pre-implementation to successful completion to ensure sustainability in the community. Like parents, school staff also emphasized the importance of tying the intervention to school priorities—raising awareness for how stress impacts learning and academic achievement and how the program will benefit school engagement and performance. In addition, teachers emphasized ongoing updates from clinicians on basic skills students are learning in their groups in order to foster collaboration and enhance planning around missed class time. Thus, integrating a system to promote communication between parents, clinicians, and teachers is important for long-term sustainability of programs and continued trust and collaboration. Parents and teachers suggested numerous methods to achieve continued partnership such as weekly emails or letters, newsletter updates, and regular phone calls.

Collaboration between mental health and school professionals is essential, however, understanding what specific factors are relevant to the implementation and sustainability in a school setting requires engaging stakeholders before and during implementation. A partnership approach can lead to successful intervention and program strategies that are supported by both parents and school staff. Community partnership emphasizes the mutual transfer of expertise and insights into the issues of concern, sharing in decision-making and mutual ownership of the expertise, data and products of the collaboration. Through such community partnership, more rapid and effective improvement in community health outcomes can be obtained and interventions have the potential to become more permanent fixtures in the community.⁵²

Implications for Behavioral Health

The results of this study highlight the importance of taking a community partnered approach in order to effectively implement behavioral health interventions, particularly those that will be implemented in community settings such as schools. A community partnered approach within schools involves partnership at multiple levels of stakeholders—parents and families, school clinicians, teachers, and school administrators. Thus, prior to implementing a school-based program, a partnership at these levels must be initiated. As suggested by participants in this study, information can then be presented in a way that highlights strengths and reduces stigma, while also capitalizing on existing positive relationships within the school community. Issues of confidentiality and trust should be discussed upfront so that they do not become barriers to program participation. Finally, assurance that the program has some

long-term sustainability increases the willingness of both parents and educators to participate and support the program, as well as problem solve how to fit the program into the logistics of each school. When multiple levels are engaged, key insights, such as those highlighted in this study, are gained and when addressed increase the potential for successful buy-in and implementation of school mental health programs. The next steps of this community partnered research and implementation involve working with school-based clinicians to deliver the program (Bounce Back) in a way consistent with the recommendations found in this study, while partnering with the research team for evaluation. As part of this process, regular meetings with stakeholders are key

Acknowledgments

The authors would like to acknowledge funding from the following NIMH grants: K01MH082125 (Langley), P30MH082760 and T32MH073517 (Santiago).

References

1. Dahlberg, LL.; Krug, EG. Violence: a global public health problem. In: Krug, EG.; Dahlberg, LL.; Mercy, JA.; Zwi, AB.; Lozano, R., editors. World Report on Violence and Health. Geneva (Switzerland): World Health Organization; 2002. p. 1-21.
2. Office of the Surgeon General (US); National Center for Injury Prevention and Control (US); National Institute of Mental Health (US); Center for Mental Health Services (US). Youth Violence: A Report of the Surgeon General. Rockville (MD): Office of the Surgeon General (US); 2001.
3. Kilpatrick, DG.; Saunders, BE.; Smith, DW. Youth Victimization: Prevalence and Implications. Washington DC: US Department of Justice, Office of Justice Programs, National Institute of Justice; 2003.
4. Finkelhor D, Turner HA, Ormrod RK, et al. Violence, crime, and exposure in a national sample of children and youth. *Pediatrics*. 2009
5. Kataoka SH, Stein BD, Jaycox LH, et al. A school-based mental health program for traumatized Latino immigrant children. *Journal of the American of Child & Adolescent Psychiatry*. 2003; 42(3): 311–318.
6. Briggs-Gowan MJ, Carter AS, Clark R, et al. Exposure to potentially traumatic events in early childhood: differential links to emergent psychopathology. *Journal of Child Psychology and Psychiatry*. 2010; 51(10):1132–1140. [PubMed: 20840502]
7. Jaycox LH, Langley AK, Stein BD, et al. Support for students exposed to trauma: a pilot study. *School Mental Health*. 2009; 1(2):49–60. [PubMed: 20811511]
8. Langley AK, Cohen JA, Jaycox LH, et al. Trauma exposure and mental health problems among school children 15-months post-Hurricane Katrina. *Journal of Child and Adolescent Trauma*. In Press.
9. Osofsky JD. Community outreach for children exposed to violence. *Infant Mental Health Journal*. 2004; 25(5):478–487.
10. Jaycox LH, Stein BD, Kataoka SH, et al. Violence exposure, Posttraumatic Stress Disorder, and depressive symptoms among recent immigrant school children. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2002; 41(9):1104–1110. [PubMed: 12218432]
11. Stein BD, Zima BT, Elliott MN, et al. Violence exposure among school-age children in foster care: relationship to distress symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2001; 40(5):588–594. [PubMed: 11349704]
12. Finkelhor D, Ormrod RK, Turner HA, et al. The victimization of children and youth: A comprehensive national survey. *Child Maltreatment*. 2005; 10(1):5–25. [PubMed: 15611323]
13. Kilpatrick DG, Ruggiero KJ, Acierno R, et al. Violence and risk of PTSD, major depression, substance abuse/dependence, and comorbidity: results from the National Survey of Adolescents. *Journal of Consulting and Clinical Psychology*. 2003; 71(4):692–700. [PubMed: 12924674]

14. Reinherz HZ, Paradis AD, Giaconia RM, et al. Childhood and adolescent predictors of major depression in the transition to adulthood. *The American Journal of Psychiatry*. 2003; 160(12): 2141–2147. [PubMed: 14638584]
15. Hurt H, Malmud E, Brodsky NL, et al. Exposure to violence: Psychological and academic correlates in child witnesses. *Archives of Pediatrics & Adolescent Medicine*. 2001; 155(12):1351–1356. [PubMed: 11732955]
16. Milam AJ, Furr-Holden CDM, Leaf PJ. Perceived school and neighborhood safety, neighborhood Violence, and academic achievement in urban school children. *Urban Review*. 2010; 42(5):458–467. [PubMed: 21197388]
17. Harding DJ. Collateral consequences of violence in disadvantaged neighborhoods. *Social Forces*. 2009; 88(2):757–784.
18. Jang KL, Stein MB, Taylor S, et al. Exposure to traumatic events and experiences: aetiological relationships with personality function. *Psychiatry Research*. 2003; 120(1):61–69. [PubMed: 14500115]
19. Cohen JA, Mannarino AP, Perel JM, et al. A pilot randomized controlled trial of combined trauma-focused CBT and sertraline for childhood PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2007; 46(7):811–819. [PubMed: 17581445]
20. Jaycox, LH. *Cognitive-Behavioral Intervention for Trauma in Schools (CBITS)*. Sopris West Press; 2003.
21. Cohen JA, Mannarino AP, Murray LK, et al. Psychosocial interventions for maltreated and violence- exposed children. *Journal of Social Issues*. 2006; 62(4):737.
22. US Public Health Service. *Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda*. Washington, DC: US Department of Health and Human Services; 2000.
23. Kataoka SH, Zhang L, Wells KB. Unmet need for mental health care among U.S. children: variation by ethnicity and insurance status. *American Journal of Psychiatry*. 2002; 159(9):1548–1555. [PubMed: 12202276]
24. Kataoka SH, Stein BD, Jaycox LH, et al. A school-based mental health program for traumatized Latino immigrant children. *Journal of the American of Child & Adolescent Psychiatry*. 2003; 42(3):311–318.
25. US Department of Health and Human Services. *Mental Health: Culture, Race, and Ethnicity A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: US Department of Health and Human Services, Public Health Service, Office of the Surgeon General; 2001.
26. Farmer EMZ, Burns BJ, Phillips SD, et al. Pathways into and through mental health services for children and adolescents. *Psychiatric Services*. 2003; 54(1):60–66. [PubMed: 12509668]
27. Jaycox LH, Cohen JA, Mannarino AP, et al. Children's mental health care following Hurricane Katrina: a field trial of trauma-focused psychotherapies. *Journal of Traumatic Stress*. 2010; 23(2): 223–231. [PubMed: 20419730]
28. Garrido EF, Culhane SE, Raviv T, et al. Does community violence exposure predict trauma symptoms in a sample of maltreated youth in foster care? *Violence and Victims*. 2010; 25(6):755–769. [PubMed: 21287965]
29. Puccia E, Redding T, Brown RS, et al. Using community outreach and evidenced-based treatment to address domestic violence issues. *Social Work in Mental Health*. 2012; 10(2):104–126.
30. Garbarino, J.; Hammond, WR.; Mercy, J., et al. Community violence and children: Preventing exposure and reducing harm. In: Maton, KI.; Schellenbach, CJ.; Leadbeater, BJ., editors. *Investing in Children, Youth, Families, and Communities: Strengths-Based Research and Policy*. Washington, DC: APA; 2004. p. 303-320.
31. Sieger K, Rojas-Vilches A, Mckinney C, et al. The effects and treatment of community violence in children and adolescents: What should be done? *Trauma, Violence, & Abuse*. 2004; 5(3):243–259.
32. Alegria M, Canino G, Ríos R, et al. Mental health care for Latinos: Inequalities in use of specialty mental health services among Latinos, African Americans, and Non-Latino Whites. *Psychiatric Services*. 2002; 53(12):1547–1555.
33. Miranda AO, Matheny KB. Psychological predictors of acculturative stress among Latino adults. *Journal of Mental Health Counseling*. 2000; 22(4):306–317.

34. Berdahl TA, Torres RA. Examining Latino differences in mental healthcare use: The roles of acculturation and attitudes towards healthcare. *Community Mental Health Journal*. 2009; 45(5): 393–403. [PubMed: 19690955]
35. Organista, KC. Cognitive-behavioral group therapy: For specific problems and populations. Washington, DC: US: American Psychological Association; 2000. Latinos; p. 281–303.
36. Bledsoe SE. Barriers and promoters of mental health services utilization in a Latino context: A literature review and recommendations from an ecosystem perspective. *Journal of Human Behavior in the Social Environment*. 2008; 18(2):151–183.
37. Fixsen, DL.; Blase, KA.; Timbers, GD., et al. In search of program implementation: 792 replications of the Teaching-Family Model. In: Bernfeld, GA.; Farrington, DP.; Leschied, AW., editors. *Offender rehabilitation in practice: Implementing and evaluating effective programs*. London: John Wiley & Sons, Inc.; 2001. p. 149–166.
38. Fixsen DL, Naoom SF, Blase KA, et al. Implementation research: a synthesis of the literature. University of South Florida: Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network. 2005 FMHI Publication #231.
39. Domitrovich CE, Bradshaw CP, Poduska JM, et al. Maximizing the implementation quality of evidence-based preventative interventions in schools: A conceptual framework. *Advances in School Mental Health Promotion*. 2008; 1(3):6–28.
40. Langley AK, Nadeem E, Kataoka SH, et al. Evidence-based mental health programs in schools: barriers and facilitators of successful implementation. *School Mental Health*. 2010; 2(3):105–113. [PubMed: 20694034]
41. Ngo V, Langley A, Kataoka S, et al. Providing evidence based practice to ethnically diverse youth: examples of the Cognitive Behavioral Intervention for Trauma in Schools (CBITS) Program. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2008; 47(8):858–862. [PubMed: 18645419]
42. Gopalan, G.; Burton, G.; McKay, MM., et al. Achieving school-family collaboration for children with emotional or behavioral disorders. In: Rosenzweig, JM.; Brennan, EM., editors. *Work, Life, and the Mental Health System of Care: A Guide for Professionals Supporting Families of Children with Emotional or Behavioral Disorders*. Baltimore, MD: Brookes Publishing Co., Inc; 2008.
43. Broussard CA. Facilitating home-school partnerships for multiethnic families: School social workers collaborating for success. *Children and Schools*. 2003; 25(1):211–222.
44. Patrikakou EN, Weissberg RP. Parents' perceptions of teacher outreach and parent involvement in children's education. *Journal of Prevention & Intervention in the Community*. 2000; 20(1–2):103–119.
45. Steven J, Kelleher KJ, Ward-Estes J, et al. Perceived barriers to treatment and psychotherapy attendance in child community mental health centers. *Community Mental Health Journal*. 2006; 42(5):449–458. [PubMed: 16964565]
46. Warren MR, Hong S, Rubin Heang C, et al. Beyond the bake sale: A community-based relational approach to parent engagement in schools. *Teachers College Record*. 2009; 111(9):2209–2254.
47. Suarez-Orozco C, Pimentel A, Martin M. The significance of relationships: Academic engagement and achievement among newcomer immigrant youth. *Teachers College Record*. 2009; 111(3):712–749.
48. Stein BD, Jaycox LH, Kataoka SH, et al. A mental health intervention for schoolchildren exposed to violence. *Journal of the American Medical Association*. 2003; 290(3):603–611. [PubMed: 12902363]
49. Rones M, Hoagwood K. School-based mental health services: A research review. *Clinical Child and Family Psychology Review*. 2000; 3(4):223–241. [PubMed: 11225738]
50. Ringeisen HKK. Context Matters: Schools and the "research to practice gap" in children's mental health. *School Psychology Review*. 2003; 32(2):153.
51. Podorefsky DL, McDonald-Dowdell M, Beardslee WR. Adaptation of preventive interventions for a low-income, culturally diverse community. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2001; 40(8):879–886. [PubMed: 11501686]

52. Wells KB, Staunton A, Norris K, et al. Building an academic-community partnered network for clinical services research: The Community Health Improvement Collaborative (CHIC). *Ethnicity and Disease*. 2006; 16(1):S3–S17. [PubMed: 16681125]

DOMAIN	SUBDOMAIN	Themes	Example quotes
<u><i>Parent engagement</i></u>	Pre-Implementation Parent Engagement Considerations	<i>Presentation of program and information</i>	<ul style="list-style-type: none"> • “The psychoeducation piece– I think that component is huge” such as explaining how experiencing stressful and traumatic events may “impact students: the learning, the attendance, test scores” (staff) • The value of having a strengths-based program in the schools: “I think talk about the opportunity to identify that particular child’s needs and use their strengths.” (parents) • One principal conveyed the idea of a parent workshop, “introducing this as life coping skills which is just another thing that we’re trying to provide for your child to make them more successful and have a better life instead of, ‘your kid has a problem.’” (staff) • “you’re going to get more resistance than you are participation because when you’re speaking of devastation in a family nobody wants to talk about it.” (parent) • “There are cultural differences. I mean, we’re talking about parents that grew up thinking: ‘I never had mental health resources at school and I turned out okay, so why do we need this?’ That kind of attitude, I can’t emphasize enough it’s a huge barrier.” (staff) • “I think how you talk about it with parents will determine part of the response. If you talked about “stress” as opposed to “trauma,” it might be easier for parents to get their minds around.” (staff) • A Latino staff member offered that “if they [parents] hear ‘trauma’ or ‘mental health’ especially in the Latino community, they’re going to be like, ‘oh that’s only for cookoo people,’” and other staff members agreed that any mental health terminology can feel very threatening, “even the word ‘social work,’” brings to mind “somebody trying to take their kids away. So I think the universal outreach should be the whole school.” (staff)
		<i>Consent and confidentiality</i>	<ul style="list-style-type: none"> • “It makes a great difference for us when we read things in Spanish if it isn’t correctly translated from English to Spanish... sometimes it’s a matter of one word to be translated differently. It causes fear in us... this will report me to immigration. It’s a simple word. But I think it’s very important how they translate it for us.” (parent) • “consent from the father has to take place in order for things to happen, so being aware of that potential barrier in some Latino families.” (parent) • “face to face meetings should include our husbands,” and stated that, “As of now, I don’t sign anything school related, he is the one who signs grade reports, and he is the one who signs anything permission related, the father.” (parent) • “The guarantee of confidentiality, while we make it, is only as good as the children respect it. And it is a close-knit community, children talk to their parents, they talk to each other. Information does get out;” “Because kids do talk. They’re going to go and share it with mom or friends, or other teachers... That’s my concern.” (staff) • “... because the stigma and sometimes how teachers talk at lunch and share information... so it depends on how they keep it confidential within the school system and not allow all the teachers to know the details of the students.” (parent)
		<i>Relational Engagement</i>	<ul style="list-style-type: none"> • “It’s because of the connection the teacher and the child have with one another. So I was agreeable with that and then also how she approached me.” (parent) • “Some of it is key informant kinds of stuff. You work with a group of people who talk with other people and help explain it to them. ELAC [English Learners Advisory Council] sometimes functions as that kind of a group, where the people who come there are more apt to be the ones who seek connections with the schools. But they all know a dozen other people that don’t come.” (staff) • “I think that would help the stigma thing to me because if I had a rapport with them I would feel more at ease with allowing my child or friend’s kids to actually be involved.” (parent)

DOMAIN	SUBDOMAIN	Themes	Example quotes
			<ul style="list-style-type: none"> "Sometimes when you write on the [weekly newsletter] you write something really reflective that parents read and reflect, oh that applies to my child. I think those are really good." (staff)
	Parent Engagement Considerations During Implementation	<i>Parent participation in treatment</i>	<ul style="list-style-type: none"> "All the homework and all the concepts." "So the parent piece is super important I would say." (staff) "In my opinion, it would help to send [something] every weekend when parents get together." (parent)
<u>Educator Engagement</u>	Pre-Implementation Educator Engagement Considerations	<i>Sustainability and trust</i>	<ul style="list-style-type: none"> "It feels like in a short period of time we've had revolving school psychologists, we've had revolving counselors...so there's little stability. I mean it comes to that, so a lot of teachers I think are a little trepidatious." (staff) "I think that the confidence and faith part is huge. I feel like you see programs come in and go off and sometimes it's hard to support a program unless you feel like it's really working and it's going to be consistent and it's going to be there." "I think that the teachers could really pave the way, because they are trusted members of the community to help something like this get started and be successful."
		<i>Awareness</i>	<ul style="list-style-type: none"> "I think the [school] community sees the need. Or I think as a classroom teacher, I see the need. There are children who need someone to talk to and help with strategies to cope with what they're going through." (staff) Really it would be wonderful to have them learn some tools, and be able to sit still and not worry and focus on the class..." (staff)
	Educator Engagement Considerations During Implementation	<i>Ongoing Communication</i>	<ul style="list-style-type: none"> "Every time my kids leave the room, if I don't feel like they're getting something really good, I want them for me. So I have to think that it's got to be something that's so useful and applicable and something that's going to be communicated back to us, that it's worth missing academic and social development." (staff) "Because as a classroom teacher unless you have a really concrete sense of what the [mental health] program is, and the content they're covering and updates on a consistent basis, it's easy to forget about or not give too much credence." (staff) "There's a disconnect between teachers who work with kids outside of the classroom and classroom teachers and parents who have students involved can be doing a better service for the kids if they feel or have a sense that the teacher really cares and knows about every aspect of what's going on at school [including pullouts]." (staff)
		<i>Logistical Considerations for school setting implementation</i>	<ul style="list-style-type: none"> "It would feel less disruptive to me if I had the kids schedule for like the ten week period ahead of time. Because then I could think, 'okay when I'm doing that lesson I have to plan something to give Robertito.'" (staff) "It seems it'd be easier to have the same time, because teachers have so many things that they have to worry about schedule-wise and I wouldn't remember if it was switched around-and it seems that's how a lot of teachers think in their heads." (staff) "I think 45-60 minutes would work, but I think the concern about 'Oh, my student will be pulled out of class for an hour a week' will be there." (staff) "... since the students that I'm thinking of may already be in some kind of counseling or Special Ed classes so they're being pulled out of other classes." (staff) "The very end of the day is the ideal time to have the child pulled." (staff) "You still might end up with kindergarteners or first graders who are coming from a non-English speaking home who aren't necessarily going to be comfortable really engaging in a group in English." (staff)

DOMAIN	SUBDOMAIN	Themes	Example quotes
			<ul style="list-style-type: none">“...things that we already have in place, it looks much less threatening. It might help us work with people who would otherwise feel a little more hesitant to let us in to work with their kids.” (staff)