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Engaging parents in evidence-based treatments in schools: Community perspectives from implementing CBITS

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Abstract

This study explored parent engagement in an evidence-based treatment, the Cognitive Behavioral Intervention for Trauma in Schools (CBITS), which was delivered in a school setting. To examine the successes and challenges in engaging parents in this school-based program, we conducted qualitative interviews by phone to obtain data from clinicians, parents, and other school personnel across eleven schools from 3 different regions of the United States. Almost all of these schools served low-income and ethnically diverse communities. We describe general impressions of parent engagement, parent reactions and preferences with regard to CBITS, barriers to parent engagement, and how to overcome barriers from multiple perspectives. Parent engagement across schools varied, with extensive outreach and relatively good parent engagement in CBITS described in some schools, while in other schools, efforts to engage parents were not as consistent. Implications for future efforts to engage parents in school-based treatments are discussed.

Keywords

parent engagement; schools; parent involvement; mental health; services

Implementation of evidence-based practices has become a central concern for researchers, clinicians, and service systems, including schools (Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007; Weisz, Sandler, Durlak, & Anton, 2005). Because schools can reach many children who might not otherwise receive care (Jaycox et al., 2010), they continue to implement numerous mental health treatments that benefit both children's emotional well-being and academic functioning (e.g., Kataoka et al., 2011). Despite increasing implementation of mental health services in schools, it remains a challenge to engage

parents in such services. Further, engaging parents in schools more broadly remains a challenge for many communities despite the positive impact of parent engagement on child functioning (e.g., Jaynes, 2007). This study explores parent engagement in an evidence-based program, the Cognitive Behavioral Intervention for Trauma in Schools (CBITS; Jaycox, 2004), which is primarily designed as a child level group treatment in schools to target trauma-related mental health symptoms but also includes two sessions for parents.

Evidence-based treatments in schools have targeted a number of problem areas such as behavioral problems, social skills, depression, and suicide. Exposure to violence and trauma is a key concern especially for urban schools; in fact, a recent study found that 61% of children had experienced or witnessed violence, trauma, or abuse in the previous year (Finkelhor, Turner, Ormrod, & Hamby, 2009). Traumatic experiences extend beyond violence or victimization to include natural disasters or terrorism (Osofsky, Osofsky, Kronenberge, Brennan, & Hansel, 2009). Still, low-income and ethnic minority children are at increased risk for exposure to violence, with high rates of violence and gang activities occurring in urban schools with large ethnic minority populations (Neiman & DeVoe, 2009). CBITS was originally developed in response to these high rates of community violence but has since been extended to treat other types of trauma, including exposure to natural disasters (Jaycox et al., 2010).

Trauma and violence exposure can lead to a number of difficulties for children, including PTSD, depression, anxiety, and behavioral problems (Lynch, 2003). Trauma exposure can also impact cognitive and academic functioning (Lynch, 2003; Overstreet & Mathews, 2011), contributing to difficulties with sustained attention, memory, and executive functioning (Beers & De Bellis, 2002; DePrince, Weinzierl, & Combs, 2009). Given the negative consequences of exposure to trauma, evidence-based programs that can reduce such symptoms are sorely needed, especially among traditionally underserved populations who are at increased risk for trauma exposure (Overstreet & Mathews, 2011).

Fortunately, there are multiple evidence-based treatments that have been developed to treat children exposed to trauma. The Cognitive Behavioral Intervention for Trauma in Schools (CBITS) is one such program, and it was specifically designed for implementation in schools (Jaycox, 2004). CBITS includes 10 child group sessions that incorporate education about reactions to trauma, relaxation training, cognitive therapy, trauma exposure, and social problem-solving (Jaycox, 2004). In addition, CBITS includes an educational session for teachers and two group parent sessions that offer psychoeducation about trauma and describe skills that students learn in their groups (Jaycox, 2004). CBITS has been shown to reduce symptoms of PTSD, anxiety, and depression in multiple studies (Jaycox et al., 2010; Kataoka et al., 2003; Stein et al., 2003). Further, because CBITS is a school-based and group program, it has the potential to impact more children than other community or individually focused programs. For example, when families were randomized to receive CBITS in schools or Trauma-Focused CBT (TF-CBT) in clinic, 98% of families began CBITS, while 37% started TF-CBT (Jaycox et al., 2010).

Parent engagement in evidence-based treatments for trauma (e.g., Lieberman, Van Horn, & Ippen, 2005) and for other problems (e.g., Eyberg, Nelson, & Boggs, 2008) is generally recognized as a key component of treatment. TF-CBT, another effective trauma intervention, includes parent management skills and communication skills to enhance trauma-related discussions between parents and children (Cohen, Deblinger, Mannarino, & Steer, 2004), while other trauma programs specifically target the parent-child relationship (Lieberman et al., 2005). Research suggests that the parental component of TF-CBT increases the positive effects of TF-CBT for children by improving parents' own levels of

depression, emotional distress about their child's trauma, support of the child, and parenting practices (e.g., Cohen et al., 2004).

CBITS reduces the amount of parent participation, making it a more feasible school-based intervention where parents are invited and encouraged to attend the parent sessions, but not mandated. Still, CBITS recommends two parent sessions plus planned phone contact to help mobilize parental support as a resilience factor and to ensure that planned activities (exposure) are successful (Jaycox, 2004; Jaycox, Kataoka, Stein, Langley, & Wong, 2012). More specifically, CBITS recommends engaging parents in learning about common reactions to trauma, supporting their child's use of cognitive and problem-solving skills, and helping with real-life exposure (Jaycox et al., 2012).

Despite being identified as a key component to many evidence-based treatments (e.g., Cohen et al., 2004) and a recommended component to CBITS, parent engagement in mental health services is often challenging. Single-parent status, low socioeconomic status, parent psychopathology, ethnic minority status, and neighborhood disadvantage have all been identified as factors related to lower rates of engagement in clinical services (Nock & Ferriter, 2005; Snell-Johns, Mendez, & Smith, 2004). Parents report barriers such as limited time and scheduling conflicts, high costs, and lack of transportation and child care (Davis, Ressler, Schwartz, Stephens, & Bradley, 2009; Stevens, Kelleher, Ward-Estes, & Hayes, 2006). In addition, when parents perceive little benefit to services, do not view the treatment goals as relevant, or view providers as judgmental or lacking empathy, they are less likely to remain engaged (Gross, Julion, & Fogg, 2001). Engaging parents in treatment for child trauma is not immune to these common barriers. In addition parents may feel guilt surrounding their child's trauma and/or have their own trauma (Lieberman et al., 2005), which can be additional barriers to engagement in child treatment for trauma.

In addition to these potential barriers, parent engagement in school-based services can be complicated (Gopalan, Burton, McKay, & Rosenzweig, 2008). Dissemination of mental health treatments into schools can reduce barriers to accessing care and help to ensure that low-income and ethnic minority children receive needed treatment, but parents may not have initiated treatment for their children, are not bringing their children to appointments like in traditional settings, and may not fully understand what type of treatment their child is receiving, while clinician efforts to engage parents are often inconsistent (e.g., Gopalan et al., 2008). Thus, engaging parents in a school-based treatment for trauma can be especially challenging as parents are often not seeking the treatment and may have trauma related stigma concerns. For this reason, more understanding of parents' views of school-based services and their engagement in such services is needed. Further, to improve implementation of evidence-based treatments that include parents in schools, we need to learn how clinicians can succeed in working with parents in this setting.

Beyond parent engagement in school-based mental health services, parent engagement in schools more broadly benefits children. Parent engagement in a child's school and academic experiences positively impacts student academic achievement (Jeynes, 2007) and is related to emotion regulation and social competence (Hill & Craft, 2003). Despite the positive impact of parent engagement in schools, similar challenges to engaging parents in treatment can arise, such as negative attitudes toward partnering with parents among school staff, parental perceptions of discrimination, lack of school outreach, and language barriers (Gopalan et al., 2008).

To explore parent engagement in CBITS, parent reactions to CBITS, and the successes and challenges in engaging parents in a school based program, we conducted qualitative interviews by telephone to obtain data from clinicians, parents, and other school personnel

across eleven schools from 3 different regions of the United States. Most of these schools serve low-income and ethnically diverse communities. We highlight findings from schools where parent engagement in CBITS worked well and contrast this with schools where efforts to engage parents were not as consistent. We explore general impressions of parent engagement, parent reactions and preferences with regard to CBITS, barriers to parent engagement, and how to overcome barriers from multiple perspectives.

Method

Participants

The data for this study is drawn from 11 schools (51 participants) across three distinct geographic regions: West Coast (4 schools), Midwest (4 schools), and Southern (3 schools). Following a community-partnered participatory research framework (e.g., Wells & Jones, 2009), school and community partners identified participating schools and assisted in recruiting this convenience sample. Of the 71 potential participants that were identified by community partners, 51 (72%) completed interviews, 15 declined participation, and 5 were unable to be contacted. Participants (including teachers, school and community clinicians, parents, administrators and regional administrators) were selected from schools where CBITS had been delivered for at least one year. Each participant provided verbal consent and received a \$20 merchandise gift card for participating in the interview. This study was conducted in compliance with the university IRB.

The purpose of the present study focused on parents' engagement in CBITS. Across the 11 schools, we interviewed 11 parents, 15 clinicians, 11 teachers, 9 school administrators, and 5 regional administrators (e.g., funding administrators, regional mental health coordinators). Parents of students who had participated in CBITS were recruited from 6/11 schools (Schools A-F). At the remaining 5 schools (Schools G-K), parents were either unable to be contacted (e.g., non-working telephone number) or declined participation in the research study. The clinicians included two psychologists, three counselors, and ten social workers. Two clinicians came from an outside agency to co-facilitate CBITS sessions. The remaining clinicians were school-based, though some partnered with outside agencies to implement CBITS in their schools. Clinicians had an average of 8.50 (SD=4.07) years of experience working in schools, ranging from 3 to 15 years. See Table 1 for a demographic summary of the participants.

Procedures

Participants took part in semi-structured phone interviews, from July 2010 to January 2011. The interviews sought to gather information about the adoption, implementation and dissemination of CBITS through questions from an interview guide that focused on a range of areas such as norms and attitudes about the role/relevance of mental health services in schools and about the perceived benefits of the CBITS program. Interview questions were developed drawing from a conceptual framework that considers the characteristics of the implementation process, contextual factors, sustainability, and financing of evidence-based interventions within community settings (Mendel, Meredith, Shoebaum, Sherbourne, & Wells, 2008). Relevant to the current study, clinicians were asked specific questions about overall parent engagement in the school and engaging parents in CBITS, such as: (1) How would you describe the parent-school connections at your school? (2) As you delivered CBITS, what are some strategies you have used for engaging and supporting parents? Parents were asked specific questions about their level of engagement in CBITS and overall parent participation at the school, including: (1) Sometimes there are also CBITS parent sessions - were you aware of any being offered? (2) How important do you think it is for parents to be involved in these services? (3) From your perspective is there a lot of parent

involvement at your school? Can you think of ways to improve or increase parent involvement? Complete interview guides are available on request.

Data Analysis

All interviews were audio recorded and later transcribed by members of the research team. Atlas 6.2 was used for qualitative analysis of major themes across interviews. These themes were developed by the research team through a series of meetings where team members identified, discussed and agreed upon common themes using a grounded theoretical framework (Corbin & Strauss, 1990). After locating the major themes throughout the interviews, simple codes were created that represented each theme; each code was given a definition list for clarity. Some adjustments were made to the codes through team discussion and two members of the research team reviewed each interview for inter-rater reliability. Following the preliminary coding of the interviews, the research team identified codes that could be distilled further, codes that could be eliminated, and codes that could be collapsed. During this phase, the research team met weekly to ensure interrater reliability and resolve any coding differences through consensus.

For the qualitative analysis of this study, codes were identified from the larger study that pertained to parent engagement in CBITS, such as Parent Engagement, CBITS Implementation, and Improvement. Using the larger study's coded data, the researchers of this study refined the analysis in order to identify recurring subthemes related to parent engagement within schools and across participants (Braun & Clarke, 2006). For the purposes of this analysis, two of the authors also reviewed full transcripts using open coding to identify additional themes relevant to this study and to ensure that all valuable information in regards to parent engagement was included within the more detailed codes and subthemes. We examined the themes from schools with parent interviews and those without parent interviews and found no clear differences in clinician and other participant responses. We also examined schools across regions to ensure results were not specific to region and found no clear patterns.

Results

General Impressions of Parent Engagement in CBITS

Descriptions of parent engagement in CBITS varied across schools, with some noting strong engagement and others describing challenges to engaging parents as part of CBITS. In addition, there was variation in what was attempted and offered to parents. Four schools described strong outreach and in-person parent sessions consistently offered, with generally good response from parents (School B, F, G, H). Other schools appeared to work with parents in multiple ways—phone, in-person, and letters, with formal parent sessions only occasionally offered and variable response from parents (School A, C, J, K). Finally three schools described not offering formal parent sessions in any consistent way, though some contact with parents was reported by all schools (School D, E, I). See Table 2 for a summary of results by school.

Schools B, F, G, and H described overall good engagement with parents. At these schools, parents, clinician, and school personnel agreed that relationships were strong due to outreach and trust, with a lot of communication initiated by the clinicians and many parents engaged in the school more generally. One School B clinician described good overall success in engaging parents in CBITS: “I think the beauty of CBITS is having the parents involved. So even from the start, I meet with the parent and the student to go through [the trauma] that has been bothering their child, and then all of this homework is getting shared with the families. So I feel like [the parent meeting] is bringing families together and teaching them

that this is just a memory, but it does not have to be an unspoken topic and doesn't have to be scary."

In contrast, parent sessions were not typically offered at Schools D, E, and I. Parent engagement in CBITS was described as the "weakest link" and identified as an area of needed improvement (School E), or not a focus of the program despite good parent engagement at the school generally (School D).

At other schools the picture was more mixed. Clinicians at Schools A and C noted that there is some engagement in the school generally from parents, and parents seem receptive to CBITS, but good attendance at parent CBITS sessions was still challenging. At school J and K, clinicians noted that they were often able to connect with parents by phone individually, and only sometimes held in-person meetings, noting "Just because of time and other barriers it would have been next to impossible to get everybody in at the same time." Describing parent-school connections, one clinician (School A) noted: "Unfortunately, it's the ones who we need to reach out to [who] are the ones who are not [as available]. So I think the parent component is strong here but not always with the parents that we need." Other clinicians (School C, E) noted that parent engagement in the school overall is fairly weak, which makes it even more challenging to engage parent in CBITS.

Parent Reactions and Preferences Regarding CBITS

Though parent engagement varied across schools, all parents (11/11) in this study reported being supportive of having mental health services, specifically CBITS, in their children's schools. Parents described the need for CBITS in their schools due to various stressors common in the community, such as drugs (7 parents), exposure to violence (4 parents), peer pressure or bullying (4 parents), gangs (2 parents), and sex (2 parents). For example, a parent from School A reported a general sense of insecurity among both parents and children: "...when someone is walking around in the city, they are not sure when there will be a gun shot." Clinicians reported similar concerns including violence exposure (5), poverty (5), peer pressure or bullying (7), and family problems (4). All parents reported feeling that it was appropriate and beneficial to have such services in the school. One parent (School D) noted that teachers might notice the need for treatment before parents: "parents are sometimes with the kids less than the teachers are on a given day...the teachers may see a change in the children quicker than the parents do." Another parent (School D) noted that children might not have access to services outside of the school: "Unfortunately, there's not enough because our mental health services are limited. There's not much money at all, you know, for our kids or adults." Due to these concerns, parents reported viewing CBITS as both needed and a positive program for their children.

In addition to supporting CBITS in their children's schools, parents also discussed the importance of their own engagement in such services (10/11 parents). This theme is highlighted by a School A parent: "It is very important because this way we can help [our kids] too." Numerous other parents (6/11 parents; School A, B, C, D, E, F) discussed the importance of knowing what their child was learning in groups so that they could support those skills and reinforce them at home: "It's really important for us to be involved because it gives us a sense of knowing how to deal [with] the issues that our kids are going through and also gives us a sense of how to work through our own issues by being in on what they are learning," (School C) and "It is very important for parents to be involved. It kind of goes back to what I was saying before, to be able to reinforce what the [child] learned and what you can do in certain situations," (School D), and "[There] has to be a bridge between the school and the home. Teachers cannot do it alone, parents cannot do it alone" (School F). "However, one parent also noted that some parents, including her, cannot always attend sessions due to other responsibilities.

Though competing responsibilities pose a barrier, parents consistently reported wanting more parent/family sessions or more contact with their child's clinician. Ten (of 11) parents specifically mentioned wanting more sessions or more contact with the CBITS clinician. Parents thought parent sessions could benefit them directly by giving them a space to talk about their own experiences and allowing them to motivate each other, "...because we [parents], at times, are facing difficult situations." (School A). Some parents suggested opening sessions up to additional family members, while others suggested a "parent package" at the beginning of the program describing CBITS sessions and offering advice to parents, as well as a "synopsis" at the end of the program describing the changes seen in the child and how to support change. In addition, some parents suggested offering sessions on family conflicts, managing parental stress, coping skills, loss and grief, and discussing sex and drugs with their children.

Barriers to Parent Engagement in CBITS

Various participants noted difficulties engaging parents in CBITS. The majority of these school clinicians (8/15) noted that lack of time limited their ability to work with parents. Many clinicians have competing responsibilities at their school, making it difficult to meet with parents. At three schools (School C, E, H), it was the first year that the clinician had been involved in implementing CBITS, although CBITS has been delivered at the schools by previous clinicians. Because the program was new to the clinicians and they were learning it as they implemented, they reported that they did not consistently offer parent sessions. The co-facilitator at School E partnered from an outside agency and reported that she had no parent contact, "I think that the weakest link of CBITS was the parent piece...I didn't see it happen. I don't think group facilitators did it...I think there were phone calls made, but there were no group meetings that I was involved in."

Across schools, clinicians and teachers noted difficulties such as non-working telephone numbers for parents, parents having multiple jobs, limited transportation, and homelessness (7/15 clinicians; 8/20 teachers/administrators; School A, B, E, F, H, J, K). For example, when asked about parent sessions, a clinician noted "I think it's challenging because our school is probably about sixty percent low-income and transportation is a barrier. We're far away from the three main neighborhoods that feed in" (School J). Parents also noted that childcare, transportation, and work or scheduling conflicts as barriers (5/11 parents; School A, B, C, F). Others noted instability in clinician presence due to budget cuts and lack of trust as barriers: "...not sure that school will have a counselor next year" (School A). In describing lack of trust a teacher states: "...the community is a big factor. They don't have a lot of trust" (School B). Parents also noted lack of awareness of services and parent sessions as a barrier: "I think the only thing is that a lot of parents are not informed" (School A).

How to Overcome Barriers

Despite barriers, respondents reported a number of strategies that helped them overcome barriers as well as ideas for how to overcome barriers in the future. At 9 of the 11 schools, clinicians described the need to make extra efforts to engage parents (12/15 clinicians; School A, B, C, E, F, G, H, J, K)—some had already done so with varying degrees of success, while others were discussing strategies to try in the future to engage parents in CBITS. For example, at Schools B, F, and H, clinicians reported making home visits when necessary to work with parents, while at school G and K, clinicians also described extra efforts to make personal connections: "I go out of my way to build relationships with parents and to help them with whatever situation they are in. So I would meet the parents whenever...if they work five different jobs, I meet them at that job site" (School K) and "You think parents are going to show up if I don't call them personally? They're not. A flyer is not going to do it. My success in the parent meeting a month ago was because I made

phone contact to every single one of those parents. It's a connection that makes a big difference in terms of parent involvement" (School G). Others described the need to make more consistent efforts: "Well I think one [solution] is trying to reach out to the parents.... get the parents more involved. Try to do more parent groups" (School A) and "There are mandatory parent meetings once a month, [this] could be a way to talk to parents either through a series of workshops or lectures ..." (School C).

Clinicians also noted the need for more staff trained in CBITS to help implement all of the components (8/15; School A, B, C, E, F, H). One clinician noted that bringing in social work interns for practicum training could help, "...ideally if I could have one social worker from the district come in and work with two interns and take a group...I just think having more trained professionals that can do the service" (School B). Clinicians also noted that more awareness of CBITS from other school personnel supports their work (12/15; School A, B, C, E, F, G, H, I, J, K). From School F, the clinician noted, "Support staff here in this building know a lot about trauma because a lot of us were trained [in CBITS], it wasn't just me. The psychologist and the nurse were trained...in general as a team we have more awareness." The clinician from School B noted, "My principal has been an amazing supporter of everything related to school mental health on this campus." A teacher at School B described a good working relationship with the clinician, "I would say I'm hands on in the sense that I'm always interested in what she's doing and she's a part of the leadership team, she meets regularly with us to develop our school plan...So I would say I count on her as a partner." Supportive relationships with other school personnel seemed to reduce stress and burden, fostering more community outreach.

Parents (11/11) also offered suggestions to improve parent attendance and engagement in CBITS. Multiple parents suggested providing transportation, providing childcare, and offering sessions after work hours to increase attendance (School B, C, F). Parents also requested more sessions, more follow-up from clinicians, and more information (School C, E), "Just stick with follow-up. If we can't make it to the actual sessions in person, there should always be contact information available to us" (School C). Another parent noted that fostering positive relationships before there are problems can help parents be more receptive to teachers and clinicians, "...if they show some type of want or desire for parents to be more involved then I feel that parents maybe want to more involved without having to just sit back and wait for things to pretty much get out of control before we are notified of anything" (School C).

Promoting Parent Engagement in CBITS

In some of the schools sampled, particularly noteworthy descriptions of factors that promoted parent engagement came up. Five schools reported having generally good parent engagement across the school (School A, B, D, F, H). A clinician from School A reported that "60-70 parents sign up every year as volunteers in the school," while a teacher from School B said "I've been fortunate that I'm really blessed with the parents, they are really giving to me and maybe because I am very active with them along the year...They're very giving and they're very willing [to be involved]." A parent (School D) noted, "Parents are very involved, it is one of the best things about this school." At most schools where general parent engagement at the school was high, clinicians noted that parents were more receptive to CBITS and to parent sessions. The exception was School D, where both clinicians and parents agreed that parents were very engaged at the school, but parent sessions were not offered as part of CBITS.

Another noteworthy factor that was discussed centered on trust, personal connections, and empathy (5/11 parents discussed this). Clinicians and school staff also noted the importance of trust at School B, F, and G, three schools that were very successful in engaging parents.

At School F, a parent stated, “I like the atmosphere because when you go into the school you don’t feel like you are an outcast and always feel welcome.” A clinician (School F) noted the importance of positive interactions with parents generally: “I would say we try to have as much communication or contact with parents as possible. We encourage teachers to call parents with good news. We just got done with parent-teacher conferences, pretty good turnout there.” A clinician at School G described the importance of personal connections with parents: “That connection is powerful and meaningful and I think that affects the outcome that you can get with parent involvement.” A clinician at School B noted that she was able to meet with all parents, but puts in extra efforts to ensure that happens, “All of the parents whose children we screened and they came up high for CBITS, they came to meet with me and have that discussion with their child and me...because I feel that it is not enough to just meet with the kid. So I would rather expend the energy into tracking [parents] down.” A parent at the same school (School B) noted the trust she felt with this clinician, “her door is never closed” and “you don’t trust everybody with certain issues in your life and to come to one like that [*name of clinician*] it was real good, it was real helpful.” Another parent (School F), when asked why she allowed her child to participate in CBITS, responded with “Well I really trusted [the clinician]. I trust her, I trust the school.” An administrator (School B) described fostering empathy and trust between his staff and community through recognition accomplishments, talking with the community to build trust towards the school (4 or 5 times a year, teachers walk around the community to talk with families about the school), and offering classes for parents through the school clinician. This administrator felt that these efforts communicate hope and understanding to the entire school community: for the parents, “And they look at it and say—I can change, I do have some control, I do have the power to make things happen. That’s inspirational” and, for the staff, “So one of my routine strategies when a teacher comes to complain about a child or constantly sends a child to the office because of some problem. I say let’s go visit the home. And believe me, all you have to do is sit in somebody’s shoes for a little while and all of a sudden the perception of what you need to do changes” (School B). A teacher (School B) noted that because of her strong relationship with parents that some of them asked for her opinion before signing the CBITS consent form.

Discussion

This study explored parent engagement in CBITS, an evidence-based program developed to treat trauma-related symptoms in schools. Overall, parent engagement varied across the eleven schools included in this study. Although a recommended part of CBITS, parent sessions were not always offered to parents due to barriers faced by clinicians or difficulty with outreach. When parent sessions were offered, schools had variable responses; with School B, F, G, and H generally have good parent engagement through consistent and extensive outreach. Clinicians also varied in how much they prioritized reaching out to parents, with some clinicians believing parent engagement was essential (School B, G) and other clinicians prioritizing work with the children due to time constraints and unfamiliarity with the protocol.

Although actual engagement varied, a notable finding of this study was how open parents were to having the program offered in their children’s schools. In fact, the majority of parents discussed wanting more parent sessions in CBITS, with many offering suggestions for additional topics such as managing parental and family stressors and how to communicate better with their children. Parents also discussed wanting more tangible materials from CBITS—flyers, brochures, or a package for parents that includes descriptions of the program and well as tools for parents to support their children. Parents who identified barriers to attending CBITS parent sessions, such as long work hours, transportation, and childcare, recommended that sessions be held in the evening or that childcare and

transportation be provided if possible. Much of the literature has described these common logistical barriers (e.g., Davis et al., 2009), along with underutilization of care resulting from stigma-related concerns, fear, or distrust of traditional systems of care especially among ethnic minority and/or immigrant populations (Copeland & Snyder, 2011; Nadeem et al., 2007). However, the findings from this study highlight the importance of not assuming that parents are disinterested in care or will not prioritize participation in services.

The logistical barriers that parents face raised in this study are consistent with prior research, identifying time, transportation, and childcare as common barriers that low-income parents report with regard to engagement in mental health services (e.g., Davis et al., 2009; Stevens et al., 2006). In addition, a number of additional logistical barriers that clinicians face were identified. Clinicians reported that lack of time was a major barrier to implementing the parent component of CBITS. Consistently calling and reaching out to parents can take a significant amount of time and when clinicians have a number of responsibilities in addition to CBITS, parent outreach may become a lower priority. Perhaps clinician efforts could be more strategic if parental preferences are assessed. For example, recent work suggests that some parents prefer active strategies and coaching, while others prefer information only (Cunningham et al., 2008). In some schools, budget unpredictability also contributed to lack of a consistent presence of clinicians in schools and lack of trust that clinicians would remain a source of support for parents.

To overcome barriers, some clinicians suggested that more staff be trained in CBITS so that there could be more support in initial organizational tasks and ongoing outreach to parents. Prior research has found that when clinicians have a network of support from others implementing the program along with administrative support, they are more likely to implement new evidence-based programs (Langley, Nadeem, Kataoka, Stein, & Jaycox, 2010). One clinician reported that social work interns have supported her work at the school, allowing her to run more CBITS groups than she would be able to on her own. Another clinician noted that training support staff in CBITS led to more awareness of trauma and support of CBITS on the team. Other schools described partnering with outside agencies to decrease staff burden. However, in one school the clinician from the outside agency had no contact with parents because the school was unfamiliar to her and parent connections were harder to establish. Thus, although partnerships between schools and agencies can reduce burden and stress, conscious efforts must be made to ensure that parent outreach remains a priority. Though time and staff support are constraining factors, clinicians with the most success engaging parents reported personally taking extra efforts to reach parents, such as meeting in person with both the parent and child to discuss the program, staying in consistent communication, and offering home visits to overcome logistical barriers.

In addition to logistical factors, a number of positive characteristics related to school-community relationships and climate emerged as important for fostering parent engagement. For example, respondents across School B described a climate where community outreach was a priority, home visits were common, and a strong and trusting relationship had been built between parents and the clinician. The clinician at School B strongly believed that parent engagement in CBITS was essential. Likewise, trust and positive interactions with parents were described at School F and G. School B, F, and G had relatively good parent engagement. Though it often requires additional effort and time, consistent outreach along with respect and empathy for the real barriers families may be facing is key for engaging low-income parents in mental health services (McKay, Nudelman, McCadam, & Gonzales, 1996; Santiago, Kaltman, & Miranda, in press).

The results from this study have a number of important implications for promoting parent engagement in evidence-based treatments that are implemented in schools. Clinician views

of how important the parent sessions were to CBITS and their approach to working with parents varied despite being a recommended component of the intervention. Thus, training in evidence-based treatments may require additional time emphasizing parent sessions and describing strategies for engaging and working with parents. For example, when clinician and support staff training is specifically targeted towards improving parent engagement and retention in services, parent participation improves (McKay et al., 1996). In addition to this study, other research has identified door-to-door outreach, persistence, responsiveness, and resource linkages as key for parent engagement (Alameda-Lawson, Lawson, & Lawson, 2010).

In order to ensure that such extensive outreach is feasible, clinicians must be supported in reaching this goal, with recognition of the time involved in parent outreach and an overall school climate that prioritizes this same goal. Services in schools are often limited by budget and staff constraints, making it important not to view parent engagement as an all or none component. Research suggests that school-based services reach many more children and even with partial or little parent engagement, children demonstrate symptom reduction (Jaycox et al., 2010). Thus we want to emphasize services in schools with limited parent engagement are still better than not offering school-based programs or referring to clinics exclusively. Still, increasing parent engagement in school-based services may enhance effectiveness. Unfortunately outcomes were not directly assessed in this study, though some parents and clinicians indicated they believed parent engagement was key to child improvement. In this study, the majority of parents described wanting more opportunities to participate in CBITS suggesting many parents will likely be responsive to school outreach efforts. University-school-community partnerships can also work together to support this goal through shared training, outreach, and resources.

Although this study had a number of strengths, such as including both parent and clinician perspectives and sampling across different regions of the United States, it also has some limitations that are important to note. Community partners assisted with recruitment of both clinicians and parents, which could have introduced bias by nominating particularly successful or involved clinicians and parents. Further, parents were not able to be recruited from 5 of the 11 schools, limiting our conclusions with regard to those schools. The sample size was also relatively small and the current study examines experiences related to implementing CBITS only. Thus, this study should be interpreted as an exploratory one given the limited sample size and focus. The results of this study may generalize to implementation and parent engagement in other programs, though additional research will be needed to examine how these findings may translate to other programs or populations. Of note, barriers related to culture or race/ethnicity were not typically raised by clinicians or parents, though this was not directly assessed in the interviews limiting our interpretation of this finding. In addition, parents did not raise stigma-related concerns, though it is possible that parents who may have not participated in CBITS due to these concerns, may not have been identified for participation in this study.

Schools have become a focal source of mental health services for low-income students and further understanding of how schools can effectively engage and integrate parents into evidence-based mental health programs is an important next step for implementation research. The findings of this study illustrate that parents are invested in school-based mental health services and perceive them to be valuable and integral to their children's well being and academic success, in contrast to a common assumption that low-income parents are less interested in mental health services. Thus, in addition to the need for replicating and extending these findings, future research should also begin to evaluate the use of various engagement strategies and the training and support needed for ongoing implementation of such strategies.

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References

- Alameda-Lawson T, Lawson MA, Lawson HA. Social Workers' Roles in Facilitating the Collective Involvement of Low-Income, Culturally Diverse Parents in an Elementary School. *Children & Schools*. 2010; 32(3):172–182.
- Beers SR, De Bellis MD. Neuropsychological function in children with maltreatment-related posttraumatic stress disorder. *American Journal of Psychiatry*. 2002; 159(3):483–486. [PubMed: 11870018]
- Braun V, Clarke V. Using thematic analysis in psychology. *Qualitative Research in Psychology*. 2006; 3(2):77–101.
- Cohen JA, Deblinger E, Mannarino AP, Steer RA. A multisite, randomized controlled trial for children with sexual abuse-related PTSD symptoms. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2004; 43(4):393–402. [PubMed: 15187799]
- Copeland VC, Snyder K. Barriers to Mental Health Treatment Services for Low-Income African American Women Whose Children Receive Behavioral Health Services: An Ethnographic Investigation. *Social Work in Public Health*. 2011; 26(1):78–95. [PubMed: 21213189]
- Corbin JM, Strauss A. Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology*. 1990; 13(1):3–21.
- Cunningham CE, Deal K, Rimas H, Gold M, Sdao-Jarvie K, Boyle M. Modeling the information preferences of parents of children with mental health problems: A discrete choice conjoint experiment. *Journal of Abnormal Child Psychology*. 2008; 36(7):1123–1138. [PubMed: 18481167]
- Davis RG, Ressler KJ, Schwartz AC, Stephens KJ, Bradley RG. Treatment barriers for low-income, urban African Americans with undiagnosed posttraumatic stress disorder. *Journal of Traumatic Stress*. 2009; 21(2):218–222. [PubMed: 18404649]
- DePrince AP, Weinzierl KM, Combs MD. Executive function performance and trauma exposure in a community sample of children. *Child Abuse & Neglect*. 2009; 33(6):353–361. [PubMed: 19477515]
- Eyberg SM, Nelson MM, Boggs SR. Evidence-based psychosocial treatments for children and adolescents with disruptive behavior. *Journal of Clinical Child and Adolescent Psychology*. 2008; 37(1):215–237. [PubMed: 18444059]
- Finkelhor D, Turner H, Ormrod R, Hamby SL. Violence, abuse, and crime exposure in a national sample of children and youth. *Pediatrics*. 2009; 124(5):1411–1423. [PubMed: 19805459]
- Gopalan, G.; Burton, G.; McKay, MM.; Rosenzweig, JM. 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*. Paul H. Brookes; Baltimore: 2008. p. 201-237.
- Gross D, Julion W, Fogg L. What motivates participation and dropout among low-income urban families of color in a prevention intervention? *Family Relations*. 2001; 50(3):246–254.
- Hill NE, Craft SA. Parent-school involvement and school performance: Mediated pathways among socioeconomically comparable African American and Euro-American families. *Journal of Educational Psychology*. 2003; 95(1):74–83.
- Jaycox, LH. CBITS: Cognitive behavioral intervention for trauma in schools. Sopris West; Longmont, CA: 2004.
- Jaycox LH, Cohen JA, Mannarino AP, Walker DW, Langley AK, Gegenheimer KL, Schonlau M. Children's mental health care following Hurricane Katrina: A field trial of trauma-focused psychotherapies. *Journal of Traumatic Stress*. 2010; 23:223–231. [PubMed: 20419730]
- Jaycox LH, Kataoka SH, Stein BD, Langley AK, Wong M. Cognitive-Behavioral Intervention for Trauma in Schools. *Journal of Applied School Psychology*. 2012; 28(3):239–255.

- Jeynes WJ. The relationship between parental involvement and urban secondary school student academic achievement: A meta-analysis. *Urban Education*. 2007; 42(1):82–110.
- Kataoka S, Jaycox LH, Wong M, Nadeem E, Langley A, Tang L, Stein BD. Effects on school outcomes in low-income minority youth: Preliminary findings from a community-partnered study of a school-based trauma intervention. *Ethnicity & Disease*. 2011; 21(3 Suppl. 1)
- Kataoka SH, Stein BD, Jaycox LH, Wong M, Escudero P, Tu W, Fink A. A school-based mental health program for traumatized Latino immigrant children. *Journal of the American Academy of Child & Adolescent Psychiatry*. 2003; 42(3):311–318. [PubMed: 12595784]
- Langley AK, Nadeem E, Kataoka SH, Stein BD, Jaycox LH. Evidence-based mental health programs in schools: barriers and facilitators of successful implementation. *School Mental Health*. 2010; 2(3):105–113. [PubMed: 20694034]
- Lieberman AF, Van Horn P, Ippen CG. Toward evidence-based treatment: Child-parent Psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry*. 2005; 44(12):1241–1248. [PubMed: 16292115]
- Lynch M. Consequences of children's exposure to community violence. *Clinical Child and Family Psychology Review*. 2003; 6(4):265–274. [PubMed: 14719638]
- McKay MM, Nudelman R, McCadam K, Gonzales J. Evaluating a social work engagement approach to involving inner-city children and their families in mental health care. *Research on Social Work Practice*. 1996; 6(4):462–472.
- Mendel P, Meredith LS, Shoenbaum CD, Sherbourne CD, Wells KB. Interventions in organizational and community context: A framework for building evidence on dissemination and implementation in health services. *Administration and Policy in Mental Health and Mental Health Services Research*. 2008; 35(1-2):21–37. [PubMed: 17990095]
- Nadeem E, Lange J, Edge D, Fongwa M, Belin T, Miranda J. Does stigma keep poor young immigrant and US-born black and Latina women from seeking mental health care? *Psychiatric Services*. 2007; 58(12):1547–1554. [PubMed: 18048555]
- Neiman, S.; DeVoe, JF. Crime, violence, discipline, and safety in U.S. public schools: Findings from the School Survey on Crime and Safety: 2007-08 (NCES 2009-326). National Center for Education Statistics, Institute of Education Sciences, U.S. Department of Education; Washington, DC: 2009.
- Nock MK, Ferriter C. Parent management of attendance and adherence in child and adolescent therapy: a conceptual and empirical review. *Clinical Child and Family Psychology Review*. 2005; 8(2):149–166. [PubMed: 15984084]
- Osofsky HJ, Osofsky JD, Kronenberg M, Brennan A, Hansel TC. Posttraumatic stress symptoms in children after Hurricane Katrina: Predicting the need for mental health services. *American Journal of Orthopsychiatry*. 2009; 79(2):212–220. [PubMed: 19485638]
- Overstreet S, Mathews T. Challenges associated with exposure to chronic trauma: Using a public health framework to foster resilient outcomes among youth. *Psychology in the Schools*. 2011; 18(7):738–754.
- Santiago CD, Kaltman S, Miranda J. Poverty and mental health: How do low-income adults and children fare in psychotherapy? *Journal of Clinical Psychology*: In session. in press.
- Snell-Johns J, Mendez JL, Smith BH. Evidence-based solutions for overcoming access barriers, decreasing attrition, and promoting change with underserved families. *Journal of Family Psychology*. 2004; 18(1):19–35. [PubMed: 14992607]
- Stein BD, Jaycox LH, Kataoka SH, Wong M, Tu W, Elliott MN, Fink A. A mental health intervention for schoolchildren exposed to violence. *JAMA*. 2003; 290(5):603–611. [PubMed: 12902363]
- Stephan S, Weist M, Kataoka S, Adelsheim S, Mills C. Transformation of children's mental health services: The role of school mental health. *Psychiatric Services*. 2007; 58(10):1330–1338. [PubMed: 17914011]
- Stevens J, Kelleher KJ, Ward-Estes J, Hayes J. Perceived barriers to treatment and psychotherapy attendance in child community mental health centers. *Community Mental Health Journal*. 2006; 42(5):449–458. [PubMed: 16964565]

- Weisz JR, Sandler IN, Durlak JA, Anton BS. Promoting and protecting youth mental health through evidence-based prevention and treatment. *American Psychologist*. 2005; 60(6):628–648. [PubMed: 16173895]
- Wells K, Jones L. “Research” in community-partnered, participatory research. *JAMA*. 2009; 302(3): 320–321. [PubMed: 19602693]

Table 1

Participant and School Demographics

Participant Demographics (N = 51)					
	Clinicians (N=15)	Parents (N=11)	Teachers (N=11)	School/Regional Administrators (N=14)	
<i>Gender</i>					
Male	1 (7%)	0	4 (36%)	3 (21%)	
Female	14 (93%)	11 (100%)	7 (64%)	11 (79%)	
<i>Age</i>					
Less than 25 yrs. old	2 (13%)	0	0	0	
25-34	6 (40%)	5 (45%)	4 (37%)	2 (14%)	
35-44	5 (33%)	5 (45%)	4 (37%)	4 (29%)	
45-54	1 (7%)	0	3 (27%)	3 (21%)	
55-64	1 (7%)	1 (10%)	0	4 (29%)	
65 yrs. of age or older	0	0	0	1 (7%)	
<i>Race/Ethnicity</i>					
African American, Black	0	3 (28%)	1 (9%)	3 (21%)	
Hispanic, Latino	6 (40%)	4 (36%)	2 (18%)	2 (14%)	
White	8 (53%)	4 (36%)	7 (64%)	8 (57%)	
Other	1 (7%)	0	1 (9%)	1 (7%)	
<i>Highest Level of Education</i>					
Less than High school	0	2 (18%)	0	0	
High school diploma, GED	0	5 (46%)	0	0	
Associates Degree	0	2 (18%)	0	0	
Bachelors Degree	2 (13%)	2 (18%)	6 (55%)	0	
Master's Degree	13 (87%)	0	4 (36%)	11 (79%)	
Doctoral Degree	0	0	1 (9%)	3 (21%)	
School Demographics (N = 11)**					
	A	B	C	D	E F
<i>Enrollment</i>	2117	771	183	398	671 431

Participant Demographics (N = 51)									
School Type Grades	Clinicians (N=15)		Parents (N=11)		Teachers (N=11)		School/Regional Administrators (N=14)		
	Public K-12	Public K-5	Public K-5	Charter 9-10	Private K-8	Public 6-8	Public 6-8	Public 6-8	Public 6-8
<i>Race/Ethnicity</i>									
African American, Black	<1%	6%	93%	7%	14%	26%			
Hispanic, Latino	98%	94%	6%	3%	6%	11%			
White	1%	-	<1%	89%	76%	57%			
<i>Students with Free/Subsidized Lunch</i>									
	100%	97%	84%	NA	30%	48%			
<i>Enrollment</i>									
	428	1340	460	389	535				
<i>School Type</i>									
	Public 6-8	Public 9-12	Charter K-8	Public 6-8	Public 6-8	Public 6-8			
<i>Race/Ethnicity</i>									
African American, Black	3%	3%	97%	33%	31%				
Hispanic, Latino	93%	89%	1%	13%	19%				
White	-	<1%	<1%	40%	42%				
<i>Students with Free/Subsidized Lunch</i>									
	87%	86%	97%	58%	56%				

** Data Source: National Center for Education Statistics: U.S. Department of Education (2010-2011 School Year)

Table 2

Summary of Parent Engagement in CBITS Across Schools

<i>School</i>	<i>CBITS Parent Sessions Offered</i>	<i>General Impressions of Parent Engagement in CBITS</i>	<i>Parent Reactions and Preferences Regarding CBITS</i>	<i>Barriers to Parent Engagement in CBITS</i>	<i>How to Overcome Barriers</i>	<i>Promoting Parent Engagement in CBITS</i>
A	Sessions occasionally offered	Parent contact through phone, in-person, letters; parents receptive to CBITS but attendance challenging; not able to engage parents who need most support	Beneficial to have school mental health services; students and families could benefit from parent/family sessions; wanted more parent/family sessions and more contact with CBITS clinician	Clinicians reported lack of time; parents reported parent lack of knowledge of school resources; parents reported instability in staffing	Clinician reported needing to make extra outreach efforts and needing more staff	Clinician reported good parent engagement at school
B	Sessions offered	Strong clinician outreach; good overall success involving parents in CBITS; parents, clinician, and school personnel believed that strong parent-school relationships were built on trust and empathy	Beneficial to have school mental health services; parents thought it was important to be involved with CBITS; wanted more parent/family sessions and more contact with CBITS clinician	Clinician reported lack of time; teacher reported need to continue to build trust with community	Clinician reported needing to make extra outreach efforts and needing more staff; development of supportive relationships between school staff; clinician made home visits when needed; parents suggested providing transportation, childcare, offering sessions after work	Teacher reported engaging parents, parents sought teacher's advice; clinician described extra effort to involve parents; parent reported trusting clinician; administrator fosters empathy
C	Sessions occasionally offered	Parent contact through phone, in-person, letters; parent engagement fairly weak	Beneficial to have school mental health services; important to know what child is learning in CBITS groups; wanted more parent/family sessions and more contact with CBITS clinician	Clinician's first time implementing CBITS	Clinician reported needing to make extra outreach efforts and needing more staff; parents suggested providing transportation, childcare, offering sessions after work as well as more sessions, clinician followups,	

<i>School</i>	<i>CBITS Parent Sessions Offered</i>	<i>General Impressions of Parent Engagement in CBITS</i>	<i>Parent Reactions and Preferences Regarding CBITS</i>	<i>Barriers to Parent Engagement in CBITS</i>	<i>How to Overcome Barriers</i>	<i>Promoting Parent Engagement in CBITS</i>
D	Sessions not offered	Some parent contact reported	Beneficial to have school mental health services; parents report that teachers might notice a need for treatment before parents and children might not have access to mental health services except through school; important to know what child is learning in CBITS groups; wanted more parent/family sessions and more contact with clinician	Clinician reported lack of time	information, and fostering positive relationships with parents	Parent reported that there is a high level of parent engagement at school
E	Sessions occasionally offered	Some parent contact reported; parent engagement in CBITS weak and needs improvement; parent engagement in school weak	Beneficial to have school mental health services; important to know what child is learning in CBITS groups; wanted more parent/family sessions and more contact with CBITS clinician	Clinician reported lack of time and staff; first time implementing CBITS; lack of awareness of CBITS among school staff; second clinician (from agency) reported lack of familiarity with school	Clinician reported needing to make extra outreach efforts and needing more staff; parents suggested more sessions, clinician follow-ups, information, fostering positive relationships with parents	Parent reported feeling comfortable at the school; Parent reported trusting the clinician; clinician emphasized the importance of positive parent interactions
F	Sessions offered	Strong clinician outreach; parents receptive to CBITS	Beneficial to have school mental health services; wanted more parent/family sessions and more contact with CBITS clinician	Clinician reported lack of time	Clinician reported needing to make extra outreach efforts and needing more staff; clinician made home visits when needed; parents suggested providing transportation, childcare, offering sessions after work	Parent reported feeling comfortable at the school; Parent reported trusting the clinician; clinician emphasized the importance of positive parent interactions
G	Sessions offered	Clinician prioritizes making	If co-facilitators come from outside	Clinician reported making personal	Clinician prioritizes	

<i>School</i>	<i>CBITS Parent Sessions Offered</i>	<i>General Impressions of Parent Engagement in CBITS</i>	<i>Parent Reactions and Preferences Regarding CBITS</i>	<i>Barriers to Parent Engagement in CBITS</i>	<i>How to Overcome Barriers</i>	<i>Promoting Parent Engagement in CBITS</i>
		connections with parents with good response		the school, they don't have a strong connection with parents; lack of time	connections with parents	connecting with parents and making personal connections with good response from parents
H	Sessions offered	Clinician reported good parent involvement			Clinician partnered with school psychologist who had strong working relationship with parents; used phone calls, home visits, and existing meeting to work with parents	Clinician reported strong outreach from her and school psychologist with good engagement from parents
I	Sessions not offered	Parent contact through phone and letters reported. Clinician also encouraged students to share homework with parents.		Parent engagement generally in school "average."		
J	Sessions occasionally offered	Clinician stayed connected to parents through phone contact and some in-person meetings when possible		Lack of transportation for parents; neighborhoods far from school	Clinician reported having some sessions by phone for parents individually	Frequent contact by phone helped engage parents who could not come in- person
K	Sessions occasionally offered	Clinician reported some in-person meetings and some phone contact; preferred individual contact to a group meeting		Families move frequently; homelessness; high rate of parental mental illness	Open door policy; meet parents at their job if needed; evening meetings; share positives with parents	Clinician reported making extra efforts to build relationships with parents