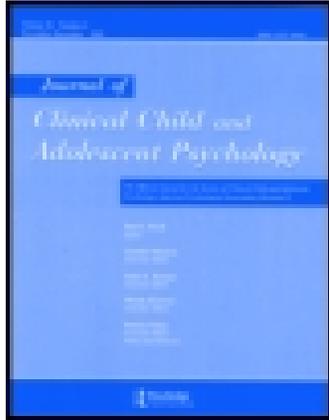


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An Analysis of Stakeholder Views on Children's Mental Health Services

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An Analysis of Stakeholder Views on Children's Mental Health Services

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The purpose was to examine the perspectives of mental health stakeholders as a means to guide the adaptation of evidence-based treatments. The Mental Health System Ecological (MHSE) model was used to organize therapist, administrator, and parent perspectives gathered using qualitative methods. The MHSE model posits the influences of client-level, provider-level, intervention-specific, service delivery, organizational, and service system characteristics on implementation. Focus groups and interviews were conducted with community mental health stakeholders and included parents, therapists, and administrators (N=21). Participants included 11 primarily Caucasian (90.48%) female participants, ranging in ages between 31 and 57 years. Data were analyzed according to the MHSE model. Frequency counts were tabulated for each theme and stakeholder group differences were determined using the Mann-Whitney test. Stakeholder groups mentioned needs at each level of the MHSE model. Stakeholder group differences most notably emerged with child and family themes, which included complexity of mental health issues, parenting differences, and family stressors. Stakeholders identified challenges for optimal mental health services for children across multiple levels of an ecological model. Implications of the findings are discussed, including the continued relevance of adapting mental health interventions by increasing their flexible application across multiple target problems and the promise of partnership approaches.

Given the high prevalence rates of psychopathology in children, as high as 20% (Hoagwood & Olin, 2002), and the high rates of children who do not receive adequate treatments (U.S. Department of Health and Human Services, 2007), significant efforts to develop and test psychological treatments have been made, leading to a multitude of evidence-based treatments (EBTs) for various childhood disorders (e.g., Regan, Daleiden, & Chorpita, 2013). Identification of EBTs has been an important

development; however, researchers have highlighted shortcomings of translating treatments developed in research labs to practice settings. For example, contextual differences have been noted that may require adaptation to extant EBTs (e.g., Ehrenreich-May et al., 2011; Hammen, Rudolph, Weisz, Rao, & Burge, 1999; Southam-Gerow, Chorpita, Miller, & Gleacher, 2008). Further, failures for EBTs to outperform usual care across multiple studies underscore the emerging understanding that dissemination and implementation will not be a straightforward matter (e.g., Clarke et al., 2002; Southam-Gerow et al., 2010; Weisz et al., 2009). There is a need to understand why these failures exist and, further, where efforts should

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be focused for child psychotherapy research. Current research within child mental health, unfortunately, often overlooks the value in mental health stakeholder perspectives towards facilitating EBT implementation. That is, providers or clinic administrators have unique experiences and thus may elucidate important issues and strengths within clinic settings that may help inform EBT implementation and adaptation. The current study aims to highlight the value in mental health stakeholder perspectives on translating EBTs to practice settings.

Scientists in an emerging field called dissemination and implementation science have dedicated their efforts to improve mental health services through a variety of novel studies and methods. Much of this work is based in a broad ecological understanding of the context in which mental health services are delivered. For example, Schoenwald and Hoagwood (2001) conceptualized this perspective as the Mental Health Services Ecological (MHSE) model, a framework that explicitly incorporates the multiple levels of practice contexts, including (a) client-level factors (e.g., referral problem/s, family context, referral source, age, gender, or ethnicity), (b) provider-level factors (e.g., specialized training and received clinical supervision, provider type, whether the provider endorses the intervention model, salary level, or anticipated job longevity), (c) intervention-specific characteristics (e.g., the nature of treatment theory, treatment focus, use and comprehensiveness of manualized treatment, and/or complexity of the intervention), (d) organizational factors (e.g., structure and hierarchical levels of authority within a setting, policies that could affect the personnel, mission of the setting, or mandates), and last (e) service system characteristics (e.g., policies and practices of referral sources and payers, interagency working relationships, or legal mandates of referral sources and other collaborators; Aarons, Hurlburt, & Morwitz, 2011; Damschroder & Hagedorn, 2011; Fixsen, Blasé, Naoom, & Wallace, 2009; Meyers, Durlak, & Wandersman, 2012; Proctor et al., 2009; Schoenwald & Hoagwood, 2001; Southam-Gerow, Ringeisen, & Sherrill, 2006). The emphasis on the multiple levels of the ecology in developing, testing, adapting, and disseminating treatments has been an important driver of recent research efforts (e.g., Brookman-Frazee, Stahmer, Lewis, Feder, & Reed, 2012; Southam-Gerow, Hourigan, & Allin, 2009). In particular, these different levels represent key foci for interventions to facilitate the dissemination and implementation of interventions (see Figure 1).

For example, research has demonstrated that children treated in community settings differ in potentially important ways from those treated in the research tests of many EBTs (e.g., Ehrenreich-May et al., 2011; Hammen et al., 1999; Southam-Gerow et al., 2008). Further, there is evidence that differences between the providers in research studies and community settings may be important to consider when transporting an EBT into the community

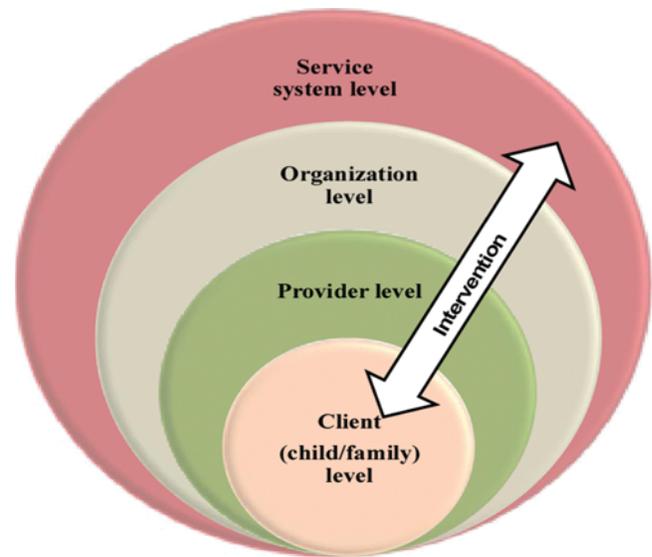


FIGURE 1 Interventions and services research occurs within the multilayer and dynamic context of mental health service delivery (Southam-Gerow, Ringeisen, & Sherrill, 2006). Adapted from Schoenwald and Hoagwood (2001). © [Rightsholder]. Reproduced by permission of [Rightsholder]. Permission to reuse must be obtained from the rightsholder. (Figure appears in color online.)

(e.g., Aarons, 2004; Addis & Krasnow, 2000). These context-related differences may influence how well a particular treatment will work when disseminated to a new setting. Thus, one can view these ecological models (e.g., Damschroder & Hagedorn, 2011; Proctor et al., 2009; Schoenwald & Hoagwood, 2001; Southam-Gerow, Rodríguez, Chorpita, & Daleiden, 2012) as guides in identifying the various directions that dissemination and implementation efforts should be directed.

The current study, an early phase of a multiphase project called the Adaptation of Depression and Anxiety Treatments (ADAPT) study represents one such effort. ADAPT is a mixed-method university–community partnership endeavor designed to adapt and test EBTs for anxiety and depression in a publicly funded mental health agency. The project comprised several phases: (a) initial partnering phase (see Southam-Gerow et al., 2009), (b) qualitative interviews and focus groups (this study), (c) single case series (Quinoy, Southam-Gerow, Hourigan, & Allin, 2013), and (d) an open trial. The present study focuses on the qualitative interviews and focus groups of ADAPT, an endeavor to better understand the perspectives of a variety of stakeholders in the public mental health setting. Although the sample size for the present study is small, the qualitative interviews are meant to identify potential adaptations to EBTs from the perspective of stakeholders.

Some might question the need for a qualitative approach. As is noted in the introduction to this special issue (Southam-Gerow & Dorsey, this issue) and in the

article by Palinkas (this issue), qualitative research includes a wide array of methods such as interviews, observation, and reviews of written documents (see also Patton, 2002). Qualitative methods are a useful approach in a variety of situations, including (a) when little is known about a particular area of science and/or when new ideas are needed to spur more focused quantitative research, (b) when there are one or more groups of stakeholders whose perspectives are poorly understood, and/or (c) when conducting partnership research. The overall goal of ADAPT was to identify optimal and localized methods for adapting EBTs for use in a large, publicly funded mental health agency in central Virginia using a participatory action research framework (see Southam-Gerow et al., 2009). Given this goal to localize EBTs, an understanding of the perspectives of stakeholders concerning treating children and adolescents was deemed an efficient way to identify specific targets for treatment adaptation as well as to maximize the likelihood of sustained change. Specifically, focus groups were the primary approach to obtaining data from stakeholders, as they can benefit and facilitate a conversation-oriented dynamic among participants.

We conducted focus group and individual interviews with three different stakeholder groups—parents, providers, and clinic administrators—focusing our questions on their perceptions about optimal ways to treat mental health problems in children and obstacles they perceive in their system for providing optimal care. We used a qualitative approach to analyzing the resulting data, using the MHSE model as an organizing framework. We hypothesized that although all three stakeholder groups would view barriers at all levels of the MHSE model, each group would emphasize barriers at different levels. Specifically, we anticipated that parents would focus on child/family-level themes, providers on provider/organization/intervention-level themes, and administrators on system-level themes. Again, we aimed to understand these barriers to guide appropriate and relevant adaptations to the EBTs used in later phases.

METHOD

Data for this study were drawn from the ADAPT project, described earlier (see also Southam-Gerow et al., 2009). The sampling employed for this clinic was purposive, such that the clinic served a locality that was diverse with regard to family income, education, race/ethnicity, and urban–rural households. The present study involved both focus group and individual interviews with three separate stakeholder groups: (a) parents of child/adolescent clients, (b) therapists, and (c) clinic administrators. Participants received a \$25 gift card for their participation. This study received Institutional Review Board approval from both Virginia Commonwealth University and the participating agency.

Focus Group and Interview Moderators

The interviewer team consisted of a Ph.D. clinical psychologist and two advanced graduate students. The Ph.D. clinical psychologist moderated the clinic administrator focus groups and conducted parent interviews. An advanced graduate student moderated the therapist focus groups because the Ph.D. clinical psychologist was to supervise some therapists later in the ADAPT project.

Recruitment Procedures

Recruitment was conducted separately for each of the three stakeholder groups. Parent participants were recruited from the current outpatient caseload at the clinic through informational flyers provided by therapists at the agency. Interested parents were instructed to contact study staff for more information and/or to participate in the study. To recruit therapists, the research team attended several staff meetings to provide information about the study to clinic providers and interested therapists were asked to sign up for a focus group meeting. Study staff recruited clinic administrators similarly, attending several administrative meetings, providing information about the study, and inviting participation. Invitations were also mailed out through email and postal mail to both clinic therapists and administrators.

The planned recruitment entailed an open invitation to all clinic-affiliated therapists who treated child/adolescent clients ($n=12$) and clinic administrators involved in child/adolescent services ($n=8$), which resulted in 11 therapist participants and seven administrator participants. At the time of the recruitment, the only nonparticipating therapist was involved in other research-related activities and thus declined participation in the current study. Although we initially hoped to recruit parent participants through active approaches (e.g., letters, in-person recruitment), the confidentiality restrictions and strict clinic policies proved to be a major limitation to parent participant recruitment. Instead researchers played a passive role in recruiting parents; that is, researchers encouraged providers to invite their parent clients to participate and were provided with letters and handouts to provide to interested families. As a result, reasons for nonparticipation of parents cannot be reported, but possible reasons include logistical barriers, such as time limitations or transportation issues, in addition to influences of the passive recruitment process.

Participants

Three female parents participated, and their average age was 40.50 ($SD=7.50$). Because of the relatively small

number, individual interviews were conducted instead of focus groups. Two parent participants identified as Caucasian and one identified as African American. Two reported being married and one reported being single. In addition, parents generally reported obtaining a high school diploma/GED or completing some college; annual family income ranged from \$15,000 to \$70,000. Nonetheless, this sample of parents is comparable to other parents in this particular metropolitan county based on race/ethnicity (primarily White; 71.2%) and median family yearly income (\$17,160; Miller, Southam-Gerow, & Allin, 2008).

Eleven providers chose to participate in one of two focus groups. The average age was 40.00 ($SD=2.43$), most were Caucasian (90.9%) with a master's-level education (81.8%), and almost half (45.5%) were male.

Seven clinic administrators volunteered to participate. The average age was 51.86 ($SD=2.60$). All administrator participants were Caucasian, primarily male (71.4%), with a master's-level education or higher.

Study Procedures

Before beginning focus group and individual interviews, all participants completed demographic information forms. In the end, three focus group interviews were conducted with (a) administrators and (b) therapists, and three individual interviews were conducted with (c) parent participants. All 75- to 90-min interviews and groups were recorded using a digital audio recorder.

The project was introduced to all participants as a way of understanding individual stakeholder needs, organization needs, and client needs when adapting treatment programs to best help families served at the clinic. Although the specific focus group and interview question guides differed slightly for each stakeholder group, the main areas covered for all groups aimed to assess participant descriptive perceptions on (a) causes of anxiety, depression, and conduct-related problems in children; (b) "ideal" treatments for anxiety, depression, and conduct-related problems; (c) barriers and limitations to making these ideal treatments available; and (d) additional comments stakeholders wished to relay to the research team before beginning the study.

Data Reduction and Analysis Plan

Two senior undergraduate research assistants transcribed the audiotaped sessions, after which the second author checked the transcripts against the recordings. The first author provided a third level of accuracy checking.

Preliminarily, irrelevant "noise" (e.g., "ums" and "ahs") was removed from the transcripts. Next, the coders unitized the data, a process that involves the

identification of the smallest piece of information that can be understood as one complete thought, or one complete unit (Rodwell, 1998). Two independent coders unitized each transcript; all discrepancies were discussed and resolved by consensus.

Next, the data were coded using a code book based on the MHSE model. This approach to coding is often referred to as framework analysis, as the coding process entails developing a priori codes to help facilitate the coding process (Flick, 2009). Codes for each level of the MHSE model were established (a) child, (b) parent/family, (c) therapists, (d) agency, and (e) system. Subcodes were also established within each of these levels (e.g., for child code: symptoms of child problem area; child attitudes/perceptions; child biology). In addition, each unit was assigned one of the three following codes (a) barrier, (b) facilitator, or (c) not applicable. Further details on the coding manual are available from the first author.

Transcripts were coded one at a time by two independent coders. After each transcript was coded, the two coders met, identified all discrepancies, and discussed them until consensus was reached. After coding three of the transcripts in this manner, a preliminary agreement level of 90% was reached and all remaining transcripts were coded independently. Consensus coding was useful in discussing complex units of data that informed coder meetings and subsequent coding. Interrater reliability checks were useful during the initial phase (i.e., first three transcripts) to identify problematic units for the two coders.

Coded data were uploaded into the QSR International's NVivo 9 qualitative data analysis software. NVivo allows for "tagging" of codes directly from transcript documents. A matrix query (Stakeholder Group \times Code Type) was conducted in Nvivo and the results were transferred into Statistical Package for the Social Sciences (SPSS 17.0, 2008) for further analysis.

A nonparametric test was used for the quantitative analysis, the Mann-Whitney test, to examine stakeholder group differences in frequency counts. This was done to compromise the non-normality nature of the data. We present the data in two complementary ways. First, we present our thematic analysis, highlighting themes within each stakeholder group. Second, we conducted quantitative analysis of the theme data to place the qualitative findings in context.

RESULTS

We analyzed our results both qualitatively and quantitatively. First, we present our results for each theme by stakeholder group, including exemplars from prominent themes. We do not present findings for the community

and intervention themes because they were rarely discussed and were often encompassed within other themes. Next, we analyzed our data quantitatively, presenting frequencies for each theme by stakeholder group and conducting statistical comparisons of themes among the stakeholder groups. By presenting our data in both ways, we aim to demonstrate the richness and meaning of stakeholder perspectives while also placing each data point in the context of the overall data set.

Child Themes

The child theme represents barriers to ideal treatment that can be attributed to factors associated with the child. There were multiple child themes discussed by all three stakeholder groups. Themes included (a) child symptoms (e.g., problem area, severity, diagnosis), (b) child abilities (e.g., insight, age, resiliency), (c) child attitudes/perceptions (e.g., cooperation, self-sabotage, avoidance), (d) current or past child experiences (e.g., trauma, stigma), (e) child behaviors (e.g., client buy-in to treatment), and (f) child biology (e.g., temperament, personality, genetics). Next, we review exemplar quotations from each stakeholder group related to the child theme.

Parent perspectives. Parents discussed a variety of child-related barriers. For example, they talked about symptoms that complicated treatment: “Why won’t she open up? Again it has to do I believe with the mood disorder, she doesn’t think or feel she has problems.” Caregivers attributed challenges in treatment to a child’s capacity for coping—“I think they don’t know how to handle stuff. ... So he just keeps on, and keeps on, and keeps on ... and each time it gets worse and worse and worse”—as well as how children process events that happen to them—“Her perception of things are different. ... I think a lot of it for a lot of children might be their perception of things. Even the way we speak to each other if the child perceives as a threatening or even when it is not meant to be.” One caregiver also noted how a child’s preference for a particular peer group complicated treatment: “Actually my daughter is drawn to those kinds of people [who bully her].”

In short, parents noted a wide variety of child-related factors that posed barriers to treatment. These barriers generally pertained to a child’s inability or unwillingness to articulate his/her problems and, consequently, learn to cope with them. Other treatment challenges, related to the influences of negative peer group affiliation on treatment.

Provider perspectives. Providers also reflected on child-related factors that served as barriers to the

delivery of effective treatment. One common theme was reflected in this statement: “I don’t like the words we use, but I think it’s very important that you understand we work with multi-problem kids. It’s not just a kid with an anxiety disorder, that’s very clear cut.” Similarly a provider noted, “There’s rarely one diagnosis, given diagnosis, of a mood disorder, anxiety, you know.” In short, cases at the agency were viewed as complex and involving multiple comorbid/co-occurring problem types. In part due to this complexity, providers saw a variety of challenges. One provider surmised that structured treatment would be a challenge for their clients: “A lot of these kids, I have some teens where you would try to do a manual-based anxiety approach, they don’t have the capacity to follow through with it.” Another remarked on the challenge of conceptualizing cases given the multiple problems: “I think a big part of it here is so many of our kids have substance abuse issues and trying to differentiate what’s what; what we’re seeing.” Finally, providers remarked on how child behavior during treatment undermined the effectiveness of treatment. For example, “And sometimes in groups I’ve seen it work two ways, sometimes they’ll be disruptive in group and try to, to sabotage group, sometimes they just feed back to you exactly what you want to hear.” Another example reflects a hypothesized underlying motivation of the child client to subvert therapy: “I see with these kids is that they sabotage themselves right when they get near success after you know you work with them for years.”

Thus, similar to caregivers, providers noted a variety of child-related barriers to effective treatment. One notable difference between caregivers and providers is that providers, given their perspective, were struck by the complexity of their child clients. They also offered more detailed descriptions of how client complexity would impinge treatment efforts.

Administrator perspectives. Administrators too spoke about child-related barriers to treatment. Similar to providers, they noted how complex the cases were. One administrator noted, “I think the thing that troubles us the most in our comprehensive system for dealing with kids who have problems, way out on the far end of the spectrum are a small group of kids, but still very troublesome group of kids, who really have extreme pathology.” Another administrator remarked, “So I think that the dilemma between the kind of real world multiplicity of issues and the information that will kind of be put together in certain and where there’s some conditions around for this particular disorder but without the other complexities in them.” However, in contrast to providers, the administrators’ discussion was not coded into other child-related themes aside from child complexities. Thus,

the administrator perspective, though similar in some respects to the provider perspective, was narrower than the other stakeholder groups.

Family Themes

What follows are examples from each group of the most prominent family-related themes. The family theme represents barriers to ideal treatment that can be attributed to factors associated with family, including (a) family abilities (e.g., family capacity to change, insight to problems and dysfunction), (b) family attitudes/perception (e.g., cooperation, or hope), (c) family experiences (e.g., past therapy experiences, recommendations, relationship with therapist), (d) family behaviors and interactions (e.g., parenting skills, difficult home), (e) family situations (e.g., family status, economic situation, transportation, time management), and (f) family symptoms (e.g., mental health).

Parent perspectives. Parents discussed a variety of family-related treatment barriers. Specifically, parents highlighted the need for treatment to be family-based. This was reflected with one parent who noted, “It’s not going to get better unless you include all family members in treatment.” In addition, parents consistently mentioned the distrust of mental health professionals due to their previous negative experiences with the mental health system. Consequently, one parent noted the importance for therapists to build a strong alliance with parents and families to facilitate retention of families in treatment: “This new counselor I have, I don’t see it [warmth and sincerity]. ... I may switch again ... the connection isn’t there.” Parents talked about the significant influence of dysfunctional family dynamics in a child’s mental health: “Parents are divorcing. ... You don’t really have time to really sit and listen to what’s going on in your kid’s life” and “I don’t think a lot of parents actually find a way to listen. ... No one’s there saying that ‘you can do it.’”

In sum, parents discussed many family-level treatment barriers. Specifically, they noted how parental dysfunction and familial discord (e.g., divorce, psychopathology) negatively influences a child’s mental health problems and further impedes treatment progress. Parents highlighted the importance of involving family in treatment as well as building trust between therapists and parents.

Provider perspectives. Like parents, providers emphasized family themes. However, their perspective focused on the deleterious effect of parent dysfunction on the child and on the treatment process. As one provider stated, “We see a fair number of kids whose

primary problem really is a dysfunctional parent and that the parents are really mentally ill and the child suffering.” Another noted, “A lot of our parents have disabilities, mental illness, different kinds of cognitive functioning, substance use” Similar to parents, providers noted the influences of familial dysfunction on the child’s emotional and behavioral mental health. For example, one provider said, “With our families there’s a lot of chaos, and that’s the problem; you can’t capture them, there’s not consistent attendance, no cooperation.” As a result of this, providers highlighted the importance of learning to work with diverse set of families and parents, because “they are the clients too.” Thus, similar to parents, providers highlighted parent dysfunction and family discord as major impediments toward successful treatment; however, providers emphasized the difficulties they face in engaging these challenging families.

Administrator perspectives. Unlike parents and providers, administrators focused more on family themes as they pertain to organizational and system-level barriers. Specifically, administrators highlighted the logistical transportation barriers that families face, as reflected by one administrator: “So a family may have needs but may not be able to get around ... but there’s a different level of service available for them versus a family that has the resources, has a car, and can get here and see the psychiatrist here,” or language barriers: “I believe there are some well, very obvious language barriers ... not just in Spanish.” Administrators acknowledged that the limited services available at the organization, coupled with the logistical barriers faced by many families, together, limit the available resources for the child “and that’s an unfortunate dilemma ... and I think kids are sort of victims in that respect.”

In short, each stakeholder discussed family/care-giver themes, though their emphases were revealing insofar as they focused on their own domain of expertise. Although reasonable, this observation may imply that stakeholders may benefit from taking alternative perspectives.

Provider Themes

The following section provides the reader with exemplars from each group of the most prominent provider-related themes, including (a) actions and behaviors initiated by providers (e.g., alliance), (b) provider attitudes/perceptions (e.g., attitudes about EBTs), (c) provider experiences (e.g., burnout, provider level of training), and (d) provider specialty (e.g., theoretical orientation).

Parent perspectives. Parents discussed a variety of treatment barriers related to provider themes. In particular, parents focused on the parent–therapist relationship. For example, one provider noted, “In some ways I feel like the counselor sometimes gives her [daughter] excuses for bad behavior, not meaning to ... and it kind of aggravates me.” Furthermore, parents emphasized feeling frustrated with different professional perspectives: “... and even different doctors and different therapists think different things” and as a result, feeling wary and distrustful of health professionals: “So I don’t know why the doctor told us that [our son had autism], was it a money thing?”

Taken together, these findings suggest that parent experiences and interactions with mental health professionals largely influence parent perspectives of providers. This speaks to the influence that a single negative interaction can have on parent perceptions of the mental health system in general, and on the potential damaging effects of mental health professional actions on parent perceptions and subsequent behaviors.

Provider perspectives. Similar to parents, providers echoed what parents discussed related to developing a positive parent–therapist relationship. As one provider noted, “... provide more empathy and nurturance. Because I think that’s really lacking, and it becomes a very hostile environment and a very problem-focused, and they forget the good times.” Providers conveyed the challenges of weighing a family’s crisis against the use of a structured treatment. As one provider relayed, “Trying to figure out how to balance all that out in terms of how to be a clinician who, because I think we do base a lot on our intuition ... at the same time, balance that out with research and so on.”

Providers, like parents, emphasized the importance of a therapeutic relationship and the consequences of a negative parent–therapist relationship as well as describing their perceptions that structured treatment were challenging in the context of treating complex cases. They did not, however, report the same level of negative interactions as did the parent participants.

Administrator perspectives. Administrators also discussed a variety of provider-level barriers. One main issue pertained to challenges with hiring therapists with adequate training. For example, one administrator highlighted issues with recruiting and hiring therapists with solid EBT training:

I sound like a broken record, but we have incredible trouble recruiting staff who have behavioral and cognitive-behavioral expertise already in hand ... because for

whatever reason, the master’s level training programs that tend to send us candidates for positions here do not emphasize that kind of training in their graduate preparation.

Another key point that administrators mentioned related to the confusion with discrepant research “world views,” even across psychological associations. For example, one administrator reflected this:

I remember years ago digging deeply into treatment for depression. ... I went through the American Psychiatric Association’s guidelines, and also the American Psychological Association’s guidelines. It was interesting they were talking about the same issue, but one had the algorithms for medication treatments, and the other had the cognitive-behavioral and interpersonal therapy pieces and medication was referenced a little bit but they were very different world views that were influenced by professionals.

In sum, administrators voiced treatment barriers associated with hiring, training, and deciphering research information and integrating it into their clinic training processes. One consistent finding here is that administrators consistently have a broad 30,000-foot view of barriers to EBT implementation, whereas caregivers and providers highlight challenges much closer to “ground” level.

Organization Themes

The organization theme represents barriers to ideal treatment that can be attributed to factors associated with mental health organizations. There were multiple organization themes discussed by all three stakeholder groups, include (a) the organization’s hierarchy and its procedures pertaining to chains of command, policies affecting personnel (e.g., hiring, compensation time); (b) organizational culture, mission, mandates; and (c) availability of resources, such as training for therapists.

Parent perspectives. One parent noted the challenges of scheduling with the therapist’s restricted schedule: “... counselor could only be here on Tuesdays and Thursday” or the organization’s lack of reminder calls: “I wish they’d give reminder calls the day before. I really wish they’d just call ... a lot of doctor’s offices do this.” Another parent highlighted the limited resources available at the organization related to child care barriers: “It would be nice if they had, like, some attendant that worked in that playroom.”

Together, these findings emphasize parent concern over the limited practical organization resources. It is clear that for parents, these types of challenges may

impede seeking services, continuing services, or attending sessions consistently.

Provider perspectives. Like parents, providers discussed the limited organizational resources; however, they primarily focused on the lack of treatment resources. For example, one provider said, “We don’t have a lot of resources for children with autism.” While another provider expanded to imply that because of these limited resources, providers “feel like we’re putting band aids on all of these wounds that we don’t have the resources to do it.”

Not surprisingly, unlike parents, providers expressed less concern about pragmatic challenges that families face, but instead focused on the limited treatment resources available for therapists. As a result, providers are concerned about the impact this may have on providers’ ability to truly address child/family mental health problems.

Administrator perspectives. Administrator perspectives on organization theme barriers were in line with sentiments presented by parents and providers. Specifically, they talked about the lack of resources with training therapists adequately, as stated by one administrator, “For those staff that wouldn’t be trained, to obviously, to get them that kind of training to support them in those efforts and I think one of the realities we face is trying to meet the needs as it comes in the door.” Another administrator compared how a community clinic compares to a private practice in availability of resources: “Here [public vs. private practice] we are here, and so we have a lot of other things that we can offer, but that’s all we have.”

All stakeholders discussed challenges associated with lacking resources at the organization; however, they differed in how broadly they perceived the problems. For example, parents discussed very specific, concrete issues related to pragmatic organizational barriers, such as childcare or appointment issues, whereas providers and administrators discussed lack of training and treatment resources for families.

System Themes

Finally, multiple system-related themes were discussed by all stakeholder groups, including (a) financing methods (e.g., funding, insurance), (b) interagency working relationships and collaborations (e.g., cross-system cooperation), (c) policies and practices of referral sources and payers, (d) access to services, (e) quality of service, and (f) research (e.g., applicability of findings).

Parent perspectives. Parents discussed treatment barriers related to multisystem barrier, such as legal, insurance, financial, and school systems. For example, one parent noted, “They [children] get into trouble with the law, substance abuse, skipping school and it’s like this, it’s like self-fulfilling prophecy, you know.” There were also parents who expressed financial mistrust in mental health professionals, as described by one parent: “Right, so I don’t know why the doctor told us that [son had autism], was it a money thing? ... Some doctors you can’t believe. ... He wanted my son to take tests they had to administer at his facility that no insurance would pay for.” In relation to school systems, parents acknowledged the importance of communication between systems (e.g., mental health and school): “I know the counselor went to her school and saw her at school a couple of times.”

Together, these findings demonstrate parent awareness of the communication of various systems regarding child mental health. Similar to other themes, however, parents seemed to hone in on the issue of mistrust with mental health professionals at the financial level.

Provider perspectives. Like parents, providers discussed system theme barriers pertaining to multisystem involvement. Specifically, providers focused on involvement with schools, the court system, lack of resources, and financial issues. One provider highlighted the miscommunication between systems: “Sometimes the collaborative effort that we have with the other systems that are involved with the kids, be it the courts ... sometimes they don’t go along with what our recommendations are for the child or the family.” Other providers focused on the need to be involved with schools as mental health educators: “We have to go out into the schools and say this kid isn’t really conduct disorder, they have a lot of anxiety, they’re bipolar” Likewise, providers discussed the need to be advocates for the children with schools, as described by one provider: “Do a lot of work with schools attending the IEPs and those types of programs trying to get resources for what the kids need.” With respect to resource limitations, providers described a lack of treatments or programs geared toward children that are constantly involved with the court system. Providers seemed to point to the lack of funds as a culprit for many of these systemic issues: “If there were more money in the system, then we’d have more services for these kids” and “... only if they have Medicaid are they going to get intensive in home.”

In sum, providers emphasized many system issues pertaining to finances, resources, and interactions with other systems (schools, juvenile justice). Unlike parents, providers went beyond simply understanding that many systems are at play in mental health, highlighting the

challenges in working extensively with many of these systems.

Administrator perspectives. Administrators also discussed multisystem involvement, policy, financial, and access to resources as potential treatment barriers. Although there is a lot of collaboration between schools and other relevant agencies, one administrator noted that the “fundamental business of each of those areas tends to be mostly within,” meaning that each agency works independently. For example, many administrators expressed having difficulty in building relationships with school staff such as school social workers, psychologists, and guidance counselors. Administrators discussed mental health policy as a barrier, as noted by one administrator:

I think there are always things happening at the state level that influence how we do our business ... a major disappointment right now in statewide ... because the major mental health initiative that the governor proposed will in fact get a lot of money in the general assembly, barely speaks about kids.

With regards to financial concerns, providers discussed the need for better financial models that are linked to collaboration: “If you want the grant money, if you don’t have those letters of agreement from other agencies that are involved or key players, you don’t have a chance at getting the money.” Finally, administrators discussed limited access to resources at a system level. For one, a statewide shortage of child psychiatrist and limited hospitals for extreme cases: “There’s only three hospitals in the metro area that will provide services to kids, when they don’t have beds available, families have to take the kids across the state, really hunt around.” Second, they highlighted access issues that families face in navigating the mental health system to receive necessary services: “And what you hear from families about their struggles to access services, and negotiating the system, and get help for their kids.”

All stakeholders discussed system-level issues, though with differing perspectives. Parents focused on expressing the frustration of navigating the various systems, while providers and administrators discussed broader issues with legal, school, and mental health systems. In particular, administrators noted the challenges posed by policy, funding, and access to services.

Theme Frequencies

We also analyzed our data quantitatively to identify differences among stakeholder groups. For these analyses, all themes were retained for analysis, even when frequency counts were low (e.g., community theme).

Table 1 also presents frequency counts for the three stakeholder groups separately. Broadly, there were 2,600 units of total word data across the 21 stakeholder participants. The parent group ($n=3$) accounted for 46% of the data (n units=1,191), or 397 units per participant, whereas the provider group ($n=11$) accounted for 45% of the data (n units=1,156), or 105 units per participant. The administrator group ($n=7$) accounted for 9.7% of the data (n units=253), or 36 units per participant.

Although all groups had a wide range of child themes represented in their data (see Table 1), parents primarily focused on symptom level of this theme as opposed to other areas related to children (e.g., experiences, behaviors). Parents also focused on other child-related themes, such as child attitudes/perceptions, child experiences, and child behaviors. Further, parents discussed family themes, such as family attitudes/perceptions, family behaviors/interactions, and family situations as well as provider-, intervention-, and organization-related themes such as provider actions/behaviors with the families, intervention modalities, and services attributes. Conversely, parents rarely discussed community-related and system-related themes.

Similar to parents, providers primarily focused on child themes. In addition, they discussed family themes, which primarily focused on family behaviors, family situations, family symptoms, and family attitudes and perceptions of mental health. Like parents, providers focused on provider actions and behaviors when discussing provider themes. In addition, providers frequently focused on intervention themes related to intervention type. With organization themes, providers primarily focused on availability of resources at the clinic and also frequently discussed system themes, such as multisystem involvement and access barriers.

Administrators also focused their discussion on child symptom-level themes and identified family-level themes related to the family’s situations. Administrators discussed community-level themes with more frequency than other stakeholder groups. In addition, they more frequently focused on provider specialty issues and intervention intensity level issues. Also, administrators frequently discussed topics related to spread of research (i.e., the extent to which research is disseminated from research to practice), whereas providers and parents did so less frequently. Specifically, administrators discussed multisystem involvement, spread of research, and access issues. Next, we test whether the frequency of themes differed significantly among stakeholder groups.

Testing for between group differences for specific themes. Statistical comparisons were made at the

TABLE 1

Table of Frequency and Percentage Data for Themes by Stakeholder Groups (Percentage of Theme Between Stakeholder Type, Percentage of Theme Within Each Stakeholder Type)

	<i>Parent</i>	<i>Provider</i>	<i>Administrator</i>
CHILD Barriers Total	90 (67.7%, 27.4%)	41 (30.8%, 22.3%)	2 (1.5%, 1.5%)
Symptoms	37	18	10
Abilities	6	10	0
Attitudes/Perceptions	11	8	0
Experiences	11	1	1
Behaviors	24	7	1
Biology	4	0	0
Other	5	2	0
FAMILY Barriers Total	145 (72.5%, 44.2%)	35 (17.5%, 19.0%)	20 (10.0%, 15.3%)
Abilities	0	0	1
Attitudes/Perceptions	43	7	0
Experiences	20	0	0
Behaviors and Interactions	36	17	3
Situations	35	6	9
Symptoms	11	7	1
Other	13	5	6
COMMUNITY Barriers Total	3 (25.0%, 0.9%)	2 (16.7%, 1.1%)	7 (58.3%, 5.3%)
Gang Affiliation	0	0	0
School Involvement	0	1	1
Drug Environment	0	0	0
Peer Environment	2	0	0
Other	1	1	6
PROVIDER Barriers Total	39 (48.1%, 11.9%)	26 (32.1%, 14.1%)	16 (19.8%, 12.2%)
Actions/Behaviors	20	14	0
Attitudes	5	5	3
Experiences	3	4	0
Specialty	8	1	13
Other	3	2	0
INTERVENTION Barriers Total	27 (32.5%, 8.2%)	34 (41.0%, 18.5%)	22 (26.5%, 16.8%)
Type/Modality	22	9	6
Delivery Setting	0	0	0
Intensity Level	0	7	12
Characteristics	0	2	3
Assessment Triage	1	3	0
Case Management	0	0	0
Other	4	14	3
ORGANIZATIONAL Barriers Total	17 (34.7%, 5.2%)	17 (34.7%, 9.2%)	15 (30.6%, 11.5%)
Policies	1	0	1
Service Attributes	5	2	1
Availability of Resources	4	14	8
Culture	3	0	0
Other	4	1	5
SYSTEM Barriers Total	7 (8.2%, 2.1%)	29 (34.1%, 15.8%)	49 (57.6%, 37.4%)
Financial Payments	6	5	6
Multisystem Involvement	0	11	18
Policies	0	0	2
Access	1	11	9
Service Quality	0	0	3
Spread of Research	0	1	13
Other	0	3	6

stakeholder group level (all three stakeholder groups) to assess differences (at the broadest level of analysis) using the nonparametric Mann-Whitney test. Because we were conducting multiple tests, we adjusted the alpha level to minimize Type I errors using the Bonferroni correction (e.g., Jaccard & Guilamo-Ramos, 2002), which entails

dividing the comparison alpha (.05) by the number of outcome variables (in this case, three) and then using this as the critical alpha level for each univariate analysis (in this case, .017).

We tested for group differences in frequencies across the seven themes, which resulted in significant group

differences for only two themes. First, in terms of child themes, all three comparisons yielded statistically significant differences: administrators-parents: $U < .001$, $z = -2.70$, $p = .007$, $r = -.85$, that is, parents had higher mean frequencies than administrators; parents-providers: $U < .001$, $z = -2.58$, $p = .010$, $r = -.69$, such that parents had higher mean frequencies than providers; administrators-providers: $U = 12.50$, $z = -2.52$, $p = .012$, $r = -.59$, that is, providers had higher mean frequencies than administrators. Second, for family-level themes, only two test comparisons yielded statistically significant findings: parents-administrators, $U < .001$, $z = -2.43$, $p = .015$, $r = -.77$, such that parents had higher mean frequencies than administrators; parents-providers, $U = 1.00$, $z = -2.44$, $p = .015$, $r = -.65$, that is, parents had higher mean frequencies than providers. All remaining tests were not statistically significant.

DISCUSSION

This article presents the results of a qualitative study designed to provide an understanding of stakeholder views of barriers within the mental health services for children and families in a single locality in central Virginia, using both qualitative and quantitative analytic approaches. With respect to the qualitative analysis, two primary findings emerged that are particularly relevant to EBT adaptation (a) child and family barriers were discussed across stakeholder groups including child symptoms and family stress and (b) administrator stakeholders consistently discussed all themes more broadly, whereas parents and providers endorsed perspectives indicative of their roles on the “front lines” of mental health services on each barrier. Quantitatively, differences emerged between groups with regard to the frequency that different themes were discussed by stakeholders. Specifically (a) parents were more likely than providers and administrators to discuss child-level and family-level themes and (b) providers more frequently discussed child-level themes than administrators. If we consider the qualitative nature of these two themes (child and family) from parent and provider groups, the most prominently discussed themes include extreme pathology, comorbidity, and financial supports associated with dealing with these “extreme” cases.

In examining the themes qualitatively, we found that parents and providers discussed child and family barriers with differing perspectives. Parents acknowledged that family dysfunction, psychopathology, and discord are deleterious factors to a child's mental health; however, they did not describe how these issues were problematic in therapy. Parents did, however, identify the parent-provider relationship as problematic to

treatment progress. Many parents were clearly attuned to the influences of a strong alliance with their child's therapists and often times discussed this relationship in the context of mistrust. On the contrary, providers focused on the negative family factors that influence a child's mental health and further impede treatment. Providers seemed to emphasize parents as problematic agents in treatment progress. For example, providers highlighted that parents were also “clients” and thus often times barriers to focusing on the child's treatment goals. It is important for providers to establish an effective communication style with parents in the early stages to ensure treatment engagement. Likewise, if it is apparent to providers that parent psychopathology or family discord will impede treatment progress for the child, it is important to build in necessary resources to help support multiple aspects of the child's ecology.

Qualitative themes also indicated that administrator stakeholders' perceptions were from a 30,000-ft view, whereas parents and providers saw barriers at the ground level. This is not surprising given the differing roles of each stakeholder within the mental health system, that is, parents and providers interact with each other and are thus more concerned about ground-level challenges (e.g., child/family themes), whereas administrators manage the clinic as a whole, and thus must manage broad systemic influences on a daily basis.

Although it was not surprising that administrators discussed the system barrier more than they discussed other themes, it was encouraging that parents and providers also recognized and discussed the importance of multisystem involvement issues in children's mental health care. However, there was a qualitative difference in how the groups discussed systemic issues. Administrators discussed challenges at the broader system-level themes, such as limited funding for research and clinics and lack of collaboration between agencies (e.g., school, medical, mental health). In contrast, parents and providers focused on issues in multisystem involvement by describing specific instances. The perspective of collaboration was within a school-clinic-home communication context. For instance, parents and providers discussed mental health supports within the school system, such as Individualized Education Programs, or other resources for children to address mental health problems at school and at home. Administrators, on the other hand, emphasized the influence of local, state, and federal policies on how mental health services were delivered. Overall, parents, providers, and administrators all perceive the challenges within coordinated system of care for children's mental health.

We also tested for quantitative differences of theme frequencies by stakeholder group. It is important to highlight that all stakeholder groups mentioned themes across all levels of the MHSE model. Although not a

surprising finding, the endorsement of barriers across all seven levels of the MHSE model suggests consistent perceptions across all stakeholder groups regarding the challenges facing those providing or receiving mental health services. More importantly, efforts to disseminate EBTs to a setting like this may need to consider the broad ecology. Approaches such as the deployment-focused model (Weisz, Jensen, & McLeod, 2005) or the Consolidation Framework For Implementation Research (Damschroder et al., 2009), both of which offer strong starting points, given their consideration of the multilevel factors involved in mental health services and their focus on ongoing community collaborations.

Stakeholder groups differed in terms of the quantity of their discussion of specific themes. These differences were most apparent for child- and family-level themes. Parents and providers discussed child-related themes more than administrators. Both groups primarily focused on treatment challenges associated with symptom complexity and comorbidity in children at their organization. Although both stakeholder groups more frequently discussed barriers at the child level, there was a qualitative difference in responses. Parents discussed types of symptoms they experience with their children and listed how these symptoms presented behaviorally or emotionally, whereas providers emphasized factors that influence child symptom complexity and severity, such as underdeveloped coping skills, family stressors, or legal issues.

In addition, parents and providers also discussed family-related challenges (family themes) at a higher frequency than administrators. Parents were more inclined to focus on their perceptions and attitudes about family influences on treatment. For example, most parents discussed challenges related to negative parenting practices (such as not setting boundaries) or negative experiences with health professionals. Consequently, they discussed issues with trust of mental health professionals that had developed because of these experiences. Providers, on the other hand, focused on treatment barriers pertaining to family behaviors and interactions. They discussed family stressors and the unwillingness of parents to engage in treatment. Of interest, one provider discussed how some parents were immediately “put off” when providers attempted to explain their use of treatment manuals and quickly “lacked trust” in providers.

Based on these data, there are potential areas for treatment adaptation. Given that parents and providers discussed many challenges at the child and family levels (e.g., symptoms, behaviors, perceptions), models of treatment that allow focus on multiple problem areas and allow for flexibility may be warranted. One example is a modular approach to treatment described by Chorpita, Daleiden, and Weisz (2005; see also Chorpita, 2007).

This approach allows for individualization of treatment content to specific client problems by means of use of a single manual that consists of treatment modules from various problem areas (e.g., anxiety, depression, conduct) and was successful in one recent effectiveness randomized controlled trial (Weisz et al., 2012). Recently, Southam-Gerow et al. (2012) reported promising results for an even more flexible, nonmanual-based approach called *Managing and Adapting Practice*, based in part on Chorpita et al.'s (2005) modular approach. Another example is the unified approach to treatment of emotional disorders, which emphasizes commonalities of emotional disorders rather than differences (Barlow et al., 2011; Ehrenreich, Goldstein, Wright, & Barlow, 2009). Both approaches are potential solutions to addressing comorbid, complex problem areas and lend themselves to practice settings; however, they lack emphasis on addressing parent/family level issues that were discussed among stakeholders.

Given provider and parent emphasis on parent and family stressors, it is important to consider how to address these concerns during the early stages of developing an EBT. This is particularly relevant, given the substantial proportion of parents with mental health needs in community settings (Evans, Edejer, Lauer, Frenk, & Murray, 2001). A study examining mental health services for children and families found that 83% of parents reported at least one detrimental factor, including mental health issues, violence, or felony (Manteuffel, Stephens, and Santiago, 2002). This is meaningful because studies have shown that parent/family stressors moderate treatment participation and outcomes (Beauchaine, Webster-Stratton, & Reid, 2005; Reyno & McGrath, 2006). Therefore, it may be essential when adapting treatment to include guidance for how to address parent/family barriers to therapeutic progress. For example, some intervention developers recommend addressing serious parent problems prior to child treatment because these parents are unable to facilitate treatment for the child (Cunningham & Henggeler, 1999). In fact, this is an essential approach for multisystemic therapy (Schoenwald, Brown, & Henggeler, 2000).

Another potential way to address case complexity and family dysfunction may be an approach like wraparound services (WRAP). WRAP aims to address children's mental health needs through individualized community-based services focused on family needs and strengths (e.g., Bruns, Sather, Pullman, & Stambaugh, 2011; Nordness, 2005). Early data on WRAP were disappointing, leading some to conclude that the approach was without merit. However, recent studies have indicated that WRAP done “right” (i.e., with fidelity) does indeed hold promise. Recent efforts demonstrate substantial widespread wrap-around implementation in the United States (Bruns et al., 2011; Bruns et al., 2014). Recent evidence has been more

promising with wraparound services—according to a national survey study of wraparound service implementation, there has been an increase in state evaluation of wraparound services (31% in 1998 to 75% in 2008), an increase in number of agency involvement, and greater diversity of child-serving systems (e.g., child welfare, juvenile justice, and education; Bruns et al., 2011). More recently, some applications of evidence-based practices have integrated an individualized approach that aligns with wraparound philosophy, such as the Managing and Adapting Practice system (PracticeWise, 2005), an approach that lends itself to individualization of across child characteristics (e.g., age, race, gender) and treatment details (e.g., setting, format) while remaining faithful to evidence (e.g., Bruns et al., 2014).

As the field grapples further with the multisystemic complexity of mental health service delivery, new and improved models will evolve to maximize system readiness to cooperate and collaborate. As one example, Glisson et al. (2010) found that outcomes of multisystemic therapy were improved in the context of an organization intervention designed to improve implementation of treatments. A broader systemic intervention may be needed to help address system-level barriers to implementation of optimal mental health services.

In short, there are numerous potential ways to address stakeholder concerns about the potency of EBTs in the face of complex, multiproblem child/adolescent clients living in challenging family situations.

Study Limitations and Future Directions

Despite the public health importance of the study and its many methodological strengths, the study also had some limitations. First, there were a small number of participants in the parent interviews. Although the provider and administrator groups contained nearly the entire population of interest, the parent interviews included only three parents, making it unlikely that *saturation* was attained (Krueger & Casey, 2000). Sample size for the present study was due to difficulty recruiting parent participants. The small sample size as well as the homogenous nature of some stakeholder groups (e.g., parents were all female) limit the generalizability of the findings. Specifically, knowledge produced might not generalize to other stakeholders or other settings. Future work could implement multiple strategies to recruit parents more effectively (e.g., providing free workshops to parents about generic topics, providing child care, transportation; Ingoldsby, 2010), specifically strategies to recruit a diverse sample (e.g., race/ethnicity, gender).

Second, the use of the MHSE model as primary reference for the coding of data has limitations. It is possible that because of this, the coders failed to capture alternative and important themes relevant to the goal

of identifying stakeholder group perspectives on children's mental health services to inform treatment adaptations and the implementation process. Indeed, this qualitative approach contrasts with grounded theory (Strauss, 1987) and emergent designs also found in the literature. Restricted themes limit the potential for alternative themes to emerge. Similarly, personal bias, preexisting opinions, or expertise about topics or themes being discussed may lead coders to find evidence confirming hunches and thus lead to faulty interpretations of the data.

Last, it is important to highlight the variant ways in which data were collected, that is, focus groups and individual interviews. The very nature of these two approaches influences responses from stakeholders. It is possible that because parents were individually interviewed, they may have felt more comfortable in disclosing certain opinions, especially because parents are accustomed to a one-on-one dynamic from therapeutic experiences. On the contrary, the focus group format used for clinic staff (clinic directors, providers) possibly created an uncomfortable environment for staff, making it difficult to disclose in the presence of fellow colleagues. These differences are likely to limit the full potential of stakeholder perspectives, and thus we must be wary of finding interpretations.

Despite these limitations, the present study provides some validation that stakeholders perceive challenges within mental health services for children across multiple levels of ecological models like the MHSE (e.g., Aarons et al., 2011; Damschroder et al., 2009; Proctor et al., 2009; Southam-Gerow et al., 2012). Although all three stakeholder groups identified themes across most of the seven levels of the model, parents and providers focused most on barriers pertaining to child and family themes. These findings allow us to highlight several themes in treatment development and implementation research and practice. Parent and provider focus on child/family themes suggests that we may need to consider alternate strategies/models to treatment development that handle child/family complexity. Most notably, the partnership approach served as the medium to engage and integrate stakeholders from this community clinic and allowed for gathering insight to further inform treatment development and dissemination. This is consistent with national policy directives (e.g., U.S. Department of Health and Human Services, 2007) that urge researchers to work with relevant stakeholders (e.g., policymakers, consumers, practitioners) on dissemination and implementation research. Accordingly, these findings highlight that development and testing of child/adolescent EBTs will require a focus across multiple levels of the mental health system ecology to maximize public health impact.

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