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Supporting Parents and Students With Emotional and Behavioral Disorders in Rural Settings: Administrator Perspectives

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Abstract

One strategy to improve outcomes for students with emotional and behavioral disorders and their families in rural settings is providing parental support. Through interviews with special education administrators and student services personnel representing several rural regions, this exploratory study sought to identify the needs of youth with emotional and behavioral challenges and their families, potential barriers to accessing school and community services, and the feasibility of implementing a phone-based parent-to-parent support program in rural communities. Findings indicated increased efforts in providing mental health services in the school, several service access barriers, and strategies for improving parent support in rural settings.

Keywords

parent support, rural schools, emotional and behavioral disorders, emotional disturbance

More than 9 million students are served in rural public schools across the United States, and more than 1.5 million of those students receive special education services (Snyder & Dillow, 2015). Rural school communities differ from schools in urban or suburban settings in several ways (Provasnik et al., 2007). For example, rural schools have higher poverty levels and lower student to support personnel ratios (e.g., school psychologists), and students have lower rates of enrollment in postsecondary education when compared with suburban and urban schools (Provasnik et al., 2007). Moreover, schools in rural settings have unique challenges in meeting the needs of students eligible for special education services. Administrators report difficulties filling openings for special education teachers, especially those who are qualified to teach students with emotional and behavioral disorders (EBD), and retaining teachers in those positions (Berry, Petrin, Gravelle, & Farmer, 2011; Mitchem, Kossar, & Ludlow, 2006). When schools are able to recruit teachers, these educators are not always highly qualified (Berry et al., 2011; Mitchem et al., 2006; Monk, 2007). Furthermore, although special educators generally report high job satisfaction (Berry & Gravelle, 2013; Provasnik et al., 2007), they often do not hold certification in the areas in which they are teaching and find that they serve students with a wide range of disabilities (Berry & Gravelle, 2013; Berry et al., 2011). Given this, in smaller rural communities, students with disabilities are more likely to be served within more inclusive settings, with special education teachers providing services within the general education classroom (Jung & Bradley, 2006).

Working with families of children with disabilities is another challenge facing many rural schools. Compared with schools in urban and suburban areas, special educators in rural schools communicate less often with parents (Jung & Bradley, 2006), and limited access to resources or services impedes the schools' ability to maintain collaborative relationships with parents (Ingalls, Hammond, Dupoux, & Baeza, 2006; Trussell, Hammond, & Ingalls, 2008). Yet teachers report wanting more training on working with families (Berry et al., 2011), and families want to be more involved with school (Blitz, Kida, Gresham, & Bronstein, 2013). However, studies reveal that parents in rural settings have lower participation in Individualized Education

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Program (IEP) meetings than parents in urban and suburban areas (Stanley, 2015). Furthermore, limited access to parental support, advocates, or educational libraries leaves parents with few options to feel confident in their ability to contribute during IEP or other school meetings (Trussell et al., 2008).

In a qualitative study examining parents' perceptions of a parenting group program implemented in a rural community (Owens, Richerson, Murphy, Jageleweski, & Rossi, 2007), parents reported several barriers to participation, including fears about confidentiality of what is discussed and being judged by others, a distrust of outsiders, and feelings that their child's problems were too severe to receive help. Parents also recommended that parenting programs for rural communities should be led by at least one parent, should be tailored to the community, and should create a support network (Owens et al., 2007).

In addition to difficulties experienced by families in obtaining appropriate school-based services for their children with EBD, there are a myriad of issues in obtaining quality mental health services in rural communities. For example, there are multiple systemic barriers, such as shortages of mental health providers in rural communities (Boydell et al., 2006; DeLeon, Wakefield, & Hagglund, 2003; Robinson et al., 2012), particularly those who specialize in children and adolescents (Aisbett, Boyd, Francis, Newnham, & Newnham, 2007). Even when mental health services are available, there are other issues that present as barriers to accessing care. Families often find it difficult to make the time to go to mental health care providers, given the time-consuming nature of ongoing mental health treatment (Robinson et al., 2012). Furthermore, mental health providers in rural communities often have long waitlists (Boydell et al., 2006), which delay youths' receipt of services. Due to geographic isolation, adequate and reliable transportation to mental health providers can be problematic (Robinson et al., 2012). Moreover, families in rural communities often experience poverty and are more likely to be uninsured or underinsured, both of which likely contribute to difficulties in affording mental health care for their child (Willging, Waitzkin, & Nicdao, 2008). Finally, for those parents whose first language is not English, limited English proficiency is a barrier for accessing mental health services (Kim et al., 2011).

One of the most compelling issues in accessing mental health services in rural areas relates to how the culture in rural communities differs from urban and suburban areas (Bischoff et al., 2014). Specifically, there is significant stigma associated with mental illness (Brown, Rice, Rickwood, & Parker, 2016; Heflinger & Hinshaw, 2010; Hoyt & Conger, 1997), and, in rural areas, this stigma is likely exacerbated given that rural communities are very small in size. Furthermore, stigma may affect families' help seeking behavior, reducing the likelihood that services are sought and accessed (Boydell et al., 2006; Hoyt & Conger, 1997; Mann & Heflinger, 2016; Robinson et al., 2012). Related to stigma are concerns regarding confidentiality and anonymity when seeking services for mental health issues (Brown et al., 2016; Robinson et al., 2012). For example, in findings from qualitative studies conducted with families of a child with mental health difficulties, participants indicated that mental health stigma was a primary barrier to accessing mental health services and that it leads to feelings of shame, isolation, and blame for the behaviors related to their child's mental illness (Boydell et al., 2006; Robinson et al., 2012). With all of these issues, parents face difficulties positively connecting to schools, mental health providers, and advocating for their child.

Both the Every Student Succeeds Act (2015–2016) and the Individuals With Disabilities Education Act (2004) stress the importance of parental involvement to elevate educational outcomes for children. Recently, the interest in support for families of youth who have EBD has expanded and three comprehensive reviews of the research literature on the topic have been conducted (Hoagwood, 2005; Hoagwood et al., 2007; Robbins et al., 2008). These reviews support that the self-efficacy and empowerment of families can be enhanced by providing family support, and this is associated with a variety of improved outcomes such as service initiation and completion, increased knowledge about the youth's condition and relevant services, and youth functioning at discharge. Second, parent support programs can reduce mental health symptoms in caregivers, particularly strain from caregiving, anxiety, and depression. Third, these reviews provide evidence that parental support can be effectively delivered by telephone (e.g., Ireys, Chernoff, DeVet, & Kim, 2001; Ireys, Chernoff, Stein, DeVet, & Silver, 2001; Ireys & Sakwa, 2006; Ireys, Sills, Kolodner, & Walsh, 1996). The delivery of parent-to-parent support programs via the phone is a promising solution to reduce barriers typically encountered by rural families.

Currently, the only phone-administered, parent-to-parent support intervention for families of youth with EBD that has empirical support is Parent Connectors. The objective of Parent Connectors is to train veteran parents of children with EBD to provide support, information, and skill building through weekly telephone contact. The four core components delivered over a school year are (a) providing emotional support, (b) promotion of benefits of actions and positive expectations, (c) providing information, and (d) instrumental support. Pilot studies of the Parent Connectors program found that participating parents had lower parental strain, increased parental engagement in education and mental health services for their child and that the program promoted an increase in academic performance for urban middle school students with EBD (Kutash, Duchnowski,

Green, & Ferron, 2011, 2013). To date, Parent Connectors has not been researched with rural families; moreover, little is known about how receptive rural communities would be to a parent-to-parent support program delivered by the phone.

Current Study

Rural communities have several unique characteristics and needs that may affect how parent support is delivered and perceived; therefore, there is a need to better understand how to improve family support and engagement for parents of student with EBD in rural schools. Although a phone-based parent-to-parent support program is likely a feasible approach for parents of children with EBD in rural communities, it is necessary to gain a better understanding on characteristics and barriers unique to rural settings. The purpose of this exploratory study was to investigate some of these characteristics through interviews with special education administrators in charge of rural, school-based settings. Specifically, we sought to (a) understand the unique needs of EBD youth in rural communities, (b) gain a picture of interventions and services provided in the school, (c) determine what types of mental health services are available to youth in schools or the community, (d) gain insight on potential interest in parent support interventions, and (e) identify if phone-based parent support would be feasible for rural settings.

Method

Recruitment

Our recruitment process was strategic, as our goal was to capture the range of diverse rural communities across the Midwestern state of interest. This included identifying major rural regions and considering geographic location and community size. From these rural regions, a master list was generated using school district and state agency websites. This list included the names, email addresses, and phone numbers of special education directors employed in rural districts or special education professionals employed by state agencies that served a geographical cluster of smaller, rural districts. From that list, potential participants were contacted via email, inviting them to participate in the study. Each participant was sent a brief introductory email introducing the research team, providing background information on the study, and inviting them to participate. Initial contact via email was successful for six potential participants. Follow-up emails were sent to those who did not respond to the initial email. This resulted in an additional seven participants. Finally, phone calls and one additional recruitment email were sent to potential participants.

Participants

A total of 20 participants were contacted, and 13 (65%) agreed to participate in the study. Participants represented seven rural districts and six state agencies serving rural districts. The sample was comprised of eight females and five males. Twelve participants were full-time employees in either the district or state agency, and one individual split time between a state agency and a school district.

Measure

A semistructured interview was developed for use in this study. The original pool of questions was generated based upon experiences of the authors administering a parent support program in suburban and urban areas. The questions were then grouped into themes and pilot tested with former special education teachers and administrators. Questions were then reduced and clarified based upon the feedback. The questions in the final interview script were centered around four primary topics that were selected to address each of the research questions: (a) characteristics of the student population with EBD, (b) available school services for students with EBD, (c) support for parents of students with EBD, and (d) access and barriers to mental health services. There was an additional question that contained eight distinct items related to peer-to-peer support. Participants were asked to provide their opinions about key components of a peer-to-peer parent support via a 3-point rating scale with 1 = *very important*, 2 = *important*, 3 = *not important*, and an option for *no opinion*. Table 1 provides a sample questions that were asked under each theme. Participants were interviewed by one of two researchers. Both practiced administering the entire interview two times prior to conducting the phone interview with study participants.

Data Coding and Analysis

Basic qualitative methods that included the use of the semistructured interview and coding were used for analysis. The interview approach was selected as it is optimal for collecting data on individuals' personal histories, perspectives, and experiences, particularly when sensitive topics are being explored (Mack, Woodsong, MacQueen, Guest, & Namey, 2005). All interviews were audio recorded, and anecdotal responses to items were also noted during the call. Although the interviews were conducted using a semistructured approach on the four targeted areas, the discussions were open ended allowing for emerging themes or topics. Several steps were used to qualitatively analyze participant interview responses. First, open coding (Miles & Huberman, 1994) was conducted to inspect responses for overarching themes or key points. Second, a coding sheet was developed based on these themes to ensure all raters coded responses in a similar

Table 1. Interview Themes and Sample Questions.

Themes	Number of questions asked within theme	Sample questions
Student population and characteristics	6	About how many youth each year does your district/school serve with emotional or behavioral difficulties? (Is that K–12? Or just for elementary . . . ask probes here) How many have an IEP for these emotional and behavioral difficulties? (probe for use of OHI if needed) In what grades are youth typically first identified for special education services? Tell me about the needs of these youth in your schools.
Available school services	10	Please tell me about the typical kinds of special education services students with EBD receive in your school/district? Where are these services located? What staff provide these services? Do you have mental health services provided within the school building?
Working with parents of students with EBD	17	Thinking about parents of students with EBD in your school/district, tell me about your school's relationship with parents. What would you like to see to help parents become more effective partners with teachers/school staff for their child? Do you think school staff/teachers would support a parent-to-parent support model in the school? Why or why not?
Access and barriers to mental health services	14	Tell me a bit about the mental health services in your community for youth? Are people generally satisfied with mental health services for youth in the community? Are there enough mental health providers in your community? How comfortable would most families be to access mental health services for their child?

Note. IEP = Individualized Education Program; OHI = other health impairment; EBD = emotional and behavioral disorders.

matter. Third, analytical coding (Corbin & Strauss, 2007) of participant responses were conducted. This approach allows for continuous grouping of open codes on participant responses to generate categories. Finally, themes were generated to determine variables related to supports in schools and communities as well as barriers for accessing services. These were then grouped into categories to allow for analysis of information. For all stages of the analysis process, opening coding and themes were discussed by a three-member research team, which included both of the individuals who completed the phone interviews. All themes were revisited until consensus was reached by all team members. Participants also completed an eight-item rating scale on the importance of parent-to-parent support in rural community settings. Frequencies and percentages were tabulated for endorsing the themes as well as the rating scale questions.

Results

Characteristics of Students With EBD

The number of children eligible for special education services for EBD in each district ranged from 11 to about 100. Participants reported between 1%–2% and up to 25% of students who were English language learners. Although respondents reported Spanish as the primary first language of students, a variety of languages were also reported (e.g., Vietnamese). Most (79%) respondents indicated that students with EBD were first identified in the second grade and up but that, increasingly, students were being identified with EBD as early as prekindergarten.

In addition to descriptive information, participants voiced additional thoughts regarding the characteristics of students with emotional and behavioral needs in their districts. For example, one of the unique challenges surrounded the high rates of substance use in some communities. At the student level, several respondents reported difficulties with managing behavior of students exposed to substances early in development. Respondents also reported an increasing trend in significant mental health difficulties for younger children.

Mental Health Supports in the Schools

Just under half (46.1%) of the participants reported that districts or state agencies contract specialized special education services with external providers. Approximately, 69% of participants reported that mental health services were provided in some capacity within school

Table 2. Mental Health Services in Schools.

Item	Respondents: State agency (*n* = 6)	School district (*n* = 7)	Total (*n* = 13)
Contract specialized special education services	4 (66.7%)	2 (28.6%)	6 (46.1%)
Mental health provided in school	5 (83.3%)	3 (42.9%)	8 (61.5%)
Provider of the service			
Licensed mental health practitioner	4 (80%)	3 (100%)	7 (63.6%)
Social worker	1 (20%)	3 (100%)	4 (36.4%)
Agency counselor	2 (40%)	1 (33.3%)	3 (27.3%)
Behavioral consultant	2 (40%)	0 (0%)	2 (18.2%)
Service written into the IEP	3 (50%)	2 (67%)	5 (38.5%)

Note. Percentages are reflective of participants who responded yes to the topic. IEP = Individualized Education Program.

settings. For example, one district reported they recently moved from a contract to a formal agreement at the middle school level, hiring a part-time licensed mental health practitioner (LMHP), whereas the high school has two LMHPs on staff, and the two elementary buildings in the district both have a mental health therapist on staff. Although the majority reported that mental health services are provided in the schools as part of a contract or school service, four participants reported no to this question indicating they do not have formal mental health services in district buildings. However, two stated that they do allow mental health providers to have access to their building to deliver services. One respondent stated, "We do have private MH therapists that will come and see kids during the school day." Participants discussed the kinds of mental health services being implemented, which consisted of primarily individual and group therapy sessions. Some participants (38.5%) indicated that these services were written into students' IEPs. Table 2 provides additional information about mental health services in the school.

School Support for Families of Students With EBD

When asked about the availability of support for parents of student with EBD in Grades K–12, 85% of participants reported that parent support was not directly available in their schools. For the two respondents who reported parent support, it consisted of either several meetings per year led by the special education director or a National Alliance on Mental Illness (NAMI) parent support group with individuals who sometimes accompanied parents to IEP meetings. In either case, participation was reported as low. Although most schools did not provide support for parents of students with EBD, many provided either general support to parents (e.g., parent training, engagement training for families of preschool students) or had programs for families of students with other disabilities (e.g., parent groups for students with autism, traumatic brain injury). However, these were not specific for families of students with EBD.

Mental Health Supports in the Community

Nearly all of the respondents (84.6%) stated that mental health services were available in the community. Fewer state agency participants reported that services were available and the emergent theme of accessibility was a concern. One participant reported, "small communities are in huge need for supports." Several commented on the lengthy drive associated with accessing services. Just more than half of the respondents reported that waitlists were common for families who were trying to access services, with five respondents indicating waitlist of a month or longer. Reports of long waits for services were more common in the school district respondents. Many of the state agency respondents were unsure if waitlists were common. When participants were asked about the perceived quality of services, two respondents stated services were of low quality, four felt services were of moderate quality, and seven reported high quality of mental health services. Based upon the literature, participants were asked about the presence of barriers to mental health services for students with EBD. Several barriers were discussed, and participants reported some of the biggest barriers to be distance (69.2%), financial means (53.8%), and time (46.2%). When discussing the barrier of stigma, just more than one third of the participants (38.5%) discussed the emergent theme of close-knit communities and confidentiality. Although this may not align to the operational definition of stigma, it is likely a contributing factor in smaller, rural communities. For example, one participant stated,

> It's getting better, but it is still there, especially in the smaller communities because they are so closely knit and everyone knows everyone and everything about everyone so they try to keep those kinds of things to themselves. In the city, you may or may not know your next door neighbor, but here it is different.

Table 3. Mental Health Services in the Community.

Item	Respondents		
	State agency (*n* = 6)	School district (*n* = 7)	Total (*n* = 13)
Availability of mental health services	4 (66.7%)	7 (100%)	11 (84.6%)
Access mental health services[a]	3 (75%)	7 (100%)	10 (90.9%)
Services have waitlists[a]	1 (25%)	5 (71.4%)	6 (54.5%)
Provider of services[b]			
LMHP	4 (100%)	5 (71.4%)	9 (81.8%)
Counselor	1 (25%)	1 (14.3%)	2 (18.2%)
Psychiatrist	1 (25%)	—	1 (9.1%)
Local agencies	—	2 (28.6%)	2 (18.2%)
Specialized in child/adolescents[a]	3 (75%)	7 (100%)	10 (90.9%)
Use of tele mental health services	3 (50%)	1 (14.3%)	4 (30.8%)
Barriers for accessing mental health services[a]			
Financial means	3 (50%)	4 (57.1%)	7 (53.8%)
Stigma	2 (33.3%)	3 (42.9%)	5 (38.5%)
Time	3 (50%)	3 (42.9%)	6 (46.2%)
Distance	5 (83.3%)	4 (57.1%)	9 (69.2%)
Language	1 (16.7%)	—	1 (7.7%)

Note. Percentages are reflective of participants who responded yes to the topic. LMHP = licensed mental health practitioner.
[a]Percentages reflective of those who marked yes to having mental health services available. [b]Percentages reflective of those who marked yes to having mental health services available; participants could have listed more than one type of provider.

Included in Table 3 is additional information regarding the mental health services in the community.

Perceptions on Phone-Based Parent-to-Parent Program

All respondents believed that a parent-to-parent phone support program would be beneficial for families in their school, that the school would be a good referral source for a parent support program, and that their school would be supportive of such a program. However, participants offered several potential access and engagement barriers to a peer-to-peer phone-based parent support program. Regarding potential practical barriers, four participants reported that there may be difficulty reaching parents due to issues such as parents frequently changing phone numbers, or not picking up the phone. Three other respondents indicated that the length of time commitment may be a hindrance for some parents. Three respondents indicated that in their communities, families like to be self-reliant, and may be reluctant to participate in a peer support program. However, to combat potential barriers, five respondents indicated that building good relationships with parents would be essential, highlighting the importance of trust and confidentiality. Furthermore, several (*n* = 4) respondents indicated that additional methods to reach parents may be necessary, such as periodic face-to-face meetings, video calls, or texting. Finally, three respondents stressed the importance of thoroughly screening the veteran peer selected to provide support.

Participants were asked to rate the importance of several aspects that might be present in a peer-to-peer parent mentoring program. Ratings were provided on a 3-point scale from 1 (*very important*) to 3 (*not important*); respondents could also indicate whether they had no opinion. Results indicated that all participants (*n* = 13) believed the program being offered at flexible times was "very important." Furthermore, nearly all (93%) participants thought that it was "very important" that the program is evidence based, does not require transportation, or does not require day care services. It was also important or very important that the invitation to participate the program would happen through school staff (100% of respondents). With the exception of one participant who had no opinion, remaining participants thought that it was important or very important that another parent (and not a professional) conducted the peer mentoring support. There were two programmatic characteristics that appeared to be of less importance: only 31% of participants felt that a phone-based program was very important and only 23% indicated that having the program being affiliated with researchers in special education was very important. Table 4 provides the mean scores for all of the Likert-type scale items.

Discussion

Although students with EBD in rural settings have many similar needs to those in urban and suburban settings, there

Table 4. Participant Perceptions on the Importance of Components for a Peer-to-Peer Mentoring Program.

Survey items	*M*	*SD*
How important is it that . . .		
. . . the program is offered at flexible times	1	0
. . . no transportation or day care is needed	1.08	0.28
. . . the program is evidence based	1.08	0.28
. . . the program is conducted by other parent and not a professional	1.5	0.53
. . . the invitation to participate would come from the school	1.69	0.48
. . . the program is phone based	1.75	0.86
. . . the program is affiliated with researchers in special education	2	0.9

Note. Participants rated items as 1 = *very important*, 2 = *important*, 3 = *not important, no opinion*.

are school and community challenges present in rural settings that pose some potential barriers for implementing interventions to improve outcomes for youth with behavioral challenges and their families. One potential method for supporting parents directly and indirectly supporting students is to improve the supports provided to parents, so they can better tailor services to meet the needs of their child. Given the interest and need to support parents by school districts, it is necessary to understand the types of supports that are most feasible for rural settings and considering how issues of accessibility, isolation, and stigma can be addressed during the development process. This study sought to explore how students with EBD are currently being served, the types of supports provided to parents in rural settings, and some of the potential barriers to accessing school and community services in rural areas, so adaptations could be made to existing programs to increase the likelihood of success in rural communities.

Mental Health in the Schools

One surprising finding from this study was the efforts of districts and state agencies to incorporate mental health services into the school settings. Based upon the responses from participants in this study, rural school districts are providing some form of mental health service in educational settings. It is important to note these services were being implemented differently based upon the respondent (i.e., state agency vs. district personnel). For example, many of the school district personnel reported that they have professionals working in the schools such as social workers, LMHPs, or counselors. Some of these professionals are supported through contractual services, whereas others are on staff in school buildings. However, most state agency participants indicated though they do use mental health service providers, they typically are contracted out and may serve as a consultant for districts versus providing direct services in the school. Although limited, prior research indicates that historically it has been difficult to provide this type of service in rural communities, let alone within the school setting (Boydell et al., 2006; DeLeon et al., 2003; Robinson et al., 2012; Willging et al., 2008). This provides some evidence that rural school districts and state agencies supporting those rural districts are expanding efforts and using innovative approaches to meet the needs of students with emotional and behavioral challenges.

Parent Support in Rural Schools

The majority of participants (85%) conveyed that there is minimal direct support for parents of children with EBD within the school setting. This finding is consistent with prior research indicating that parents have difficulties finding support in rural school settings (Trussell et al., 2008). Although all participants conveyed they have attempted to provide options for parents in the past, barriers such as transportation, child care, and time were all stated as reasons for low attendance. These findings were consistent with other small studies investigating parental engagement in rural schools (Boydell et al., 2006; Owens et al., 2007; Stanley, 2015; Trussell et al., 2008). Two of the school district participants indicated ongoing parental support (e.g., support groups, trainings) is provided within the building, but consistent with prior research, regular parent participation is limited (Owens et al., 2007; Stanley, 2015). All of the participants reported they would support the implementation of a phone-based parent-to-parent support program and perceived that parents might be more likely to engage in this type of support.

Mental Health Services in Community Settings

When discussing the availability of mental health services in the community, our findings align with those from previous studies (Boydell et al., 2006; DeLeon et al., 2003; Robinson et al., 2012; Willging et al., 2008). Participants revealed that when services were available, several had waitlists, many families did not access the services, and distance, time constraints, and financial means serve as barriers for many of the families. Contrary to prior research (Aisbett et al., 2007), the majority of participants (84.5%) did indicate that mental health services were available in the communities, particularly in the larger towns housing the bigger school districts, and that many of the providers specialized in working with children and adolescents. Combined, these findings were of interest, given that even if services were available and providers specialized in working with children and adolescents, the barriers of waitlists, financial means, time constraints, and distance continue to be present for families living in rural communities.

Finding methods not only to provide services but also to allow families in rural settings to access these services is imperative.

Feasibility of Phone-Based Parent-to-Parent Support

Participants conveyed the importance of providing supports for parents who have a child with EBD; however, it is evident there are limited programs available and several barriers for accessing supports or services exist. Both school district and state agency personnel indicated that a phone-based program appeared to be a unique solution to some of the existing challenges. All participants indicated that strengths of this approach included being offered at flexible times, removing the accessibility barrier as it does not require transportation or day care, and that a parent-to-parent peer mentor was used as the primary support.

However, this study presented several interesting variables to be considered for a phone-based support, such as Parent Connectors, to be successful in rural settings. First, participants conveyed there may be difficulties with frequent phone number changes and resistance to answering phone calls. Second, it would be important to consider various methods of communication (e.g., video calls, text messages, or face-to-face meetings) to allow parents to build trusting relationships. This was of particular interest as establishing connections and building trust has been reported as a challenge for parents and schools in rural settings (Ingalls et al., 2006; Trussell et al., 2008). Participants extended upon this idea further to convey a phone-based approach would likely help reduce stigma and promote engagement by parents. Finally, thoroughly screening peer-parents and ensuring they are familiar with supports and resources available to the specific rural community for which they are serving was a frequent recommendation. It was also discussed that due to the small nature of these communities, it would be important that the veteran parent had a positive experience with the schools and understood the importance of maintaining confidentiality.

Limitations and Future Directions

Although the overall purpose of this exploratory study was to understand some of the broader issues facing rural school and community settings in supporting students with EBD and their families, the findings should be considered in conjunction with several potential limitations. First, the participants in this study were recruited from various state agencies and school districts in one state located in the Midwest. State agencies and school districts provide programs that are likely different depending on the size and available resources within that rural setting. Thus, barriers discussed or strengths of certain communities may not generalize from one rural setting to another. A second limitation is the small sample size in this study. However, it should be noted that, across all 13 participants, nearly all of the geographic regions within the state were represented in this study by a mixture of large school districts and state agencies representing clusters of smaller districts. Third, as with any self-report or interview data, there could be bias, due to social desirability, inaccurate recall, or ability to respond to questions.

In the future, researchers should explore needs, barriers, and considerations for intervention development in rural settings for youth with EBD and their families, and research should be expanded to multiple states and include even more diverse rural settings. Future studies could replicate this exploratory work in other states and with additional stakeholder groups such as parents of students with emotional and behavioral challenges and special education teachers. Furthermore, pilot work is needed to explore the feasibility and effectiveness of parent support interventions for children with EBD in rural settings. For example, interventions that have been attempted in urban settings may need to be slightly modified and then piloted with rural school samples. Future studies could also pilot strategies for school personnel (e.g., special education teachers, school psychologists) to gain more skills to improve parental support for families of students with EBD.

Conclusion

This exploratory study conveys current school and community-based supports for youth with EBD and their families living in diverse rural settings as well as specific barriers and challenges that are present for supporting this population. These findings have important implications for both evidence-based practice and research. First, understanding current approaches to support both students with EBD and their families can assist with streamlining efforts and prevent a duplication in services. Second, although many of the identified barriers may not be surprising, they are important to understand when developing interventions aimed at supporting rural schools and communities. Finally, this information offers insight for improving parents' engagement in school and mental health services for their child, and methods for assisting parents in establishing positive relationships with schools. Each of the findings from this exploratory work is integral to future work in developing interventions or supports that support families of children with EBD in rural settings.

Authors' Note

The opinions expressed are those of the authors and do not represent views of the Institute of Education Sciences or the U.S. Department of Education.

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