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ORIGINAL ARTICLE

# Gathering Diverse Perspectives to Tackle "Wicked Problems": Racial/Ethnic Disproportionality in Educational Placement

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## Highlights

- Racial/ethnic disparities in educational placement represent a complex, "wicked" problem.
- Eliciting perspectives from diverse stakeholders can generate ideas for addressing wicked problems.
- Stakeholder recommendations targeted students, school personnel, systems/agencies, and communities.



**Abstract** Among students receiving behavioral health and special education services, racial/ethnic minority students are consistently overrepresented in settings separate from general classrooms. Once separated, many young people struggle to improve academically and face significant difficulty upon trying to return to a general education setting. Given the complex, ongoing, and multifaceted nature of this challenge, racial/ethnic disproportionality can be identified as a "wicked problem," for which solutions are not easily identified. Here, we describe our community-engaged research efforts, eliciting perspectives from relevant partners in an ongoing dialogue, to better integrate diverse stakeholders' perspectives when attempting to address such disparities. We conducted focus groups and qualitative interviews with members of three stakeholder groups: community-serving organizations, individuals with lived experience of behavioral health conditions, and state-level policymakers, with a shared interest in addressing racial and ethnic disparities. Participant responses illustrated the "wickedness" of this problem and highlighted the need for additional supports for students, families, and school personnel, increased collaboration across relevant systems and agencies, and reduced barriers related to funding. Overall, this methodology bridged differing perspectives to develop, in concert with our partners, a shared language of the problem and a core set of issues to consider when seeking to effect change.

**Keywords** Qualitative research · Education · Behavioral health · Racial/ethnic disparities · Community-based participatory research · Wicked problems

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## Introduction

For decades, scholars have called attention to the overrepresentation of racial/ethnic minority youth among students receiving special education service for learning and behavioral difficulties in the United States, noting that racial/ethnic minority students receive these services outside the general classroom more frequently than White students (Connor et al., 2019; Skiba et al, 2008; Zhang et al.,

2014). Although some youth with these challenges can benefit from the individualized attention provided in a separate educational environment, too frequently, removed racial/ethnic minority students show little to no educational or behavioral improvements (e.g., Powers et al., 2016). Further, once placed in a separate classroom, these students face significant difficulty returning to a general education setting (Hoge & Rubinstein-Avila, 2014).

Racial/ethnic disparities in educational placement should be considered an example of a "wicked problem" (Rittel & Webber, 1973). In this context, rather than "immoral," "wicked" refers to the challenges these problems present for anyone hoping to solve them (Head, 2008). Wicked problems are not easily defined, persist over time, and can shift in nature and scope, so finding a successful solution remains challenging (Coyne, 2005). Further, attempts to resolve such complicated problems can often result in *more* problems (i.e., iatrogenic effects) via unexpected negative consequences, which can discourage attempts at reform (Sarason, 1971; Weick, 1984). Educational inequity has been identified as particularly complex, with multiple contributing factors, and several unsuccessful attempts at addressing it (e.g., McCall & Skrtic, 2009; Sarason et al., 1985; Sullivan, Artiles, & Hernandez-Saca, 2015). Prior efforts have likely been unsuccessful, at least in part, because of siloed approaches that fail to consider larger systems, as affected individuals from various groups (e.g., parents, policymakers) frequently hold differing perspectives about how the problem should be defined, what improvements should be made, and what approaches should be used to solve it (Kreuter et al., 2004).

Although many stakeholders agree that racial/ethnic disparities in educational placement should be tackled, challenges arise when attempting to define potential causes of the problem. Experts have pointed to cultural mismatches between school personnel and students of color, conscious and unconscious biases of school teachers and administrators, limited resources for interventions for students with disabilities, and deficient procedures for identifying and referring students of color to needed services as contributing to the current state of disproportionality (Ahram, Fergus, & Noguera, 2011; Voulgarides et al., 2017). Similarly, and likely because of the myriad contributing factors identified, no one attempt at resolving this issue would provide a perfect solution—and could even promote other difficulties. Like so many other wicked problems, any methods of improving this issue must be multidimensional in nature; no simple solutions will suffice. In fact, scholars have argued that social problems, such as educational disproportionality, should not be perceived as "solvable" in the typical scientific manner of concrete problem definition and once-and-for-all solutions (Sarason, 1978). Instead, reformers should aim to work collaboratively across groups to think more broadly about existing problems and facilitate opportunities for diverse stakeholders to share their perspectives about wicked problems and identify methods of ameliorating them (Head & Alford, 2015).

To begin the process of addressing "wicked problems" like disproportionality in educational placement, researchers should conceptualize their efforts as more of a collaborative process than typical researcher-driven approaches, allowing the course of research and intervention development to be informed by practice and policy, rather than just vice versa (Lavis et al., 2005; Straus et al., 2009; Tseng, 2012). These strategies enable meaningful interactions between researchers and individuals who can provide important insights on the topic under study. Calls for such cooperative research techniques have strengthened considerably of late, such that new journals and a new term, "engagement science" (also called community-engaged research), have been created to describe and disseminate such work (e.g., Dungan et al., 2019; Stephens & Staniszewska, 2015). This burgeoning field focuses on developing methods to encourage stakeholders' active participation in research—beyond that of a typical study participant—so they feel their voices have been heard, they are invested in the outcome of the process, and they feel empowered to take future action (Weber Shandwick & Canvas8, 2014).

Studies have frequently identified personal contact and collaboration between researchers and end users as an important bridge to facilitate implementation of research evidence; these strategies demonstrate more effectiveness than printed materials or didactic meetings (Mitton et al., 2007; Oliver et al., 2014). If researchers aim to facilitate group and/or system change, they must undertake an interactive, multidisciplinary, and two-way process consisting of continuous contact with users (Gagnon, 2011; Khoddam et al., 2014). Engaging community partners with a common interest in addressing target challenges allows researchers to create a shared learning environment, to better understand how partners conceptualize existing issues and research findings, and to collaboratively generate interventions based on both the research evidence and the realities of the target settings and populations, thereby improving likelihood of program adoption (Glasgow & Emmons, 2007; Leslie et al., 2014).

Researchers focused on *other* wicked problems have previously engaged with stakeholders in this collaborative way. For example, studies investigating racial/ethnic disproportionality in state child welfare systems have used focus groups to gather perspectives from affected individuals, such as caseworkers, legal personnel, families, and community members, in Texas and Oregon (e.g., Dettlaff

& Rycraft, 2008; Miller et al., 2012). Similarly, focus groups were used with school personnel and parents in North Carolina to identify barriers to fair disability screening among Latino preschool children (Hardin et al., 2009) and, along with individual interviews, with school personnel and education administrators in Tasmania to consider what has contributed to local high school dropout rates (Cranston et al., 2016). Through these inquiries, researchers developed a fuller picture of the factors contributing to the "wicked problem" at hand, thereby recognizing the complexity of the problem and the need for multifaceted solutions. However, these techniques frequently stop the process at identifying contributing factors, thereby missing out on the opportunity to involve stakeholders in the development of acceptable potential solutions to these wicked problems. Further, such strategies have yet to be applied to the issue of racial/ethnic disproportionality in educational placement—a nationally recognized problem with no clear answer. Beyond improving our understanding of the challenge, considering such educational inequities from multiple, relevant viewpoints should help to identify ecologically valid strategies for ameliorating the problem.

### Current Study

Recognizing that racial/ethnic disparities in educational placement can be classified as a "wicked problem," we set out to achieve three objectives with the current study. First, we sought to better understand this problem through the eyes of diverse stakeholders from across the United States. Second, to better facilitate their connection to the research and investment in future reform strategies, we asked participants to identify potential methods for addressing observed disparities. Third, by sharing the results of this work, we aimed to demonstrate the benefit of this collaborative approach for identifying important considerations to make when attempting to address wicked problems. To accomplish these goals, our research team partnered with three stakeholder groups with unique perspectives who shared an interest in addressing racial and ethnic disparities in behavioral health. Rather than school personnel, who frequently participate in such investigations, we chose to work with non-system actors, including community-based health advocates, individuals with behavioral health histories, and state-level behavioral health policymakers, whose personal and professional experiences could provide helpful, and as-yet unexplored, insights into addressing this wicked disproportionality problem.

In 2016, we held three focus groups—one for each stakeholder group—where we: (a) presented findings from research using a national dataset that investigated racial/ethnic disparities in educational placement for youth with behavioral health problems (Green et al., under review), (b) elicited reactions and feedback to this information, (c) engaged participants in discussion about the ways in which they observed and/or were otherwise impacted by such disparities, and (d) generated recommendations for ways to address these disparities. We then followed up by conducting in-depth interviews with selected focus group members to expand on recommendations and potential methods of implementing them (Lambert & Loiselle, 2008).

## Methods

This project was implemented through a collaboration between the Disparities Research Unit (DRU; "research team") of Massachusetts General Hospital in Boston and several site leaders from external partners throughout the United States, each representing a unique stakeholder group: policymakers, community health advocates, and persons with lived experience (PLE). A social ecological framework (Schensul, 2009) guided our group selection process, as we sought to obtain perspectives from stakeholders at multiple levels of influence. Specifically, we expected that PLEs would share experiences illustrating the intra- and interpersonal components of this wicked problem (micro), that community advocates could contribute insights at the organizational and community levels (meso), and that policymakers could weigh in on issues at the larger policy level (macro). Eliciting feedback from members of all three groups would allow for a deeper understanding of this multifaceted problem.

Site leader partners were identified based on their work with individuals from diverse backgrounds, health and behavioral health disparity expertise, and previous collaboration with the research team on projects related to racial and ethnic disparities. These leaders included the following: A male partner with Mexican American and American Indian/Alaska Native heritage who, through his position at a Midwestern college, coordinates community groups in multiple states that work with racial/ethnic minority groups on issues of health and service disparities ("community health advocate" partner), three female leaders (who identify as Black, White, and Puerto Rican) from a Massachusetts organization serving individuals with a history of behavioral health and substance use issues ("PLE" partner), and two female administrators (who identify as Black and White) from a non-profit organization serving state health policymakers across the United States ("policymaker" partner). On average, these representatives were approximately 50 years of age. Site leaders were incorporated early in the process and helped

develop study aims and procedures. The research team was comprised of nine women, two-thirds of whom identified as White; one team member each identified as Black, Asian, and biracial. Additionally, two members of the research team identified as Latina, specifically Chicano and Puerto Rican. On average, members of the research team were approximately 40 years of age.

Our data collection process began with a series of three focus groups—one for each stakeholder group—where we presented empirical research findings demonstrating racial/ethnic disparities in educational placement and elicited feedback regarding participants' interpretation of the findings and how they might suggest addressing these disparities. These focus groups provided a basis to complement quantitative research through broad exploration of study results and the generation of feedback and laid the foundation for further inquiry (Stalmeijer et al., 2014). Responses from focus groups were synthesized and further explored via in-depth interviews with participants, to improve data completeness and facilitate a more comprehensive understanding of perspectives from each stakeholder group (Lambert & Loiselle, 2008).

## Focus Groups

### *Participants*

Partner-site leaders met with the research team to discuss the purpose and content of focus groups, then invited members or contacts of their organizations to participate. PLEs were recruited for the study during a weekly community meeting for individuals with a history of behavioral health challenges. Community health advocate groups were contacted and asked for representative participants based on their focus on issues related to mental health and health, especially within their local racial/ethnic minority communities. Finally, state health policymakers were invited thoughtfully, to reflect diversity regarding geographic region and agency focus that could contribute unique insights. Beyond shared membership in a particular stakeholder group (i.e., PLE, community advocate, policymaker), group homogeneity was not prioritized as a recruitment goal, as it was expected that heterogeneity of participant experiences would promote richer discussion and allow for contrasting opinions (Wibeck et al., 2007). Given the study's focus on obtaining perspectives from stakeholders outside of educational systems, participants were not required to demonstrate an ongoing connection to schools, and thus, their personal experiences with educational systems varied.

One focus group was held for participants from each external partner organization, such that a total of three groups were conducted either in person or by webinar based on site preferences. Our policymaker group consisted of 19 participants from eight states (AL, CO, CT, DE, LA, MN, OH, and VA) who represented diverse agencies across departments of health, early childhood, families and children, minority health, medical assistance, behavioral health services, and human services. Of the 14 participants who completed a demographic survey, 86% identified as women; 71% were White, 21% were Black, and 7% were Multiracial; no participants identified as Hispanic. Our PLE group was comprised of 10 participants from Massachusetts; 70% identified as women; 40% were White, 30% were Black, 10% were American Indian/Alaska Native (AI/AN), and 20% endorsed "Other" when asked about race. With regard to ethnicity, 40% identified as Puerto Rican, 30% as non-Hispanic, 20% as other Hispanic, and 10% as Cuban. Finally, our community health advocate group consisted of seven participants from four states (CA, GA, IN, and NM); of the six who completed a demographic survey, 67% identified as women; 50% were White, 33% were Asian, 17% were Black, and 17% were AI/AN. Additionally, 50% identified as non-Hispanic, 33% identified as other Hispanic, and 17% did not respond to the question about Hispanic ethnicity. More detail about demographic characteristics for each focus group is provided in Table 1.

### *Procedures*

In the six months preceding the focus groups, three in-person meetings and phone calls were held with site leaders to develop agendas and materials and to review focus group interview procedures. Site leaders reviewed research team findings regarding racial/ethnic disparities in educational placement and recommended ways to make the information accessible to their respective audiences. Recommendations included creating a glossary defining novel terminology, using everyday language, and displaying information visually. Site leaders also recommended that participants receive and review relevant information in advance of the focus group. Thus, the research team developed unique information packets for each group (i.e., community health advocates, PLEs, policymakers) that summarized the research study, provided background information about the focus group topics, and listed questions that might arise during discussion. Participants received these packets two weeks before their focus group convened and were asked to carefully review the materials.

Focus groups were facilitated by one to two site leaders—each of whom had prior experience leading focus group discussions—with in-person support from three to four members of the research team; the PLE focus group also included two interpreters that performed real-time English translation and interpretation for native Spanish speakers. Given that participants were based in various

**Table 1** Participant information for focus groups and individual interviews

| | No. of participants | Completed survey | % Female | Mean age (*SD*) | Race | Ethnicity |
|---|---|---|---|---|---|---|
| Focus groups | | | | | | |
| Community health advocate group | 7 | 6 | 66.67 | 54.83 (8.80) | 3 White; 2 Asian; 1 Black; 1 AI/AN | 3 Non-Hispanic; 2 Other Hispanic |
| PLE group | 10 | 10 | 70.00 | 44.60 (10.49) | 4 White; 3 Black; 2 Other; 1 AI/AN | 4 Puerto Rican; 3 Non-Hispanic; 2 Other Hispanic; 1 Cuban |
| Policymaker group | 19 | 14 | 85.71 | 54.77 (7.90) | 10 White; 3 Black; 1 Multiracial | 13 Non-Hispanic |
| Individual interviews | | | | | | |
| Community health advocates | 3 | 3 | 100.00 | 52.67 (10.02) | 1 White; 1 Black; 1 Asian | 2 Non-Hispanic; 1 Other Hispanic |
| PLEs | 5 | 5 | 80.00 | 48.40 (9.76) | 2 Black; 1 White; 1 AI/AN; 1 Other | 2 Other Hispanic; 2 Non-Hispanic; 1 Puerto Rican |
| Policymakers[a] | 11 | 6 | 83.33 | 53.33 (8.36) | 6 White | 5 Non-Hispanic |

PLE = Persons with lived experience. [a]The 11 policymaker interviewees were representing five different states and completed interviews in five separate conference calls with site leaders. Each interview included between one and four policymaker participants. Represented states reflected geographic and political diversity.

areas nationwide, focus groups for policymakers and community health advocates were held via conference call and webinar; the PLE focus group was conducted in person. After brief introductions, members of the research team presented information from a study of racial/ethnic inequities in educational placement (Green et al., under review. The presentation included the following elements:

- a review of literature linking educational attainment and health outcomes;
- an overview of the variety of educational placements for youth with psychiatric disorders, ranging from full inclusion (regular classrooms) to substantially separate classrooms and schools;
- an introduction to disproportionality in educational placements based on race/ethnicity, focused on the over- and/or under-representation of certain groups of students in restrictive educational settings; and
- the presentation of study results suggesting that racial/ethnic minority students were significantly more likely to be in separate classrooms and schools for emotional and behavioral disorders than their White peers and that, compared to White students with service use needs, students of color were more likely to be placed in separate classrooms at an earlier point in their service use trajectory.

Following each presentation, group facilitators asked participants to react to the study and respond to several questions related to defining the problem, identifying factors to help researchers understand the described disparities, prioritizing the need to address this issue, suggesting—in detail—appropriate methods for intervention, identifying challenges associated with implementing such methods, and brainstorming ways to share recommendations with other groups. Questions were developed with the goal of inviting participants to generate recommendations for resolving disparities outlined in the presentation and were purposefully open-ended and non-directive in nature. See Appendix A for the lists of questions used to facilitate each group. Sessions were 120 to 180 minutes in length and were recorded with consent of participants. Community health advocate and PLE focus group participants received a $25 gift card to compensate for their participation; policymakers were unable to receive compensation for their participation because of restrictions associated with their agencies.

### *Method of Analysis*

Data generated via focus group interviews were rapidly analyzed to inform the development of materials to guide subsequent in-depth interviews. To do so, one member of the research team transcribed each focus group audio recording and extracted recommendations for addressing identified disparities based on relevance and frequency. Then, to ensure credibility, each group's transcript and list of extracted recommendations were sent to the respective site

leader(s) for review and discussion. For policymaker and PLE site leaders, consensus was reached by phone. During this process, related or overlapping recommendations were combined and ideas that were mentioned or supported by multiple participants were prioritized, resulting in a list of four major recommendations from each group. Community health advocate site leaders chose to work internally with their organizations to refine the initial list of recommendations and developed a list of five major recommendations that was then shared with the team. Together, site leaders and the research team agreed to build follow-up interview guides based on these recommendations.

## In-Depth Interviews

### *Participants*

After focus group responses were summarized and finalized with site leaders, in-depth interview invitations were extended to members of the focus groups who were active participants in the focus group discussion and could further elaborate their group's recommendations. For example, because the PLE focus group recommended that schools include students with behavioral health needs in their general classrooms whenever possible, participants who endorsed related experience (i.e., they or their child had been separated from class for behavioral health needs) were invited to complete in-depth interviews. Policymaker site leaders chose to conduct interviews via five state-based conference calls, each with one to four participants all representing the same state, to increase the amount of feedback they received. The other two site leaders held three to five individual phone calls or in-person meetings with their respective participants to complete in-depth interviews. The three community health advocates interviewed all identified as women and came from Asian, Black, other Hispanic, and White racial/ethnic backgrounds. The five PLE interviewees were mostly women (80%) and endorsed a variety of racial/ethnic backgrounds (i.e., AI/AN, Black, White, Other race, Puerto Rican, and other Hispanic). Finally, just six of the 11 policymaker interview participants reported demographic information; these participants were mostly women (83%), and all endorsed a non-Hispanic White racial/ethnic background. More detail about demographic characteristics for interviewees from each group is provided in Table 1.

### *Procedures*

To prepare for in-depth interviews, the research team invited Dr. Edison Trickett, a community psychologist with expertise in community-based research and intervention, to lead a webinar and training session with site leaders. This training reviewed recommendations and domains emerging from focus group data and provided suggestions and guidelines for conducting in-depth interviews (e.g., how to frame queries to avoid yes/no answers); it also introduced concepts related to qualitative data analysis and thematic coding. Next, the research team organized a conference call with site leaders to review the training and finalize the list of questions used during the in-depth interviews. As with focus groups, tailored interview guides were developed for each stakeholder group. Each guide instructed interviewers to first report recommendations generated by the corresponding focus group and then ask questions to expand on recommendations, with a focus on problem solving and policy or practice change. Interviewers were also encouraged to further tailor their questions to each participant—for example, by referencing specific suggestions the participant made during the focus group and asking for further elaboration.

Once interview materials were finalized, site leaders scheduled interviews with group members. Prior to their interviews, community health advocates and policymaker participants received informational material reviewing the intent of the interview, a list of recommendations generated by their focus group, a fact sheet about the study purposes, and the interview guide; interviews were then completed by phone with their respective site leader(s). PLE participants reviewed interview materials with two site leaders before completing their interviews in person.

During each interview, site leaders first reviewed the content of the interviewee's focus group, including the results of the study describing racial/ethnic disparities in educational placements for school-based behavioral health services and the specific recommendations that were elicited from focus group participants. The interviewer(s) then asked participants to discuss each recommendation in more detail (e.g., clarifying vague terms like "support") with a focus on prioritization of recommendations, problem solving related to implementing such recommendations, and methods of strategy dissemination. Interview sessions lasted 30–60 minutes and were recorded with participants' consent. Community health advocate and PLE participants received a $30 gift card to compensate for their participation; policymaker participants were unable to receive compensation because of restrictions associated with their state agencies. All focus group and in-depth interview procedures were approved by the Massachusetts General Hospital/Partners Healthcare Institutional Review Board.

### *Method of Analysis*

In-depth interviews were transcribed verbatim by a member of the research team, de-identified, and shared with

site leaders. We then performed a cross-case thematic content analysis that identified major themes related to recommended strategies for and barriers to addressing racial/ethnic disparities in educational placement. Coding and data analysis were performed by three investigators from the research unit and one site leader from each external partner. Analysis was inductive, with codes and categories emerging from participants' narratives, and followed several steps. We first performed open coding by independently reading the accounts line by line to identify codes; afterward, we grouped and labeled key categories. Next, we separately reread accounts to perform axial coding, identifying relationships among categories and organizing them into themes. We integrated the information in each theme to draw a coherent representation of the material and organized the information in the data corpus under these emerging themes and subthemes. Throughout the analysis process, the team met regularly to discuss coding challenges and disagreements. When disagreements arose, we identified the source of the discrepancy and coded sections were reviewed again until consensus was reached (Corbin & Strauss, 2008).

## Results

Stakeholder feedback reflected the complexity of disproportionality in educational placement. Although participants were not exposed to information generated by participants from other groups and, thus, could not explicitly disagree with each other, responses included diverse, sometimes contradictory views of the problem and its contributing factors—suggesting its "wickedness." Examples of these issues are displayed in Fig. 1. For instance, when discussing separate settings for individuals with emotional challenges, some PLE participants recalled traumatic experiences of labeling and stated they did not want their children similarly labeled. However, others voiced concern that interventions provided a needed support and frequently started too late for remediation. In contrast, policymaker participants emphasized concerns about early misidentification of behavioral disturbances and classroom removals for young children who might then face difficulties returning to a general classroom setting. Policymakers also noted that early consultation programs may be a useful tool to prevent missing important behavioral health needs for youth of color. Often, suggestions reflected how stakeholders interacted with these issues in different ways, thereby uncovering other unique challenges, as is common for such "wicked problems." As an example, PLE participants suggested that variability of special education classroom quality and family supports implied larger systemic issues of inequity in economic opportunity and educational access. Additionally, PLEs and community advocates identified cultural misunderstanding among predominantly White decision makers as an important contributing factor for observed disparities.

### Stakeholder-Identified Recommendations

When asked to identify potential strategies for addressing educational disproportionality, perspectival differences between and among stakeholder groups became apparent. For instance, policymaker participants largely suggested seeking system-level changes (e.g., improve data sharing between relevant agencies, develop early childhood consultation programs via needed partnerships). In contrast, PLEs often focused on ways that individual schools and teachers could change their typical practices (e.g., keep students in regular classes with additional supports; increase teachers' understanding of behavioral health issues) and community health advocates frequently emphasized the potential for external groups and tools to contribute to resolving this wicked problem (e.g., working with community- and faith-based groups to support students, developing online tools for youth to share their mental health experiences).

Despite their different backgrounds and experiences, members of our three stakeholder groups developed several recommendations for addressing racial/ethnic disparities in educational placement with an overlapping focus. Their recommendations were broad in scope, describing needs of students, teachers and school administrators, and regional and federal agencies. Participants also identified barriers to addressing these disparities. Tables 2 and 3 include a summary of recommendations and barriers gathered across the three groups.

#### *Support and Programming for Students*

Across groups, participants generated recommendations for the development of effective supports and interventions that could address mental health and education-related challenges without removing students from general education classrooms. Members of the PLE group stressed the need to keep students who receive mental health services in inclusive classroom settings to avoid harmful stigmatization and damage to self-worth. One focus group participant explained both positive and negative experiences across several schools: "My very last year of school. . .their special needs program was terrible. . .it was just a table full of coloring books, sticks, and glue and a whole bunch of random things. It didn't keep my attention; I just wanted to leave and get my GED." They also recognized potential challenges related to growing classrooms and, thus, also recommended that schools hire

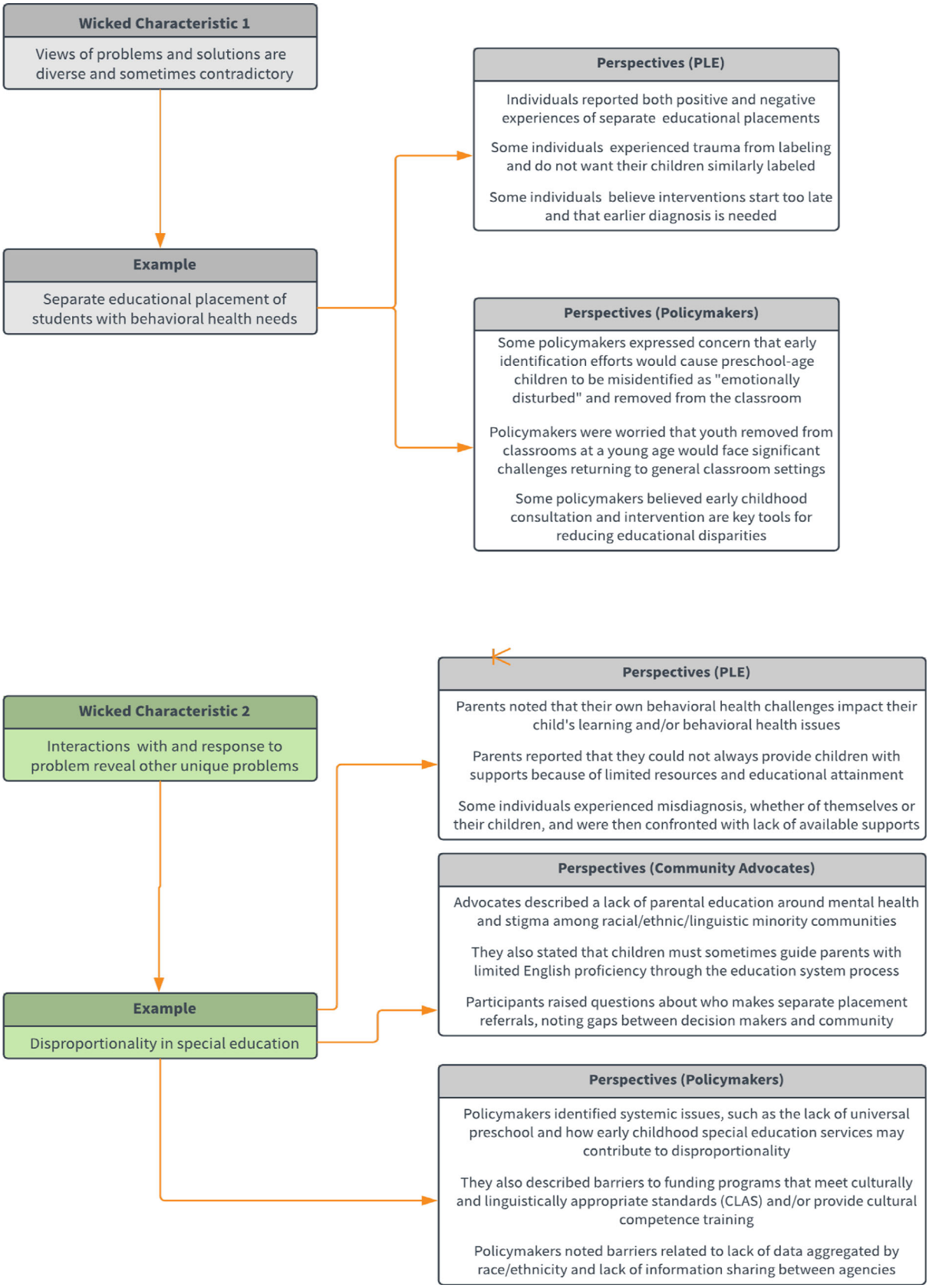


**Fig. 1** Example "wicked" characteristics of racial/ethnic disproportionality in educational placement

**Table 2** Recommendations that emerged from community health advocate, PLE, and policymaker focus groups and in-depth interviews

| Target audience | Recommendation | Quotes from participants |
|---|---|---|
| Students | Maintain students in general classes; develop effective intervention; and support for students without stigmatizing | *PLE*: "When those kids get … put into somewhere else, if that somewhere else is positive that's good, but if that somewhere else just takes them down- it's forced upon them that they are less and they're not going to be anything- that's what the teachers, the system is teaching them." |
| | | *Policymaker:* "People are much more comfortable with talking about inclusive classrooms, and having typical peers, and special education students in the same room, and not segregating them, and that's definitely a strong conversation that people have a conviction to solve." |
| | Create programs that improve early identification and referral of youth with mental health needs | *PLE:* "It has to start in school. Because they grow up. We grow up. They're way too late. In the poor communities, they wait too late." |
| | | *Community Health Advocate:* "As most experts know, when we have scenarios where children are dropping out of school … most mental illnesses…really start to display when someone's younger. And if the warning signs aren't caught or it's culturally not acceptable to talk about it." |
| | | *Policymaker*: "I think that trend is still happening at a very early age… I think really focusing on what's happening in the younger, the preschool years is a key piece to helping resolve this down the road." |
| | Provide students with support in diverse settings | *Community Health Advocate*: "Mentoring…involvement… and engagement of the community is important and the faith-based organizations know how to do that best." |
| | | *Community Health Advocate*: "Most immigrant churches, you know Asian, African churches, and Hispanic churches too…, they are playing a role like a community center…. So I think that … working with the local churches is one of the best ways we can engage with this kind of issue." |
| | Provide support to students in response to social needs | *PLE*: "You can't just have a kid and do this, you have to address the family, you have to address the environment." |
| | | *PLE:* "I wish… there could be, like a tutor. Now that would help a lot of kids, that you know, has a disabled parent or not a disabled, you know, no matter what. Like some college kids, that's going for education… to donate one hour of… their time, a volunteer, to help kids like my daughter." |
| | Explore online tools that let youth share their experiences with mental health | *Community Health Advocate:* "To find the right people to tell their stories in a compelling way would be…a critical element. And to tell multiple stories, so that there's not just one Asian story, and one African American story… So, many faces, many stories that are different, but you know, finding the common thread, in that, some of the students who have mental illness, they struggle, and some people, in spite of that, they thrive. There's multiple stories, of their struggles and how they cope with it. And to show different dimensions of that, rather than just one kind of redemptive story." |
| School personnel | Train staff in mental health advocacy, implicit bias, and cultural competence | *PLE:* "That relates to the training that teachers get…, the way that they are taught to appreciate and develop their own knowledge of other cultures, of other races." |
| | | *PLE*: "I think the teachers and the people at the school should be going back to school to get more advanced level classes than what they had in the past. There's a lot of teachers…trying to help my kids, however they're doing it the old school way and they cannot [understand] the kids of this era." |
| | | *Policymaker*: "Health equity has a lot to do with the cultural competence of the folks that are providing services whether it is the teachers or administrators or others…." |
| | | *Policymaker:* "There's a rich body of work on curriculum, and best teaching and learning practices, and all of those…educational pieces, that's part of the training for people going into that field. Conversations about race, and data and bias, and…racial disparities… has not been part of the training." |
| | Increase teachers' and staff members' understanding of behavioral health and social issues facing students and families | *PLE*: "Not everybody's the same. Not everybody's coming in from an environment, that demographic that if I need paper I have it, if I need a computer I have it …." |
| | | *PLE*: "[Y]ou've got to buy your own school supplies, and not everybody has that. I don't have it. [They say] 'Oh well, maybe you need to take her to the library.' Do you have transportation for me to get there?" |
| | | *Policymaker:* "[W]e have a large professional development…area, where our mental health consultants, either at a location or educators can sign up for a centralized registry, [offer] different trainings around social emotional development, approaches to learning, and … other topics." |
| | Hire individuals to assist in addressing students' needs | *PLE*: "Teachers that sincerely care, overstep their boundary and start going into social work, rather than being an educator. They should have individuals assigned for that role, in every school…. That's way too much pressure on the teacher … just way too much on the teacher's plate, I think." |

**Table 2.** Continued

| Target audience | Recommendation | Quotes from participants |
|---|---|---|
| | | *Community Health Advocate:* "[A] community health worker . . . lives in our community, knows our community. And that person could . . . encourage parents to use community centers and churches to get help for their children. They could also . . . just simply educate around the issue of mental health. And they could actually be in the community, you know, go shopping with them . . . a trusted individual. . .." |
| | | *Policymaker*: "There is also the mental health consultation approach which really works on the capacity building for the adults in children's lives, so it's less about intervention with the children themselves. . . [it's] really to address the attitudes, beliefs, and behaviors of the adults. . .." |
| | Actively reach out to students and members of the public | *Policymaker:* "There's this whole issue of stigma in general, around mental health issues, but this other idea around social norming around help-seeking behavior, has emerged as an interesting untapped arena." |
| | | *Community Health Advocate:* "Coming up with pointed and effective campaigns to communicate to our constituents and to the public. [D]epending on the population, oftentimes they don't have access to high-end electronics. So we have put together a multifaceted campaign from anything from material on paper, to social media campaigns, to going to the churches, going to the school systems, having town halls, utilizing social media, utilizing the tools that are out there. . . . We take that material and let people know how they can get assistance. . . and where they can get information." |
| Systems and agencies | Utilize systematic data collection to raise awareness and track progress | *Community Health Advocate:* There will be some people saying, 'we don't see an issue, we're doing what we should be doing' . . . but you have to push back to say, 'Well, you need to look at the research, you need to see how this White child is doing compared to this African American and Latino child the same age, have the same diagnosis, and what's the issue here?' . . . we need to increase awareness around the issue." |
| | | *Policymaker:* ". . . there's a suspension expulsion legislation, and K-12 data, but we don't have good accountability measures to say, 'are we making a difference?' yet." |
| | | *Policymaker:* ". . .I think that maybe we don't have that many measures because we're not sure what to measure. And so, . . . since we don't do that, we track the number of services but we don't have a comparison base to say, 'and if we didn't do this, and have this, this would have been the outcome.'" |
| | Improve data sharing models across agencies that are affected by this issue | *Policymaker*: "I think, some of the data sharing. . . there are just a whole lot of barriers with the interaction with the school system with some of our other agencies." |
| | | *Policymaker:* "[I]t's not just the departmental concerns for data sharing, but it's really our lawmakers and citizens that have a lot of hesitation about data sharing. So it sounds good . . . but the reality of it, when you get right down to it is, it feels very difficult." |
| Other recommendations | Develop collaborations and coalitions; develop policy position, informed by community members, to guide action to address issue | *PLE:* "I think that there needs to be communication with the teacher, the kids, and their parents and make a space for common work within the family, the kid, and the teacher." |
| | | *Community Health Advocate*: "[H]ow do you convene a national meeting that helps to address or create, say, a policy recommendation for policy and national leaders to look at, to implement." |
| | | *Community Health Advocate:* "[R]each out to schools, . . . parents and families, community leaders, and people in the research area, bring those individuals together, and just have a conversation around the issue of, of students living with psychiatric problems and being placed in the school system, and the differences that occur because of race and ethnicity. And then, look at how do we go about solving the issue." |
| | | *Policymaker:* "We've had a multipronged approach that included not only working out of our central office, but working with all our various partners across the state, including our mental health boards, our providers, other state agencies, and other community entities." |
| | Develop training program for parents to better advocate on behalf of their children | *Community Health Advocate*: "Starting with the parents, just educating them about their child, the health issue that they have, and then [for] the ones who don't speak English, make sure that they get that type of education to learn the language so they become advocates for their child." |
| | Promote solidarity within and between communities | *Community Health Advocate:* "We need to do a lot of back work to recognize and to build solidarity that we do share a common interest. . .I think with Asian Americans . . . we still have a lot of work to do in terms of where do we see ourselves in this diverse complicated world. And so, first to identify ourselves as people of color, and to recognize the struggles as well as. . .the accomplishments that we benefit from, from the African American community and the work that they've done. And that the issue of mental illness. . . doesn't just involve African Americans. I think there has to be intentional, kind of connection, and linking and making sure that Asian Americans recognize that their self-interest is also tied to this kind of work." |

**Table 3** Potential barriers that emerged from focus groups and interviews with community health advocates, PLEs, and policymakers

| Theme | Subtheme | Illustrative quotations |
|---|---|---|
| Institutional racism and staff bias | | *PLE:* "[Teachers should] not look at me like as if I was trash because I'm Black or where I'm coming from." |
| | | *PLE:* "It's brutal, just to survive the school. And then. . .in the back of the class being ignored. And that comes the mental health, with that kid that don't know how to socialize, don't know how to talk to other kids. So that's more isolation, . . . more not, knowledge, that's more not bein' part of the class and the teacher, because they have so many kids. 'Oh, another one,' you know 'Ohh, they're stupid. They just don't want to learn. . .. Or the ones who talk out because they feel that they're not getting anything out of it, and they're sent down, pushed out of school or like my child . . . had learning problems. I tried to help. [child] got into an argument with a teacher once. . .. The teacher told [child] that [child] was stupid, [child] was dumb, [child] wasn't going to be anything else than a criminal." |
| | | *Policymaker:* "The implicit bias conversations have very mixed reviews. So part of it's just 'Oh, this wasn't done well enough,' or, 'I don't want to be talking about this, because people are just gonna use it as an excuse for not doing their job.' I think it's exposing a lot of bias in their agency, in their reactions, and, and it's uncomfortable for the people who put themselves out there." |
| Limited data about racial/ethnic disparities in educational placements | | *Policymaker:* "But you won't often see a direct mention to race, or ethnicity in many driving documents. And that's a very interesting challenge, because then when we try to have the conversation about equity or racial equity, they'll want to use the term high-risk or low income. So that, to me is still a major challenge and a fear. . . that this work is going to become harder, because we now are living in a climate where we don't want to talk about differences according to race, and even income, to be honest." |
| | | *Policymaker:* "There's nobody saying you have to look at your suspension and expulsion rates and make sure that it's proportional to the population, the demographics of your state. . .. There's like no, nothing, nothing like that." |
| | | *Policymaker:* "Our data system went live last year. . .. I don't think, we had collected anything on race or ethnicity." |
| | | *Policymaker:* "We're building our capacity to look at data. I think that it's not a common part of our practice to sort of disaggregate by race and make sure that utilization is as would be expected." |
| Funding | | *Community Health Advocate:* ". . . the other obstacle would be 'Well, we don't have the money. We can't do that.'" |
| | | *Community Health Advocate:* "I think what we face. . . is not the resources or the enthusiasm, but it's often the amount of funding that you have that you can be wide and deep." |
| | | *Policymaker:* "We don't have the funding to look at that long term . . . longitudinally. There's some complexity of course, so we are unlikely to have funding to look at those kids, into their school experiences, and in addition, individual child-specific or child-focused work is only one portion of their overall activities. So, they're doing a lot of program-wide consultation and that's really been difficult to look, therefore, at the individual child level." |
| | | *Policymaker:* "Main challenges are time and money. Finding the funding to implement, and then finding the money to scale up and, and sustain." |

additional staff to assist teachers and to better address youths' needs.

Participants across groups highlighted the importance of early identification of and intervention for behavioral health needs during preschool or early grade school, given that K-12 schools may vary widely in their policies regarding management of behavioral problems (PLE: "In the poor communities, they wait too late."). Members of the PLE group discussed positive outcomes of such early intervention programs, including reduction of behavioral health symptoms related to anxiety, depression, low self-esteem, and reductions in the exposure to violence and abuse. However, some policymaker participants expressed concern that early screening programs would simply accelerate placement disparities, allowing younger children to be diagnosed with behavioral health issues, be placed separately, and never be integrated back into the general classroom. Some policymakers referenced programs from their respective states that had successfully improved early access to treatment for children from underserved communities without removal from general classrooms. For example, one state policymaker described a "school-linked mental health" program in which community mental health providers entered the schools to facilitate increased access to behavioral health services, especially among groups of youth who struggled to obtain services in the community. Another policymaker described legislative efforts aimed at eliminating suspensions and expulsions for students from kindergarten to second grade.

Members of all groups emphasized the need for holistic and integrative approaches to prevent and treat behavioral health challenges. For example, community health advocates noted the multiple stressors (e.g., poverty, racism, social isolation) many students face and recommended that they receive support and intervention both in and outside of schools—preferably from an interdisciplinary team including mentors and faith-based organizations in the community to address their needs. They discussed the availability of state and private grant funding for providers seeking to perform this work and recommended that schools and community organizations pursue funding to better support students with behavioral health needs without furthering disparities. Continuity of services between school and home was also emphasized, particularly by members of the PLE group, with suggestions for interventions and prevention mechanisms that promote healthy lifestyle habits such as diet, exercise, and meditation. Community health advocates also acknowledged the power of storytelling, noting that students with a history of these experiences might benefit from the opportunity to share online and communicate with other young people across the country facing similar challenges.

*Support and Training for School Personnel*

Participants from all groups generated recommendations about support and professional development for teachers and other school personnel to reduce educational disparities. For example, PLE and policymaker group participants acknowledged the role that teachers—whether consciously or unconsciously—can play in exacerbating existing disparities. To address that issue, participants suggested mandatory training in cultural competence and implicit bias for teachers and other providers (Policymaker: "We're actually doing all staff training on implicit racial bias this spring, and it's a relatively new conversation in some ways."). They also emphasized the need for schools to utilize more culturally sensitive screening measures when making educational placement decisions.

Members of the PLE group stressed the need for teachers and school administrators to have a better understanding of the behavioral health issues and social needs that their students face, particularly regarding the availability or scarcity of resources at home (PLE: "[They say] 'Oh, well, maybe you need to take her to the library.' Do you have transportation for me to get there?"). However, they also recognized the added burden posed for teachers whose primary objective is to educate students. Thus, participants suggested that schools employ individuals—like social workers—whose sole job would be to address these behavioral and social issues, allowing teachers to remain focused on instruction. Similarly, community advocates suggested that schools employ Community Health Workers and Family Partners as liaisons between PLEs, families, and their communities, and hire Certified Peer Specialists to support PLEs in their navigation of and communication with the different systems they navigate for their children and/or themselves (e.g., educational system, behavioral health system). Policymakers noted that teachers might also benefit from consultation with community-based behavioral health experts to develop a better understanding of children with behavioral health needs and identify better methods for working with them in a general classroom. These recommendations echo principles developed and outlined by researchers at the University of Washington, who studied ways that partnerships between public school systems and university mental health centers can help support the mental, emotional, and behavioral needs of students (Bruns et al., 2016).

Finally, participants across groups highlighted the need for teachers and school personnel to fight stigma and encourage students to seek help when needed, recommending that schools, communities, youth systems, and faith-based groups work collaboratively to raise awareness and increase empathy for individuals with behavioral health needs. Members of the PLE group recommended that schools improve their capacity to actively reach out to students rather than wait for problems to arise. Similarly, community health advocates suggested that schools might educate students and the public using online tools and social media. One community advocate explained a process for collecting stories about mental health from communities of color and showing them to diverse groups to collect feedback, build solidarity, and allow viewers to say "That really resonates, that story is something that I also experienced. . .".

*Coordination among Relevant Systems and Agencies*

Community health advocate and policymaker participants emphasized the need to collect data about emotional challenges and placement status across racial/ethnic groups to assist with monitoring disparities, developing evidence-based interventions, and informing policy to determine state and federal regulations and reimbursements. One policymaker stated, "we are not [yet] tracking specific data about who's getting kicked out." Further, policymaker group members suggested that these agencies—including Medicaid, the Department of Mental Health, and the Department of Education—develop improved communication and data sharing methods, both internally and with school systems, while maintaining compliance with federal laws (i.e., Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA)). Several policymaker

group members endorsed this idea, noting that data are frequently stored within separate systems and agencies (e.g., education systems, healthcare systems, behavioral health systems) and that the siloed nature of these agencies often limits the frequency with which they work together to solve systemic problems. One respondent felt tying performance and sustainability to funding requirements might help make strides, noting "There's nobody saying you have to look at your suspension and expulsion rates and make sure that it's proportional to the demographics of your state." Finally, policymakers emphasized the need for schools to collect data using culturally appropriate assessment measures to accurately assess an intervention's effectiveness for youths from varying backgrounds.

Participants from all three stakeholder groups highlighted the need for collaboration among PLEs, families, schools, communities, faith-based organizations, and policymakers to design and implement interventions aimed at reducing educational–behavioral health disparities. PLEs viewed parents as key advocators for their children, particularly in protecting against institutional racism and discrimination, and promoted ongoing collaboration between families and teachers. Members of the community health advocate group emphasized the need to build bridges between families, communities, and school personnel through workgroups and coalitions that included representation of different stakeholders. They also encouraged coalition building between members of different minority groups, organizations, and states to foster greater solidarity and shared experiences. Policymakers were more systemic, emphasizing the importance of working collaboratively to ensure buy-in from PLEs and communities when implementing evidence-based interventions, while also improving program coordination to prevent service duplication.

Similarly, community health advocates suggested that school systems and other organizations develop a joint policy position to guide local, state, and national action on educational–behavioral health disparities. Participants stressed the importance of incorporating members of the community into policy development, for example, by holding forums to generate ideas from parents, students, community members, and other agencies. Community health advocates also proposed that schools or community organizations establish a training program for parents of children with behavioral health challenges to help them learn about their child's development, the best ways to help them at home, and how best to advocate for their child within the school system. Participants noted that these programs should be especially prepared to work with parents with limited education and limited English language ability, as they would likely need additional support.

### Barriers to Addressing Racial/Ethnic Disparities in Educational Placement

Participants across groups cited institutional racism and staff bias as major barriers to the elimination of these disparities. They also described miscommunications that can emerge from cultural differences and result in distrust between PLEs and school staff. Policymakers reported that separate state agency structures for human services and education departments hinder the ability to effectively coordinate data on behavioral health and educational needs. Some participants reported that little to no data are collected on race/ethnicity, further limiting the ability to monitor trends in these disparities.

Members of all stakeholder groups identified limited funding as a main barrier to designing and implementing interventions to reduce these disparities. Additionally, they noted that shifts in state government priorities, political climates, and changes in leadership can contribute to lack of continuity in intervention programs and a limited ability to carry out long-term efforts. Frequent shifts in priorities can also affect the sustainability of successful programs. Finally, given current models that primarily reimburse services for diagnosable problems, participants noted that few resources exist for prevention programs or services for children without a formal diagnosis.

## Discussion

This study describes our efforts to engage relevant partners in an ongoing dialogue about the "wicked problem" of educational–behavioral health disparities and work collaboratively to identify potential methods for reducing these disparities. This methodology allowed our team to examine the challenge from differing perspectives, thereby offering opportunities for reciprocal learning between researchers and diverse stakeholders who might otherwise be considered passive recipients or beneficiaries of research findings (Dungan et al., 2019). The complicated overlaps and relationships among federal and state policy, local governance and school districts, and individual experience highlight the need to understand how relevant stakeholders perceive, engage with, and generate potential solutions to this problem. Any attempt at progress toward addressing recurrent wicked problems within educational systems requires improved understanding of underlying social complexities (Bore & Wright, 2009).

Through this work, we have applied techniques used to better understand "wicked problems" to a novel issue: racial/ethnic disproportionality in educational placement. We also advance the use of these techniques, such that we not only identified factors contributing to this wicked

problem, but also elicited recommendations for ameliorating this problem from relevant stakeholders at multiple ecological levels of influence. The diversity of insights that emerged supports the need to engage in this qualitative inquiry as a precursor to any attempts at addressing this problem or other wicked problems. For example, though a policymaker might agree that socioeconomic factors contribute to educational inequity, they may lack awareness of parents who cannot access a library for lack of transportation or adequately advocate on their child's behalf because of limited formal education or understanding of school systems. Thus, obtaining insights from just one group would limit the ability to identify a comprehensive understanding of the problem and enact policy that sufficiently reconciles differing views. Using these techniques to obtain multilevel stakeholder perspectives can inform reform efforts so that they better avoid unintended consequences for another affected group of stakeholders.

With the important contributions of partner-site leaders and stakeholder participants, this study produced a core set of issues that resonate with stakeholders and therefore should be considered when seeking to effect change. Three major forms of action to address existing disparities were identified as follows: (a) support and programming for students, (b) support and training for school personnel, and (c) better coordination among relevant systems and agencies. Specific discussions related to the first form of action further clarify a blueprint that collaborative initiatives—such as the Supportive School Discipline Initiative, a joint effort between the U.S. Departments of Education and Justice—might review as a first step to expanding support and programming for minority students with behavioral health problems. These recommendations might also lead to further development of socioemotional learning programs aimed at better supporting and addressing the needs of youth of color (Barbarin, 2013; Bierman et al., 2010).

Additionally, generated recommendations underscore the need to help support and train school personnel, while considering limited behavioral health resources that often impede change efforts (Farrell & Coburn, 2017). District leaders might look to develop strategic partnerships with outside organizations to assist with enacting reform, working together to develop a shared vision of both the problem of racial/ethnic disparities in educational placement and the pathways for resolution (Chorpita & Daleiden, 2014). They should also create organizational plans that build collective knowledge and enact clear, evidence-based policies and practices to reduce disparities and improve behavioral health outcomes for youth of color. For example, groups hoping to address educational disparities might advocate for the use of programs that have demonstrated success, even in schools with limited resources, such as the Positive Behavioral Interventions and Supports program (Lewis & Sugai, 1999) or other research-based programs that support behavioral health (e.g., Bohanon & Wu, 2011; Cook et al., 2015).

Our stakeholder groups also emphasized the importance of multisectorial collaborations and inter-organization coordination. Existing literature supports this point. For example, a meta-analysis examining programs targeting system-level change found that interventions implemented in collaboration with community-based agencies showed significant improvement in youth social and emotional skills (Durlak et al., 2007). Thus, strong links between schools and both families and community-based agencies may be integral to successful behavioral health promotion and prevention among students (Lewallen et al., 2015; Weare & Nind, 2011).

We acknowledge study limitations; for example, recruitment methods likely created focus groups in which participants knew each other—this composition may have affected willingness to speak openly. On the other hand, participants with prior relationships—especially PLEs, who would have known each other in the context of a supportive environment—may have felt more at ease and therefore more willing to share their personal experiences (Gill et al., 2008). Further, in-depth interviews would have allowed participants to provide responses they may have felt unwilling to share in a group setting. As an additional limitation, by conducting just one focus group for each type of stakeholder, responses obtained might reflect the unique composition of each group rather than more broadly generalizable perspectives from similar stakeholders (e.g., Morgan, 1997). However, rather than seeking theme saturation, we used focus group data to illustrate the ways in which perspectives obtained from different stakeholders might vary and, even with just one group per stakeholder type, we achieved this goal. Regarding data analysis, we recognize that developing in-depth interview guides based on results from focus group interviews created a short period of time during which we could analyze focus group data. Rapid analysis of these data prevented us from employing the same rigorous processes we used to analyze in-depth interview transcripts. To improve credibility of these findings, we engaged in forms of member checking, with both stakeholder group leaders and participants themselves during subsequent in-depth interviews.

Although between- and within-group heterogeneity might be perceived as a study limitation, this design supported a richer, more nuanced exploration of the problems posed by racial/ethnic educational disparities. Across groups, participants may not have interacted with the same school or state systems, but participants' diversity of experience allowed them to contribute unique examples of the ways in which educational disproportionality has developed

or has been resistant to reform efforts. For instance, when one state policymaker identified potential methods for addressing disparities, another participant could weigh in on the pitfalls that plagued similar attempts in their own state and further discussion could ensue. Additionally, recruiting PLE participants locally—as opposed to other stakeholders, who participated by phone and via webinar—made participation more accessible to PLEs with limited resources. Their experiences may reflect those of PLEs nationwide; however, further research should explore this assumption.

### Considerations for Future Research

Given that the rich findings described above were obtained a stakeholders from outside the traditional educational system, future work might seek to engage groups of students, teachers, and other individuals directly involved with schools on a daily basis to share their own reactions and methods for addressing disproportionality as well as to discuss the feasibility of the resolution strategies identified by current participants. Further, future investigation might seek to enact and evaluate some of the suggestions generated through this study, such as hiring additional supports for teachers, creating more mentoring programs for students, and engaging more community members in addressing these issues. Perhaps, before engaging in a traditional experimental trial, researchers might benefit from employing novel methods of simulation testing (e.g., Alegría et al., 2017) to examine potential effects of policy change. Results from these methods might inform the level at which future reform efforts are targeted (e.g., at the classroom, school, or systems level) and how best to monitor implementation of new policies.

Overall, stakeholder comments presented here may help to shift affected individuals from the mindset of "someone needs to do something," to one where "everyone," collectively, can work together to act and target one or more of these suggested areas. This approach encourages educational and health systems, community organizations, students, and families to consider confronting the problem as part of a multisectorial team rather than facing it on their own. The procedures described here also presented some challenges that other groups hoping to engage in similar efforts to address "wicked problems" should consider. Navigating contexts that incorporate multiple voices—such as those who receive, conduct, and administer policy for educational–behavioral supports—can help to inform a blueprint or plan of action. However, researchers attempting to replicate this work are advised to allow themselves a considerable amount of time to do so, as it can be a time-consuming enterprise. In addition to the time required to identify and develop relationships with relevant collaborators from varying backgrounds, researchers must also take time to ensure they can present research findings to each of these groups in a tailored way. Then, stakeholders must be given the opportunity to reflect and discuss the findings, offering their perspective about how the problem is defined and how it might be resolved. These conversations should occur as part of an ongoing dialogue, as ideas for resolving problems will often require further refining before they can be put into action. Community psychologists are well-suited to engaging in this work, as "advancing stakeholder participation [and] multi-level collaboration" are critical organizing principles for the field (Tebes et al., 2014, p. 482).

As a "wicked problem," racial/ethnic disparities in educational placement can appear overwhelming and impossible to solve. It is important to note that collaborations like the one described here serve as a central—but not final—step toward addressing wicked problems (Head & Alford, 2015), because wicked problems are never truly solved, "they are simply resolved over and over again" (Bore & Wright, 2009, p. 245). Our findings further highlighted the "wickedness" of this issue, identifying multiple components and multiple affected groups—each of which has its own interpretation of the problem and possible solutions. Similarly, responses elicited from this collaborative process demonstrate that no single program will completely solve this issue. However, responses also suggest that we can make meaningful impact by listening to individuals directly affected by the challenge and considering their perspectives when developing and implementing interventions aimed at making improvements, even small ones.

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## Conflict of Interest

The authors declare that they have no conflict of interest.

## Ethical Approval

The authors of this manuscript have complied with APA ethical principles in their treatment of individuals participating in the research, program, or policy described in the manuscript. This research has been approved by the Massachusetts General Hospital/Partners Healthcare Institutional Review Board.

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## Appendix A: Interview Guides for Each Focus Group

### Community Health Advocate Focus Group

Defining the Issue

- Based on the slide presentation, what would you conclude about mental health service differences?
- What was surprising to you about this research?
- What was surprising to you based on your experiences?
- How would you define the problem presented in this study, if you think there is one?

Prioritizing Issues

- After seeing this presentation and reviewing the materials, what areas would you tackle first to reduce these disparities?
- Why would you select this area over others?
- Do you think others in your area would have the will to address this as a priority? How about you?

Addressing the Problem

- How would you address this problem?
- What policy changes or interventions might you propose?
- How would you design it?
- What would be your main obstacles?
- What would you need to carry out your proposal?

Establishing an Agenda to Solve the Problem

- How would you map an agenda for starting your recommendation of policy/system change?
- What information would you need to have to know you are on the right track?
- Who would you discuss your plan with to get feedback and refine it?
- How would you get this feedback?

Sharing Your Recommendations
- Imagine you got a lot of positive feedback on your proposal. What would be your next steps?
- Which audiences would you involve? Why?
- How would you tailor discussions for these different audiences?
- What is the most important piece of information to convey?

## PLE Focus Group

Defining the Issue
- Based on the research results, what would you conclude about mental health services differences?
- What surprised you about these results?
- What findings surprised you based on your own experience?
- Are there additional instigators of these mental health outcomes (or service differences), beyond the ones presented in the project, that you believe are central to understanding these mental health outcomes (and/or service differences)?
- Could you describe them?
- In your own words, how would you define the disparities problem, if you think there is one?

Prioritizing Issues
- After reviewing all of this information and using your expert knowledge, what areas would you tackle first as a way to reduce these disparities?
- Why would you choose this (these) area(s) over others?
- Do you think other people with lived experience would have the will to address this as a priority problem?
- How about you?

Addressing the Problem
- How would you address this problem?
- What policy changes and/or systemic intervention would you propose to solve this problem?
- What would your recommendation or proposal be?
- How would you design it?
- How passionate do you feel about undertaking this problem?
- What do you see as your main obstacles in addressing this problem?
- Could you elaborate a scenario of how you would address these problems?
- What steps would you follow to move your recommendation forward?
- What would you need to carry out this proposal?
- Who would need to be involved?

Establishing an Agenda to Solve the Problem
- How would you map a short-term agenda for starting up your recommendation of policy/system change?
- What information would you need to collect to know you are on the right track?
- With whom would you discuss this plan to get feedback and refine it?
- How would you go about getting this feedback?
- What barriers do you anticipate when putting in motion your proposal?

Sharing Your Recommendations
- Imagine you got a lot of positive feedback on your proposal, how would you go about trying to get others to adopt it?
- Which audiences would you target?
- Why?
- How would you tailor your discussions to these different audiences?
- What is the most important piece of information to convey to these audiences?
- Policymaker Focus Group

Defining the Issue
- What do you find most striking about these results?
- How do you think these results compare to your state?
- Are there additional factors, beyond the ones presented in the project, that you believe are central to understanding these disparities? Could you describe them?
- In your own words, how would you define the disparities problem and communicate it to your colleagues?

Prioritizing Issues
- After reviewing all of this information and using your expert knowledge, what areas would you prioritize to be tackled as a way to reduce these disparities?
- Why would you select this area over others?
- Where do you believe this issue would fit within the priorities of your agency? The priorities of other stakeholders?
- What other issues would take precedence? Why?

Addressing the Problem
- Are there any efforts underway in your state to address this issue?
- How would you address this problem?
- What policy changes or systemic intervention would you propose to address this disparities problem?
- What do you see as your main obstacles in addressing this problem?
- What steps would you follow to move your recommendation forward?

- What would you need to carry out this proposal?
- Who would need to be involved?

Establishing an Agenda to Solve the Problem

- How would you map an agenda for starting your recommendation of system change?
- What information would you need to have to know you are on the right track?
- Who would you discuss your plan with to get feedback and refine it?
- How would you go about getting this input?
- What barriers do you anticipate when putting in motion your proposal?

Disseminating the Recommendations

- Imagine you got a lot of positive feedback on your proposal. How would you go about building the case for adoption?
- Which audiences would you involve? Why?
- How would you tailor discussions to engage these different audiences?
- What is the most important piece of information to convey?