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Aims and Policies

Best Practices in Mental Health is a refereed publication intended for an interdisciplinary audience of mental health practitioners, administrators, and scholars. The journal publishes original, practice-focused articles that are in keeping with the best possible evidence about what works in clinical, community, and/or organizational settings. Each issue includes information on innovative programs, interventions, new research efforts, book reviews, and descriptions and links to relevant websites.

The journal seeks to provide readers with an array of articles on topics ranging from the micro application of a single practice intervention, such as psychoeducation, to macro applications such as accreditation standards. Manuscripts are solicited from the entire mental health community and also invited from other educators, researchers, policy makers, and practitioners whose focus is on strengthening the knowledge base of mental health practices.

Categories of Best Practices

Best practices is a term with a broad definition that has numerous applications. The journal reviews four areas of mental health practices: (1) best practices, (2) emerging practices, (3) practice-based evidence, and (4) evidence-based practice. We ask that contributors ensure submissions meet at least one of these categories of best practices as described below.

Best practices for mental health can be described as a method or technique that has consistently shown results superior to those achieved with other means and is often used as a benchmark for others to base their practices on. Additionally, best practices guidelines are determined through a thorough process that includes research findings, clinical experience, and implementation guidelines which are then debated and discussed by panels of specialists including clinicians, researchers, program administrators, and client advocates.

Emerging practices are defined as treatments and services that are promising, are less thoroughly documented than evidence-based practices, and have a strong research foundation but fewer than five scientifically rigorous published studies. Emerging practices are often administrative or clinical practices that have proven effective at achieving a specific aim, hold promise for other organizations, and show effectiveness in small-scale projects where research designs are less rigorous or self-reporting measures are used.
Practice-based evidence is defined as evidence of real-world data collection and focuses heavily on improving practice. Descriptions are focused on effectiveness and practice, and studies often describe routine practices that have high external validity but little inferential generalizability.

Evidence-based practices are those interventions for which there is consistent scientific evidence showing that they improve client outcomes, with one or more replications of the original studies.

Overall, best practices are broadly seen as activities, programs, and guidelines that have been created based on careful identification and synthesis of the best available evidence in a particular field of practice.

Types of Articles

Best Practices accepts regular articles and brief reports, both of which can include conceptual papers (e.g., descriptive best practices), research reports (e.g., empirically supported best practices), and specialty topic literature reviews (e.g., best practices for transition-age youth). Anyone interested in submitting such material should contact the editors. From time to time, the editors will solicit articles on special topics and will feature such special topics as consumer-selected best practices, commentaries, and field notes. Book reviews are a regular feature of the journal and are usually solicited by the editors.

The following section describes the recommended format and procedures for conceptual and research manuscripts and book reviews.

Conceptual articles. The format for conceptual articles is introduction, best practices program or intervention description, preliminary findings, discussion (e.g., including implications for best practices), and conclusion. The introduction can include literature review, issues, problem statement, and identification of best practice category. The program or intervention description can include theoretical perspective, program description or design, components, steps for implementing best practice, or curriculum description. Preliminary findings can reference evaluation efforts and results, and note whether informed consent and institutional review board approval was obtained. The discussion section can describe findings, limitations of the intervention or program, recommendations for future development, and implications for best practices. The conclusion section pulls it all together and refers to main findings or conclusions supported by the discussion.

Research reports. The standard format for research reports is introduction, methods, results, discussion (with implications for best practices), and conclusion. In the last paragraph of the introduction, state the purpose of the research as either a statement or a research question, indicate type of study design (e.g., experimental, survey), and identify which category of best practice this article represents. Include descriptive data of participants or population, dates for original data collection, and statement of whether informed consent or institutional review board approval was obtained. In the methods section, describe the data analysis procedures in a manner understandable to nonstatisticians. In the results section, report findings directly related to the research purpose or question. This section can report numbers of all percentages (in either text or table) as well as statistically significant results (e.g., values, degrees of freedom, probability levels). The discussion section should describe limitations as well as explicitly discuss the findings in relation to application and implications for best practices.

Book reviews. The journal’s intent is to publish book reviews that are relevant to readers interested in resources for best practices in mental health. Books to be considered for review should be sent to Robert H. Keefe, PhD, ACSW, School of Social Work, 685 Baldy Hall, University at Buffalo, State University of New York, Buffalo, NY 14260-1050, or rkeefe@buffalo.edu. Potential reviewers should contact Professor Keefe.
Submission of Manuscripts

General Requirements

Best Practices reviews material for publication on condition that it has not been previously published, including electronic publication, and is not being reviewed for publication elsewhere. For peer review, all submissions must:

1. Be sent electronically to bpmh@lyceumbooks.com as one file folder containing multiple documents. For example, the folder must have separate e-files for the following:
   - cover letter;
   - title page with author names, affiliations, and contact information;
   - article manuscript without author names on the title page, but including an abstract, key words, full article text, references, and acknowledgments;
   - tables and figures (if any), submitted as separate files, with a corresponding callout in the text.

   Files should be prepared using Microsoft Word and saved as .doc (not .docx) files. All tables and figures must fit on the page with portrait (not landscape) orientation; PowerPoint figures are not accepted. The entire article manuscript must be without author identification. E-mail or phone inquiries may be made directly to either editor: Vikki L. Vandiver, vandivv@pdx.edu, 503-725-5007; or Kevin Corcoran, cikc@pdx.edu, 503-962-0995.

2. Conform to the Publication Manual of the American Psychological Association, 6th edition (APA) for citations and references only; text style should follow the Chicago Manual of Style, 16th edition. Please use person-first (e.g., person with schizophrenia, not schizophrenic; research participants, not subjects) and nonsexist language.

3. Be double-spaced (including tables), using 12 point font (Times New Roman preferred) with 1-inch margins. Do not use bold or underline. Number pages numbered in the upper right-hand corner.

4. Conform to word and page limits. Regular articles should not exceed 5,000 words (about twenty pages). Brief reports should not exceed 800 words (about four pages). Book reviews should be about 600 words (about three pages).

5. Identify in the cover letter all authors and their contact information, include a statement claiming that the manuscript is not under review elsewhere, and note which category the manuscript should be reviewed under (best practices, emerging practices, practice-based evidence, or evidence-based practice).

Arranging the Manuscript

Best Practices uses a blind review system, thus all manuscripts must have a separate title page that can be removed when the manuscript is sent for review. As described above, please provide TWO title pages, one with title of manuscript and all authors’ names, affiliations, and contact information; and a second title page in the article manuscript with NO author identification.

Authors. Only principal writers should be listed as authors. Persons listed as authors must have made substantial contributions to the article and must be able to take public responsibility for it. Other contributors may be named in the acknowledgments. For each author, list no more than two academic degrees or certifications and the primary current affiliation (including specific title and department, agency, or university affiliation).
Acknowledgments. Acknowledgment of individuals or groups is limited to those who contributed to the article's intellectual or technical content. List all financial support, including grants and support from foundations and/or the pharmaceutical industry. For grants, include the grant number and full name of granting agency.

Abstract and key words. The abstract is meant to be a brief, succinct summary of the manuscript, no longer than about 150 words. It is recommended that authors follow the format sections described for conceptual or research papers (given above). Following the abstract, list key words that characterize your manuscript (e.g., geriatric depression; home care; screening); please provide two or three terms.

Manuscript. Whether your manuscript is a regular article (about twenty pages or 5,000 words) or a brief report (about four pages or 800 words), please structure the sections using the guidelines listed under conceptual or research.

Tables and figures. Include tables only when they present relevant numerical data more clearly than can be done in text; all tables should be referenced in text. Please limit tables to one or two per article. Figures can be used to illustrate a variety of relationships (e.g., logic models, flow charts, or program diagrams). These should be formatted in Microsoft Word (using SmartArt, drawing tools, or a text box), portrait orientation, no use of color, uncluttered, and clearly presented. Each table or figure should have its own electronic file, clearly labeled. Be sure to indicate in the text approximately where each table or figure should appear.

References. Please use care when preparing your article references. References cause the greatest loss of time and productivity when your article is being reviewed, copy edited, and typeset. Limit references to relevant published material cited in the text. Prior to submission of your article for review, please check to see that spelling of names, titles, years of publication, up-to-date URLs, and page numbers are correct and consistent. Please refer to previous issues of this journal for publishing style, and consult the APA Publication Manual for any questions on how to prepare your references.

Review Process and Editorial Decision
Manuscripts submitted for publication are sent for blind peer review to three editorial board members. Final decision for publication rests with the editors.

Timeline. The journal is published twice yearly (January and June). The peer review process takes approximately one month, after which time the editors will communicate the editorial decision to the author(s) along with a summary of information about the decision and, if appropriate, recommendations for revision of the manuscript for publication or resubmission for a second review. Once final manuscripts are accepted and revisions (if needed) are completed, a future publication and issue date will be provided to the author(s).

Revised manuscripts. Authors may be asked whether they wish to make suggested revisions, and if so, a time frame will be given for turnaround.
Letter from the Editors

“Evidence” for Best Practice

Kevin Corcoran and Vikki L. Vandiver

This journal was conceived from the need to develop and disseminate information on best practices in mental health. To a measurable degree it has succeeded. And yet, in the decade since its conceptualization much has changed in best practices. This has resulted in considerably more published articles, books, and manuals distinguishing what works (or seems to work based on probability) from what seems not to work in the treatment of persons with mental health conditions.

One change has been the broadening of the scope of what is meant by best practices: that is, the amount of available evidence balanced against its probative or persuasive value. A broader scope seems necessary, in part, because best practice has always included evidence. The idea of using evidence in practice is not new and has always been a part of clinical practice (Corcoran, 2007).

Historically, no example is more persuasive than the Greek practice of medicine. Their approach to health care was based on observations or data, that is, evidence. Although these observations were not highly accurate (i.e., valid), they were consistent (i.e., reliable). Key to this approach were observations of blood drying, resulting in the theory that there are four types of bodily fluids or humors: blood, phlegm, bile, and black bile. This was consistent with the Greeks’ quadratic world view: four seasons, four components of the environment (hot, cold, wet, and dry), four directions (north, east, south, and west), four elements in the universe (earth, wind, fire, and water), and so forth (Barry, 2004). It all made perfect sense and was based on evidence.

It would be 600 years before further advancement was made, by way of Galenic medicine (Galен, 130–200 CE), a mere tinkering with the Hippocratic notions using a critically different method, known as active observations. Galen was quite influential, and his procedures were considered the best practice throughout the Christian and Muslim worlds. Galenic medicine was evidence-based and treatments were derived from observations. With integrity, the theory of balance and imbalance in the body system (i.e., the four body humors being out of whack) produced such interventions as bloodletting, sweating, urinating, defecating, vomiting, and other methods of purging to restore the balance between blood, phlegm,
bile, and black bile. Of these methods, the best practice soon became bloodletting, whereas vomiting, urinating, and defecating fell into disfavor. If tenacity is a criterion for knowledge (Rubin and Babbie, 2010), then there is something to be said about Galen and best practice, as both Near Eastern and Western medicine would wait another 1,500 years before any noticeable advancement would occur. And yet, perhaps this illustrates that the problem with traditions is that they get old.

The defining issue of best practices, then, is not evidence per se, but the probative value of that evidence when applied to the proper question. The challenge for researchers and practitioners of best practice is to understand how sound evidence is established and to use practices for particular problems that are based on persuasive evidence. Over the decades the gold standard has been the randomized controlled trial, and rightfully so, but not without internal and external threats to validity.

Some best practices have had the benefit of extensive research, whereas recent interventions for new or different mental health conditions, such as those found at sites including the Substance Abuse and Mental Health Services Administration, Robert Wood Johnson Foundation, and Hazelden & Dartmouth Psychiatric Research Center, have not. In contrast, work with Indian youth using culturally appropriate interventions is quite new (see Vandiver, 2013), but the evidence, although from less rigorous procedures such as quasi-experimental designs, is promising and suggests an emerging best practice.

Vandiver (2013) delineates four ways of considering what is best practice:

1. research evidence proving that a practice works (i.e., evidence-based);
2. practitioners’ opinions about what works in practice (i.e., clinical consensus such as those produced by the Institute of Medicine);
3. cultural and local context that determines if and how a practice works here and now (i.e., practice-based evidence), along with a scientific framework that incorporates culturally based interventions (again, practice-based evidence); and
4. guidelines or a general plan of action that requires specification to fit the particular circumstances in which the system of care is being implemented.

All of these sources of best practice will be considered for publication in Best Practices in Mental Health.

One type of evidence that the editors believe is slightly new to this journal appears in the inclusion of articles based on practice-based evidence. Although the debate between evidence-based practice and practice-based evidence continues, it is clear that both are of considerable value. It can be argued even to the most rigid empirical scientist that experience matters. In all likelihood, with experience, scientists become much more proficient than they were when they entered the field. We improve because we observe our practices and refine our skills.
Gladwell (2008) illustrates this concept in his delightful discussion of the 10,000-hour rule. For various reasons it seems that 10,000 hours of practice is the magic number of hours needed to make an expert. As all musicians, athletes, artists, and authors know, success results from practice, practice, and more practice. This hypothesis does seem to work, and in every sense of the word, experience is “practice-based evidence.” We hope to include exceptional pieces that illustrate this, along with articles using more rigorous methodologies. After all, the goal of Best Practices in Mental Health is to develop and disseminate what seems to work.

To this end, the format of the journal has been changed. We intend to continue the strong tradition of special issues once a year or so, and to organize the entries to include an editorial, research articles, brief reports, book reviews, and a new section by Kristin Beers and Stephanie Sundborg that reviews websites on a particular topic. This section will be called Website Review, and the first entry is a review of sites about attention deficit hyperactivity disorders, which seems appropriate because many of the articles in this issue concern youth and young adults. Finally, all authors will be asked to conclude with a section specifically addressing the implications for best practice, with the intent of providing directions for practitioners. We welcome manuscripts of all types, and hope you find the new format satisfactory.

References
Mindfulness therapies have gained considerable attention recently in empirical literature, revealing promise for the reduction of a variety of psychological and physiological symptoms among adults. Studies have offered promising results regarding the efficacy of Acceptance and Commitment Therapy (ACT), Dialectical Behavior Therapy (DBT), Mindfulness-Based Cognitive Therapy (MBCT), and Mindfulness-Based Stress Reduction (MBSR) for use with problems such as depression, anxiety disorders, borderline personality traits, internalizing and externalizing problems, chronic pain, psychosis, and epilepsy. Only in recent years have researchers begun to investigate the impact of mindfulness therapies on adolescent illnesses. To date, however, there has been no synthesis of research on mindfulness therapies with adolescents. Using specific inclusion and exclusion criteria, a systematic synthesis of the literature yielded a final sample of fifteen studies (two ACT, twelve DBT, and one MBSR). When they were not reported in the studies, effect sizes (Hedges’s $g$) were calculated for all outcome measures using Comprehensive Meta-Analysis 2.0 software. The majority of included studies reflected moderate to very large effect sizes regarding the impact of the mindfulness therapies on outcome variables; however, only particular variables were significant. Findings from this systematic review offer a first step toward understanding the impact of mindfulness therapies with adolescents.

**Key words:** Acceptance and Commitment Therapy; Dialectical Behavior Therapy; Mindfulness-Based Cognitive Therapy; Mindfulness-Based Stress Reduction Therapy; systematic review

“It is our own thoughts, inaccurate beliefs, unrealistic expectations, and insatiable desires that obscure and distort our direct perceptions. Thinking is actually the
problem, not (as we often assume) the solution” (Semple & Lee, 2008, p. 64). This quote highlights the primary difference between the traditional cognitive behavioral therapies (CBTs) and mindfulness therapies. Although both assert that thinking contributes to the problem, traditional cognitive-behavioral therapists put substantial emphasis on altering thinking as a means to change behavior (Craske, 2009). Alternatively, the mindfulness therapies seek to alter individuals’ context and relationship with their thinking rather than the actual thoughts (Greco & Hayes, 2008).

Mindfulness, or third-wave, behavioral therapies are relatively new and have gained popularity in research literature during the last two decades (Keng, Smoski, & Robins, 2011). These therapies have revealed particular promise for the reduction of a variety of psychological and physiological symptoms among adults (Keng et al., 2011; Montgomery, Kim, & Franklin, 2011). Specifically, studies have offered promising results regarding the efficacy of Acceptance and Commitment Therapy (ACT), Dialectical Behavior Therapy (DBT), Mindfulness-Based Cognitive Therapy (MBCT), and Mindfulness-Based Stress Reduction (MBSR) with issues such as depression (Grossman, Niemann, Schmidt, & Walach, 2004; Ma & Teasdale, 2004; Teasdale et al., 2000; Vowles & McCracken, 2008), anxiety disorders (Dalrymple & Herbert, 2007; Grossman et al., 2004), borderline personality traits (Dimeff & Koerner, 2007), chronic pain (Dahl, Wilson, & Nilsson, 2004; Wicksell, Melin, Lekander, & Olsson, 2009), eating disorders (Wisniewski, Safer, & Chen, 2007), and epilepsy (Lundgren, Dahl, Melin, & Kies, 2006).

Only in recent years have researchers begun to investigate the impact of mindfulness therapies on adolescent illnesses (O’Brien, Larson, & Murrell, 2008). Burke (2010) recently conducted a review of MBCT and MBSR interventions with both children and adolescents. To date, however, there has been no systematic synthesis of research investigating all four mindfulness therapies with a focus on adolescents. Therefore, the primary purpose of this study is to offer an overview of each third-wave therapy, its utility with adolescents, and corresponding empirical support by calculating effect sizes for treatment effects. An ancillary aim of this review is to explore the extent to which mindfulness therapies may offer delinquency treatment providers a therapeutic approach to address identified limitations currently existing in the utilization of the most efficacious or evidence-based delinquency treatment interventions.

Background

Acceptance and Commitment Therapy

As reported by Fletcher and Hayes (2005), the primary aim of ACT is to foster psychological flexibility. Specifically, they define psychological flexibility as “the ability to fully contact the present moment and the psychological reactions it produces as a conscious person and to persist or change behavior in the situation in the service of chosen values” (p. 319). Ultimately, ACT promotes psychological flexibility through six core processes: acceptance, presence in the moment, cogni-
tive defusion, self as context, values, and committed action (Hayes, Luoma, Bond, Masuda, & Ellis, 2006). These six processes are considered to be interrelated and often require the use of one process to fully explore another. Although overlap and a collective reliance on more than one of the processes are often necessary in treatment implementation, not all six constructs need to be utilized for effective intervention. Developmentally appropriate activities and metaphor exercises based on the ACT processes have been developed for the treatment of adolescents (e.g., Wicksell & Greco, 2008).

Research on the efficacy of ACT has primarily been dedicated to intervention with adults. Over the past decade, researchers have reported on the promising effects of ACT with a variety of psychological and physiological health problems such as anxiety disorders (Dalrymple & Herbert, 2007; Woods, Wetterneck, & Flessner, 2006), depression (Vowles & McCracken, 2008; Vowles, Wetherell, & Sorrell, 2009), distress associated with psychotic symptoms (Gaudiano & Herbert, 2006), chronic pain (Dahl et al., 2004; Vowles et al., 2009; Vowles & McCracken, 2008; Wicksell et al., 2009), epilepsy (Lundgren et al., 2006), trichotillomania, chronic skin picking (Woods et al., 2006), and diabetes (Gregg, Callaghan, Hayes, & Glenn-Lawson, 2007).

Dialectical Behavior Therapy

Dialectical Behavior Therapy is based on the premise that a dialectic worldview can exist between clients’ mindfully accepting themselves and simultaneously striving for change (Linehan, 1993). As opposed to ACT, MBCT, and MBSR, DBT is largely influenced by traditional cognitive behavioral therapy and is employed through specific treatment stages with accompanying treatment goals (Dimeff & Koerner, 2007). For example, the goals associated with Stage 1 (achieving reasonable and immediate life expectancy, maintaining control of actions, and having adequate connection to treatment) are taught through skills training to develop the following (Dimeff & Koerner, 2007):

- emotion regulation;
- distress tolerance;
- skillful responses to interpersonal situations;
- observation, description, and participation skills in the absence of self-judgment, while simultaneously remaining aware and focused on effective skills; and
- behavior management through utilizing strategies that are not self-injurious.

Initially developed to treat suicidal adult female patients diagnosed with borderline personality disorder (Linehan, 1993), DBT has also demonstrated a positive impact on adults who have substance dependence with borderline personality disorder (McMain, Sayrs, Dimeff, & Linehan, 2007), eating disorders (Wisniewski et al., 2007), and depression with personality disorder (Lynch & Cheavens, 2007). For adolescents, DBT consists of a combination of individual, group, and family
therapy and targets change for adolescents displaying borderline personality traits (Woodbury, Roy, & Indik, 2008). Rathus and Miller (2000) identified specific dialects central to the use of DBT with adolescents that would address the balance between (1) leniency and authoritarianism in the familial context, (2) pathologizing normative behaviors and normalizing pathological behaviors, and (3) forcing autonomy and fostering dependence.

Mindfulness-Based Stress Reduction Therapy

Mindfulness-Based Stress Reduction was first developed in the 1970s for people with a diverse range of physiological problems (Kabat-Zinn, 1990). Not considered a third-wave therapy, MBSR is the only intervention included in this review that does not incorporate any behavioral techniques. The integration of mindfulness practice into Western medicine and health care has largely been credited to Jon Kabat-Zinn, the creator of MBSR (O’Brien et al., 2008). Unlike ACT and DBT, in which mindfulness is only a component of treatment, MBSR professionals consider mindfulness techniques to be the primary method of treatment (Grossman et al., 2004). These mindfulness techniques are influenced by Buddhist mindfulness meditation practices, but are offered in a secular context (Baer, 2003; Dryden & Still, 2006; Kabat-Zinn, 1990). Delivering services in a group setting for eight weekly sessions, the MBSR therapist is an expert in mindfulness meditation who regularly practices techniques individually (Kabat-Zinn, 1990, 2003; Segal, Williams, & Teasdale, 2002). Grossman and colleagues (2004) conducted a meta-analysis that investigated the efficacy of MBSR with adults and revealed positive results with both psychological and physiological health outcomes. They found a statistically significant effect with both mental health outcomes (increased psychological well-being and decreased depression symptoms, anxiety symptoms, and affective perception of pain) and physical health outcomes (reduced medical symptoms, physical pain, and physical impairment) for participants who received MBSR.

Age-appropriate techniques and language for this therapy have been developed for children and adolescents. For example, Saltzman and Goldin (2008) detailed some techniques they utilized during an eight-week MBSR group with youth enrolled in an after-school program. They described how they employed a mindful eating exercise at the beginning of each group with apples, tangerines, or fig-filled cookies. The children were instructed to describe the texture, color, and smell of the snack before eating. When they ate the first bite, they were asked to close their eyes and notice how the texture felt in their mouth, how their teeth and tongue worked, and how the taste changed (Saltzman & Goldin, 2008). Exercises such as mindful eating in MBSR are employed to allow youth to purposefully slow down and become aware of a particular situation.

Mindfulness-Based Cognitive Therapy

Developed from MBSR, MBCT is considered to be an integration of mindfulness techniques and cognitive behavioral therapy (Segal et al., 2002). Different from
the other three mindfulness therapies included in this review, MBCT was first intended solely to prevent the relapse and recurrence of adult depression (Dimidjian, Kleiber, & Segal, 2010). It is delivered through eight weekly two-hour group therapy sessions (Segal et al., 2002) and has shown promise with depression relapse (Ma & Teasdale, 2004; Teasdale et al., 2000) and anxiety symptoms among adults diagnosed with bipolar disorder (Williams et al., 2008). Since its inception, MBCT has been altered for youth diagnosed with anxiety disorders. Semple, Lee, and Miller (2006) highlight three primary structural changes between mindfulness-based cognitive therapy for children (MBCT-C) and traditional MBCT:

1. treatment is delivered over twelve weeks in weekly ninety-minute group sessions
2. several experiential learning techniques are employed in each session to achieve developmentally appropriate engagement
3. treatment includes family involvement

**Mindfulness and Delinquency Treatment**

States spend approximately 7.1 million dollars each day housing juvenile offenders in residential facilities (Justice Policy Institute, 2009). In efforts to reduce nationwide spending on residential care for adjudicated youth, great attention has been given to the implementation of evidence-based practices (EBPs) through diversionary, community-based treatment programs (Greenwood, 2008). Many EBPs for youth at risk of delinquency are grounded in a systems and ecological perspective (Bronfenbrenner, 1979; von Bertalanffy, 1968), requiring change in one or more of the systems (e.g., family, school, and neighborhood) with which the juvenile interacts. Current delinquency treatments with the strongest evidence base are Multisystemic Therapy (Henggeler, Melton, & Smith, 1992), Multisystemic Therapy for Youth with Problem Sexual Behaviors (Borduin, Henggeler, Blaske, & Stein, 1990), and Multidimensional Treatment Foster Care (Chamberlain, 1990). Although other EBPs for treating delinquency exist, these are currently some of the only ones tested with youth offenders in randomized controlled trials (RCTs).

Practitioners have experienced difficulty in replicating such community-based treatments with juvenile offenders in natural settings (Henggeler, 2003). Contributing to this problem is the lack of any standardized system for rating programs (Greenwood & Edwards, 2011) and workforce capacity. Barriers to “scaling up” EBPs with juvenile offenders include:

- availability of resources necessary for a multilevel approach (Bond, Drake, McHugo, Rapp, & Whitley, 2009)
- clients’ severity and range of mental health disabilities
- parents’ severity and range of mental health illnesses
- lack of parental engagement in treatment (Greco & Hayes, 2008)
Mindfulness-based interventions are one potential treatment approach that could ameliorate some of the challenges associated with EBP implementation with juvenile offenders.

Mindfulness therapies have a unique approach to treatment that may conceptually address some of the identified gaps in delinquency intervention. According to Erikson’s stages of development, adolescence is a period marked by the need to establish one’s identity and self outside of the familial context (1950). Adolescent thought transitions from childhood into more abstract cognition that applies hypotheses and deductive reasoning to provide an ability to grasp the complex concepts associated with mindfulness (O’Brien et al., 2008). Further, Bowenian theorists assert that problematic outcomes within a family system are partly the result of individuals’ inability to differentiate themselves from the family system (Walsh, 2006). According to Walsh, delinquent youth often come from what Bowenian theorists would consider to be an enmeshed (undifferentiated) family system.

Research further highlights that problematic factors associated not only with the family but also with peers, school, and community contribute to placing an adolescent at risk for engaging in delinquent behavior (Hawkins, Catalano, & Miller, 1992; Shader, 2004). For the client whose system (family, peers, school, and/or community) is too difficult to change or whose system refuses to participate in treatment, or for the client who does not have access to the resources necessary to participate in one of the aforementioned multisystemic therapies, there is little evidence suggesting alternate efficacious treatment.

Because mindfulness therapies teach the individual unique techniques that encourage behavior change in the presence of difficult circumstances and thoughts, delinquent youth coming from a difficult system may benefit from these therapies by embracing and understanding their differentiated identity. Further, as mentioned previously, mindfulness therapies have revealed promise with adult psychological and physiological outcomes, some of which are frequently considered risk factors for delinquency. Thus, the ancillary aim of this review is to explore the extent to which mindfulness therapies may offer a therapeutic approach to address the needs of some delinquent youth, an approach that is currently absent from the most efficacious systematic interventions.

Research Aims

The aims of this review are twofold. First, there is no systematic review that investigates the efficacy of all four mindfulness therapies with adolescents. Thus, the authors aim to ascertain the level of efficacy of mindfulness therapies applied to adolescent populations. Secondly, although a large evidence base exists for efficacious delinquency treatment, several gaps in implementing these EBPs with
delinquent youth have been identified. Accordingly, this article will explore the extent to which mindfulness therapies for adolescents offer an approach for addressing the existing EBP limitations, with the goal of examining the use of mindfulness therapies with juvenile delinquents.

**Methods**

In order to conduct the systematic review, the authors searched the following databases: CINAHL, Dissertation Abstracts International, ERIC, MEDLINE, and PsycINFO. Four groups of search terms were used:

1. Acceptance and Commitment Therapy and adolescen* or youth or teenage*
2. Dialectical Behavior Therapy or Dialectical Behavioral Therapy and adolescen* or youth or teenage*
3. Mindfulness-Based Cognitive Therapy and adolescen* or youth or teenage*
4. Mindfulness-Based Stress Reduction and adolescen* or youth or teenage*

As suggested by Littell, Corcoran, and Pillai (2008), for the most effective systematic searches, the authors included dissertations, non-English publications, and articles from various countries. When articles were not offered in English, the authors contacted the original authors for an English translation of the results. Two authors conducted the initial search independently and fully concurred on the initial search sample of 296 articles.

The final sample was identified by applying the following inclusion criteria to the initial search sample: (1) studies must utilize one of the mindfulness therapies with adolescents (ages twelve to eighteen); and (2) studies must employ a randomized controlled trial, quasi-experimental, or single-group pre-test/post-test design. These inclusion criteria reduced the final sample to fifteen studies. Then both authors independently coded the remaining fifteen studies and compared coding to resolve discrepancies.

When not reported in the articles, effect sizes (Hedges’s $g$) were calculated for all outcome measures using Comprehensive Meta-Analysis 2.0 software. These individual effect sizes were then averaged together based on similar outcome constructs. Effect sizes are reported for each individual study in the results section. When studies reported multiple follow-up points, the first follow-up point was selected to help calculate effect sizes. Effect sizes were interpreted based on classification by Cohen (1988), with 0.20 indicating a small effect size, 0.50 indicating medium, and 0.80 and above indicating large. All effect sizes were reported such that positive effect size estimates favored mindfulness therapies. A 95-percent confidence interval (CI) level was calculated for each study’s effect size measure (Lipsey & Wilson, 2001).

Because of the limited number of studies per mindfulness therapy and the varied outcomes targeted, studies were not combined in a traditional meta-analytic approach. In addition, this decision not to combine study effect size estimates allowed for the inclusion of several single-group repeated measure design studies.
that could not be combined with independent group design studies in a meta-
alysis (Lipsey & Wilson, 2001).

The authors chose to draw from concepts asserted by the ACT creators in their
operational definition of outcomes associated with mental health. Because ACT
therapists do not focus on the label of a specific mental illness, but instead focus on
an overall increased psychological flexibility or psychological well-being for all
clients (Hayes et al., 2006), all mental health-related outcome effect sizes were
grouped and are reported as psychological well-being. Outcomes not deemed as
mental health outcomes were reported individually.

Results

The initial search yielded 296 articles (46 ACT, 209 DBT, 14 MBCT-C, and 27
MBSR). The authors attempted to contact the original authors for data when arti-
cles did not contain sufficient data for effect size calculation. Studies employing
RCT, quasi-experimental, or single-group pre-test/post-test designs utilizing one of
the mindfulness therapies with adolescents (ages twelve to eighteen) were
included in the final sample of fifteen (two ACT, twelve DBT, and one MBSR).
Although there were some studies (using qualitative and case study approaches)
being conducted on the impact of MBCT-C with adolescents, no studies were
found that employed one of the aforementioned research designs.

From this final list of reviewed studies, four studies utilized an RCT design, four
employed a quasi-experimental design, and seven utilized a single-group pre-test/
post-test design. As seen in table 1, the majority of mindfulness therapies con-
ducted with adolescents targeted outcomes associated with psychological well-
being, particularly with regard to symptoms associated with depression, anxiety,
and borderline personality disorder. Only one study (Biegel, Brown, Shapiro, &
Schubert, 2009) used MBSR with adolescents. Medium-range effect size results
\( g = 0.424 \) for this RCT study were found regarding adolescent psychological well-
being. Although the direction of the effect size was positive, the 95-percent confi-
dence interval ranged from –0.034 to 0.882, indicating that the effect size is not
statistically different from zero. Thus, no difference in treatment effect between the
control and MBSR groups can be asserted.

The studies that investigated ACT's efficacy with adolescents were the only
studies that observed outcomes ancillary to psychological well-being. Wicksell,
Melin, and Olsson (2007) used a single-group repeated measures design to exam-
ine psychological well-being, school attendance, medication use, and pain impair-
ment in their ACT study. Overall, a medium effect size \( g = 0.488 \) was calculated
for medication use, and large effect sizes were calculated for psychological well-
being \( g = 0.767 \), school attendance \( g = 1.062 \), and pain impairment \( g = 1.158 \).
All three of these large effect sizes were statistically significant based on
their confidence intervals not containing zero. Wicksell and colleagues (2009) fol-
lowed up with a more rigorous RCT study using ACT with adolescents. Their
results indicated a small effect size for psychological well-being \( g = 0.322 \), and a
large effect size \( g = 0.680 \) was calculated for pain impairment. Although effect
sizes were positive for both outcomes, the confidence intervals indicated no statis-
tical difference.
### Table 1  Adolescent Mindfulness Intervention Effect Sizes

<table>
<thead>
<tr>
<th>Citation</th>
<th>Study design</th>
<th>Outcome constructs</th>
<th>Effect size (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mindfulness-Based Stress Reduction</strong> N = 1</td>
<td></td>
<td>Psychological well-being (global functioning, state and trait anxiety, psychological stress, psychological well-being, depression, obsession-compulsion, interpersonal sensitivity)</td>
<td>0.424 (−0.034, 0.882)</td>
</tr>
<tr>
<td>Biegel et al., 2009</td>
<td>RCT</td>
<td>Psychological well-being (global functioning, state and trait anxiety, psychological stress, psychological well-being, depression, obsession-compulsion, interpersonal sensitivity)</td>
<td>0.424 (−0.034, 0.882)</td>
</tr>
<tr>
<td>Wicksell et al., 2009</td>
<td>RCT</td>
<td>Psychological well-being (depression, internalizing/catastrophizing)</td>
<td>0.322 (−0.392, 1.037)</td>
</tr>
<tr>
<td>Wicksell et al., 2007</td>
<td>Single-group pre/post</td>
<td>Psychological well-being (depression, internalizing/catastrophizing)</td>
<td>0.767 (0.198, 1.336)</td>
</tr>
<tr>
<td>Apsche et al., 2006</td>
<td>RCT</td>
<td>Psychological well-being (depression, suicidal ideation)</td>
<td>−0.438† (−1.289, 0.412)</td>
</tr>
<tr>
<td>Cwik, 2006</td>
<td>RCT</td>
<td>Psychological well-being (mood regulation, depression, overall mental health functioning)</td>
<td>0.138 (−0.577, 0.853)</td>
</tr>
<tr>
<td>Denaro, 2007</td>
<td>Quasi-experimental</td>
<td>Psychological well-being (suicidal ideation, depression, anxiety, anger)</td>
<td>0.520 (−0.419, 1.458)</td>
</tr>
<tr>
<td>Goldstein et al., 2007</td>
<td>Single-group pre/post</td>
<td>Psychological well-being (suicidality, emotional dysregulation, mood symptomatology, depression)</td>
<td>0.638 (−0.098, 1.335)</td>
</tr>
<tr>
<td>James et al., 2008</td>
<td>Single-group pre/post</td>
<td>Psychological well-being (borderline personality traits, depression, hopelessness, global functioning)</td>
<td>1.202 (0.566, 1.838)</td>
</tr>
<tr>
<td>Katz et al., 2004</td>
<td>Quasi-experimental</td>
<td>Psychological well-being (depression, hopelessness, suicidal ideation)</td>
<td>0.208 (−0.325, 0.741)</td>
</tr>
<tr>
<td>McDonnell et al., 2010</td>
<td>Single-group pre/post</td>
<td>Psychological well-being (global functioning, nonsuicidal self-injurious behavior)</td>
<td>0.801 (0.575, 1.027)</td>
</tr>
<tr>
<td>Miller et al., 2000</td>
<td>Single-group pre/post</td>
<td>Psychological well-being (borderline personality disorder symptoms: confusion about self, impulsivity, emotional instability, interpersonal problems)</td>
<td>0.942 (0.495, 1.389)</td>
</tr>
<tr>
<td>Nelson-Gray et al., 2006</td>
<td>Single-group pre/post</td>
<td>Psychological well-being (aggression, internalizing and externalizing problems, oppositional defiant disorder symptoms, depression)</td>
<td>0.487 (0.115, 0.860)</td>
</tr>
<tr>
<td>Rathus &amp; Miller, 2002</td>
<td>Quasi-experimental</td>
<td>Psychological well-being (suicide attempts, suicidal ideation, behavioral symptoms)</td>
<td>0.800 (0.128, 1.472)</td>
</tr>
<tr>
<td>Wineman, 2009</td>
<td>Quasi-experimental</td>
<td>Psychological well-being (emotional awareness, emotional dysregulation, depression, suicide risk)</td>
<td>0.448 (−0.169, 1.065)</td>
</tr>
<tr>
<td>Woodbury et al., 2008</td>
<td>Single-group pre/post</td>
<td>Psychological well-being (suicidal ideation, impulsive-addictive behavior)</td>
<td>0.422 (−0.004, 0.849)</td>
</tr>
</tbody>
</table>

† indicates comparison group did better than MBT.
The mindfulness therapy with the most studies conducted with adolescents was DBT. All DBT study outcomes included in this review coalesced around psychological well-being. Studies by Cwik (2006) and Apsche, Bass, and Houston (2006) were the only two DBT studies that employed an RCT design. Cwik (2006) reported having a small effect size ($g = 0.138$) for psychological well-being, whereas the other study reported a medium effect size ($g = -0.0438$) favoring the Mode Deactivation Therapy (MDT) control group (Apsche et al., 2006). Neither one of these studies was statistically significant based on the 95-percent confidence interval scores. Apsche and colleagues (2006) also examined physical aggression, with results favoring the MDT control group of adolescents, but not enough statistical information was available to calculate an effect size for this measure.

Several studies used a quasi-experimental design to examine the effect of DBT on the psychological well-being of adolescents. Effect size results varied, as studies revealed one small effect size ($g = 0.208$, Katz, Cox, Gunasekara, & Miller, 2004), two medium effect sizes ($g = 0.520$, Denaro, 2007; $g = 0.448$, Wineman, 2009), and one large effect size ($g = 0.800$, Rathus & Miller, 2002). However, only the study by Rathus and Miller (2002) had a confidence interval that indicated difference in treatment effect between the comparison and DBT group.

Half the DBT studies used a single-group repeated measures design, and psychological well-being effect size results were calculated for all six studies. Three studies had medium effect sizes ($g = 0.638$, Goldstein, Axelson, Birmaher, & Brent, 2007; $g = 0.487$, Nelson-Gray et al., 2006; $g = 0.422$, Woodbury et al., 2008). However, only the study by Nelson-Gray and colleagues was statistically significant. Three of the single-group design studies ($g = 1.202$, James, Taylor, Winmill, & Alfoadari, 2008; $g = 0.801$, McDonell et al., 2010; $g = 0.942$, Miller, Wyman, Huppert, Glassman, & Rathus, 2000) offered large statistically significant effect size results. Each of these three findings was statistically significant.

**Discussion**

**Best Practice with Adolescents**

Mindfulness therapies, often considered third-wave behavioral therapies, have become popular over the previous decade in research literature and in the practice community. Although substantial research has recently highlighted the efficacy of particular mindfulness therapies with various psychological and physiological illnesses, this review indicates that research on the efficacy of mindfulness therapies with adolescents is still in its infancy. Nevertheless, this review offers insight into understanding and identifying unique interventions that may offer promise for adolescents who have been identified as difficult to treat.

**Acceptance and Commitment Therapy**

Of the mindfulness therapies, ACT studies incorporated a wider variety of outcomes. This is consistent with the ACT literature that has investigated the effi-
cacy of ACT with adults who have many psychological and physiological problems (Montgomery et al., 2011). At-risk adolescents, particularly those who are at risk of becoming delinquent, often display multiple internalizing and externalizing symptoms (Shader, 2004). Thus, intervening effectively with regard to all identified problems for the juvenile delinquent has been deemed a difficult task (Greenwood, 2008). Although the review reveals that much more work is needed to understand the efficacy of ACT with adolescents, it may be an option to consider for youth who become involved in the juvenile justice system.

A medium effect size was calculated for medication use, whereas large effect sizes were computed for three other measures (psychological well-being, school attendance, and pain impairment; Wicksell et al., 2007). All three of these large effect sizes were statistically significant. However, when Wicksell and colleagues (2009) followed up with a more rigorous RCT study using ACT with adolescents, they found positive but nonsignificant effects. The more rigorous RCT study produced nonsignificant smaller effects, highlighting the need for more research to determine the efficacy of ACT with adolescent populations.

Dialectical Behavior Therapy

Consistent with the available research on adult mindfulness therapies, DBT research with adolescents is more robust than that for the other interventions included in this review. Different from other mindfulness therapies, DBT focuses on outcomes associated with borderline personality traits (Linehan, 1993). Because this personality disorder has been considered difficult to treat, DBT has gained considerable attention in both practice and research. Borderline personality disorder has been found in approximately one-fourth of delinquent boys (Eppright, Kashani, Robison, & Reid, 1993) and is correlated with antisocial personality disorder among juvenile and criminal offenders (Taylor, James, Reeves, & Kistner, 2009). Further, Taylor and colleagues found that borderline personality traits are associated with poorer clinical and psychosocial functioning in delinquent adolescents. Thus, this mindfulness therapy may be relevant for this difficult-to-treat population.

Of the four approaches examined in this review, the majority of the studies examined the effectiveness of DBT. However, half of these DBT studies used a single-group repeated measures design rather than a more rigorous research methodology such as RCT. Although two of the DBT studies were RCTs, neither was statistically significant based on the 95-percent confidence interval. Several DBT studies employed a quasi-experimental design to examine the effect of DBT on psychological well-being among adolescents. Only one of the quasi-experimental studies (Rathus & Miller, 2002) produced statistically significant results, indicating a significant difference in treatment effect between the comparison and DBT groups. Half of the DBT studies used a single-group repeated measures design, with four of these studies (James et al., 2008; McDonell et al., 2010; Miller et al., 2000; Nelson-Gray et al., 2006) revealing significant results. The findings on the efficacy of DBT with adolescents is mixed, and, as in the case
of ACT, additional research is necessary. The more rigorous RCTs did not produce significant results, whereas four of the single-group repeated measures studies did reveal significant treatment effects.

Mindfulness-Based Stress Reduction and Mindfulness-Based Cognitive Therapy

Mindfulness-Based Stress Reduction Therapy was first created in the 1970s, and it is surprising that only one study met inclusion criteria for this review. This one MBSR study indicated that there was no difference in treatment effect between the control and MBSR groups (Biegel et al., 2009). Additional research is needed to evaluate the use of MBSR with adolescent populations. There were also no MBCT-C studies that met the authors’ criteria for inclusion. Thus, the authors are unable to draw any conclusions about the effectiveness of MBCT-C based upon their review.

Implications for the Treatment of Adolescents and Juvenile Delinquents

Based on this review, it appears at first glance that DBT may show the most promise among the mindfulness therapies examined for the treatment of adolescents. This assessment comes with two caveats, however. First, most of the positive treatment effects and largest effect sizes in the studies included in this review were produced from less rigorous, single-group pre-test/post-test designs. Secondly, from a clinical perspective, DBT can be difficult to implement. It requires organizational support to ensure treatment fidelity, and is more challenging to use for an independent practitioner. To illustrate, DBT’s treatment approach requires weekly two-hour skills training groups, weekly individual psychotherapy sessions, between-session telephone coaching support, and mandatory weekly consultation team meetings for the clinician implementing the DBT treatment (Swenson, Torrey, & Koerner, 2002). Other researchers, such as Rizvi (2011), have noted the complexity and difficulty of implementing DBT, especially for novice clinicians. Guthrie (2006) also notes similar challenges when using DBT with adolescents. This raises questions about the transportability of DBT, particularly for the type of settings that typically provide treatment to juvenile delinquents, because it can be challenging to hire and retain a qualified mental health professional in these settings. Additionally, these concerns are similar to the aforementioned problems regarding the use of EBPs identified for delinquent populations.

In this review MBSR demonstrated a medium treatment effect that approached statistical significance. Moreover, findings from Wicksell and colleagues (2007, 2009) showed promise for ACT. It appears that both MBSR and ACT may be more feasible to implement with delinquent populations than DBT, and the treatment effects that they produced are not too different than what is typically reported for psychosocial interventions in reviews of the adolescent treatment literature (Weisz & Jensen, 1999). Hence, because delinquent populations usually present with a variety of psychosocial problems that are considered very difficult to treat,
mindfulness interventions may be beneficial to practitioners working with delinquent populations.

**Limitations**

There are limitations to this study that inhibit the ability to analyze and interpret the data. First, it is important to note that this analysis takes the average scores across several measures. Every time a score is averaged, its sensitivity and precision are diminished. For example, in the Wicksell (2009) study, there were three measures for pain with scores of 0.489, 0.559, and 0.993. The average of these three scores is 0.680. The medium effects of 0.489 and 0.559 both contained zero in their confidence interval, but the large effect of 0.993 did not. Yet, the average of the scores produced a confidence interval that contains zero, resulting in a nonsignificant result, even for the large effect.

Second, there were several effect sizes (viz., Biegel et al., 2009; Goldstein et al., 2007; Wicksell et al., 2009; Woodbury et al., 2008) that approached statistical significance (see table 1). This is related to the first limitation, as it is plausible that these effects did not reach significance as a result of averaging the measure scores. Additionally, the nonsignificant confidence interval findings in some of the effect sizes may be a function of the width of the confidence intervals, which could indicate that the study was small and low-powered, and resulting in the possibility of a type II error in some cases (Davies, 2009). Also, many of the studies reviewed had small sample sizes, which limit statistical power to detect treatment effects. In addition, the design of the studies reviewed was limited in external validity and thus generalizability.

Also, the studies included in this review were not limited to RCTs, and several are open to several threats to internal validity. Additional research, employing stronger research designs, should be conducted before mindfulness therapies can be considered sufficient treatment for delinquent adolescents.

Finally, there is a possibility that effect sizes were overestimated for single-group repeated measure designs (Lipsey & Wilson, 2001). Effect sizes calculated for these less rigorous study designs may be misleading because they tend to be higher than those of the more rigorous experimental designs. Thus, some of the positive treatment effects reported above should be interpreted with caution.

**Conclusion**

Despite these limitations, this systematic review enhances the ability to critically examine the extent to which mindfulness therapies may be useful in the treatment of adolescents and juvenile delinquents. Based on this analysis, there is mixed support for ACT, DBT, and MBSR. Yet, clinically speaking, the more applicable approaches appear to be ACT and MBSR. This is particularly true because they pertain to the treatment of juvenile delinquents, especially because they are likely to be more transportable than DBT given the barriers to scaling up
evidence-based approaches within juvenile justice treatment settings (e.g., funding, staff resistance, capacity of agencies to support complex approaches, and workforce availability; Greenwood & Edwards, 2011).

References


Youthful Offender Diversion Project: YODA

Catheleen Jordan, Peter Lehmann, Kristin Whitehill, Lieu Huynh, Kingsley Chigbu, Richard Schoech, Jamie Cummings, and Debra Bezner

A university-court collaboration developed a youth offender diversion project (YODA) in response to an ongoing trend of youth arrests for violence toward non-intimate-partner family members (e.g., mothers or sisters) in Tarrant County, Texas. The YODA program is a three-phase approach using assessment, case management, and individual and family solution-focused brief therapy. This article reports on the benefits and process of the collaboration, as well as objectives for further study. Preliminary program evaluation results are promising.

Key words: case management; community-based treatment; diversion programs; family violence; juvenile justice; solution-focused brief therapy

This article describes a youth offender diversion project (YODA) that was developed in response to an ongoing trend of youth arrests for violence toward non-intimate-partner family members (e.g., mothers and sisters) in Tarrant County, Texas. In September 2010, approximately 120 youth offenders charged with domestic violence toward non-intimate-partner family members were awaiting hearing. Of concern was the effect of this behavior on adolescent and family development. Youth offenders are young persons typically aged seventeen through twenty-five, who usually live with adult caregivers and who have been charged with misdemeanor family violence. Before YODA, these youth offenders received
deferred adjudication and assignment to one-size-fits-all anger management courses, sometimes with career offenders. No systems of care existed to assess the particular short- and/or long-term strengths and risks or sufficiency needs of the youthful offender. Likewise, improvements in family functioning that might help promote positive behaviors (e.g., good family ties and supportive relationships) were not addressed. Family involvement has been shown to be a critical requirement for ending youth violence (Guerra, Kim, & Boxer, 2008). Consequently, a substantial need existed to better understand the factors contributing to this growing problem and to develop a mechanism to increase the likelihood that youth can end their violence and make a transition to a healthy independent adulthood.

To address this need, the YODA program was designed for these youth and their families and aimed to prevent future non-intimate-partner family violence through an innovative and collaborative community-based volunteer diversion program. YODA developed from a collaboration between Criminal Court #5 in Tarrant County and the University of Texas at Arlington School of Social Work. This program requires an assessment of youth and family factors contributing to violence, as well as case management and individual and family interventions to prevent future violence. This article will focus on the following topics:

- solution-focused brief therapy (SFBT) as diversion
- the benefits of a collaborative community-based diversion program
- the process used to establish a university-judicial relationship
- program evaluation results
- the potential for transferring the intervention and collaborative community programming to other populations

**Solution-Focused Brief Therapy as Diversion**

Solution-focused brief therapy, which was chosen as the clinical basis of the YODA program intervention, is a strengths-based intervention. As a continuing response to treating aggression in adolescents, some researchers have added a strengths-based element to the requirements for successful treatment. Strengths-based approaches highlight and develop youth strengths and competencies to reduce risk (Guerra & Leaf, 2008). As part of the YODA project, a focus on strengths attempts to “mobilize talents, knowledge, capacities, and resources in the service of achieving clients’ goals and visions” (Saleebey, 2006, p. 1). Strengths-based approaches are grounded in the profession’s paradigm of helping people achieve health and well-being. A greater emphasis is placed on finding what is right, effective, and strong within individuals as opposed to a focus on identifying problems. In the following section, the authors advocate for the use of SFBT as a strengths-based model of practice for the YODA diversion program.

**Solution-Focused Brief Therapy and Supporting Evidence**

Solution-focused brief therapy was developed by Steve de Shazer (1940–2005), Insoo Kim Berg (1934–2007), and colleagues beginning in the late 1970s...
in Milwaukee, Wisconsin (see, for example, Berg, 1994; Berg & Steiner, 2003; Berg & Dolan, 2001; de Shazer, 1985, 1988). It is future-focused and goal-directed, and it emphasizes potential solutions to the problems that bring clients to therapy. The SFBT approach assumes that all clients have some knowledge of what would make their lives better, even though they may need (at times, considerable) help. Although everyone who seeks help already possesses at least the minimal skills necessary to create solutions, help is needed to describe the details of a better life by asking the miracle question in addition to carrying out new tasks. All clinical therapy is in the form of specialized conversations that can include client- and therapist-approved tasks/assignments. With SFBT, the conversation can be about any number of problems the client brings, but with a focus on developing and achieving the client’s vision of solutions for a better future. A number of techniques and questions help to clarify those solutions and the means for achieving them. These include but are not limited to looking for previous solutions and exceptions, coping and scaling questions, client goal setting, the miracle question, compliments, and inviting the client to do more of what works.

Supporting Empirical Evidence

Although the evidence base for SFBT is still preliminary (Corcoran & Pillai, 2009), strides have been made in advancing the usefulness of SFBT. The following is a summary of support for SFBT, including support relevant to the YODA project:

- The Office of Juvenile Justice and Delinquency Prevention (2008; www.ojjdp.gov) has recognized SFBT as a promising model of practice.
- Currently there are eighty-nine documented studies of SFBT (European Brief Therapy Association, 2010), including two meta-analyses, three systematic reviews of the literature, and eighty-three follow-up research-based papers. These studies include thirteen randomized/control group findings, thirty comparison studies, and forty naturalistic studies summarizing a variety of mental health issues.

Four SFBT studies, all with domestic violence batterer intervention programs, were found. Although none contain adolescent samples, the model and process of the client groups including content (e.g., violence against a significant other) may be relevant for working with youthful offender populations.

The Benefits of a Collaborative Community-Based Diversion Program: YODA

The university-judicial collaboration generated a diversion program available to youth offenders between the ages of seventeen and twenty-five. The program consists of three phases using SFBT, a designated model of promise (Office of Juvenile Justice and Delinquency Prevention, 2008). Solution-focused brief therapy has not previously been used with this specific population. Phase 1 involves refer-
nal from Tarrant County Court #5 to the University of Texas at Arlington (UTA)
School of Social Work (SSW) Center for Clinical Social Work (referred to as the
Clinic) to assess self-sufficiency needs, mental health risks, and stressors. Following
the referral, a multidimensional assessment looks at the extent to which family
issues have contributed to past negative behaviors and how family strengths
may contribute to greater positive outcomes. Case management to provide needed
resources occurs in phase 1. Phase 1 assessment leads to the intervention plan for
phases 2 and 3 by identifying youth and family needs.

Phase 2 consists of individual SFBT with the youth offender; case management
continues in this phase as needed to increase youth self-sufficiency behaviors and
skills. Phase 3 includes family SFBT at the Clinic if the family agrees to participate.
Phases 2 and 3 will eventually include a web-phone system, called teleherence, to
optimize client outcomes. The teleherence system will deliver messages and
reminders through text messages or voice phone calls, ask questions, collect client
voice messages and trigger alerts to staff, present counseling booster audios such
as motivational messages in the voice of the counselor, and flag potential problems
or opportunities for the case manager using smart algorithms.

Expected benefits of this collaborative effort include:

- diverting youth from the criminal justice system
- providing an opportunity for charge dismissal through efforts of the youth
toward self-sufficient behaviors
- assisting families with stressors to improve family relationships

**Process Used to Establish a University-Community Collaboration**

Establishing YODA required obtaining community support to fund the project,
developing procedures for youth enrolled in the project, and measuring outcomes.

**Funding the Project**

In 2010, the UTA-SSW received a large grant from the Amon G. Carter Founda-
tion. The purpose of this grant was to encourage partnerships between UTA-
SSW faculty researchers and community agency personnel with the goal of pro-
miting innovative research-practice collaborations, as well as improving the lives
of individuals and families residing in Tarrant County.

Each year, grant proposals are developed by faculty-agency collaborators and
submitted for review by a committee of nationally recognized experts in order to
determine which proposals will receive funding. The YODA program resulted from
a partnership between Professor Peter Lehmann and Professor Catheleen Jordan
at UTA-SSW; and Judge Jamie Cummings and her assistant, Debra Bezner, from
Tarrant County Criminal Court #5. The project was funded in January 2011, and
the first clients enrolled in March 2011. Court personnel referred youth to the pro-
ject and monitored progress. The university researchers supervised the adminis-
tration of the intervention and the research component.
Procedures

It is important to note that YODA is a voluntary program. Youth charged with assault in Tarrant County Criminal Court #5 may be offered the option of entering the program, but not all youth are offered this option. Participants’ lawyers, district attorneys, and the judge decide who will be offered this option based on prior offenses, attitude and willingness to work toward change, and level of competency. Those who are offered the opportunity to enter the program are generally presented with alternative plea arrangements negotiated by their lawyers. Next, the potential client meets with the case manager, receives an explanation of the program, and decides whether to join YODA or accept the plea. If the client chooses to participate in the diversion program, he or she is provided with information about the requirements he or she must meet in order to remain enrolled and complete the program. One of these requirements is a strict attendance policy; clients are required to attend each session. If two sessions are missed and the case manager believes the reasons for absence are invalid, the client is reported to the court and either dismissed from the program or sent to jail (the length of jail time is determined by the judge). Compliance with the program is a condition of the client’s bond and therefore a condition of the client’s agreement with the court. Furthermore, if the client is not making strides in SFBT sessions offered by the counselor and improvement is not being achieved, he or she is subject to dismissal.

Upon enrollment in the program, clients are required to complete a competency interview and assessment packet containing standardized measures (described further below). The assessments are completed within the first or second session with the case manager. Upon completion of assessments, the client begins SFBT with the case manager and continues routinely until completion of the program. Frequency of sessions is based on a subjective assessment by the case manager regarding client need as well as his or her progress in achieving self-identified goals and goals identified by the case manager. Family therapy is a last step in phase 3 if the assessment shows that it may be helpful and if family members agree to participate.

Measures

The outcome measures for YODA are classified as short- and long-term outcomes. Short-term outcomes include identification of problems, goal development, and initial steps toward achieving goals. Identification of problems and goal development are pivotal components of SFBT and are completed within the first two sessions. If goals are not established, clients are unable to move forward with treatment. All clients are required to identify problems and goals as conditions of their involvement in the program. If for some reason this is not done, clients are referred back to the court for sentencing.

Short-term outcomes are assessed weekly by the client throughout treatment using a goal attainment scale. Clients are asked to rank progress toward their goals
and objectives on a ten-point self-anchored scale. At the midway point in the program (generally around two to three months), clients report to the judge for a midterm evaluation of their progress in terms of goal attainment as reported by the case manager using the client’s self-reported data. Finally, upon completion of the program, the case manager provides the court with a similar updated evaluation of the client’s progress over the course of the program.

In terms of the short-term outcomes, it is important to emphasize that, in order to complete the program, clients are not required to have achieved all of their goals. Some of the goals may take several years to complete (e.g., graduation from high school or college), and the length of time to complete them would exceed the time during which the client is enrolled in the program. However, the client must demonstrate progress toward achieving the objectives included in each goal before completion of the program is considered.

Short-term outcomes also may include assessment, using standardized measures, of the client’s level of self-sufficiency, resilience, aggression, family relations, mental health, goal attainment, stress, and alcohol and substance abuse. In terms of middle outcomes, positive results would represent a shift from the baseline measurement. For example, through treatment it is hoped that levels of aggression, substance abuse, mental health issues, and stress would decrease whereas levels of resiliency, self-sufficiency, and family relations would all increase or improve. Either of these results would be considered positive.

The long-term outcome for YODA is to reduce the occurrence of violent reoffense among the clients participating in the program. This is measured by searching arrest records at both six months and one year after the program completion date.

Below is a list of the measures used for short-term measurement:

- **The Child and Youth Resilience Measure (CYRM):** This measure contains twenty-eight items rated on a five-point Likert scale. Responses are summed, with higher levels indicating higher levels of protective factors associated with resilient individuals.

- **The Solution Building Inventory (SBI):** This scale measures the client’s ability to develop solutions and access both internal and external resources when faced with conflict. Fourteen items are scored on a five-point Likert scale.

- **The Novaco Anger Scale and Provocation Inventory (NAS-PI):** This is a two-part assessment containing eighty-five items rated on a three-point Likert scale. The NAS-PI assesses for anger as a problem of psychological functioning and physical health as well as for therapeutic change.

- **Multidimensional Adolescent Assessment Scale (MAAS):** The MAAS comprises fifteen subscales totaling 177 items. The items are ranked on a seven-point Likert scale, and scores for each subscale are calculated separately. The subscales include problems with school, aggression, family relationship problems, suicidal thoughts, feelings of guilt, confused thinking, disturbing thoughts, memory loss, alcohol abuse, and drug abuse.
The assessments are completed during the first two sessions of enrollment in YODA and upon completion of the program. Change in scores from the pretest to the posttest is used to measure program success.

**Program Evaluation Results**

The program evaluation provides a multidimensional view of YODA’s effectiveness. Both process and fidelity assessment as well as outcome evaluation summaries are discussed; focus is on the organization/services and clients. The process evaluation assesses the delivery of the program, and the outcome evaluation determines if the intended outcomes are in fact achieved. Although data collection primarily consists of self-reports collected by the SFBT case manager, data collection and analysis are monitored and performed by the two faculty co-principal investigators and a PhD-level graduate assistant. This evaluation seeks to address and offer implications and findings in three areas:

1. Has YODA been implemented according to plan?
2. Does YODA operate in the intended manner?
3. Is YODA meeting the intended outcomes?

**Question 1: Implementation and Process Evaluation**

Process evaluation addresses how well the program is being delivered to the target population. Implementation and process are evaluated on the basis of client records and a bimonthly report of client contact.

The YODA staff and court personnel work side by side so that court records are readily available. All youth in this age group who commit a crime are referred to the court. The docket is reviewed once a month, and court personnel provide a list of the offenders to the YODA case manager. Nonattendance or noncompliance is dealt with through collaboration between YODA and court personnel. The process has worked smoothly from the beginning, with most offenders who were offered an opportunity to join YODA accepting the opportunity and those who violated YODA policy (i.e., were rearrested or did not attend required sessions) being removed.

**Question 2: Program Fidelity**

Program fidelity refers to whether the program is being delivered as intended and in this case refers to the SFBT component. This portion of the evaluation is under development. A fidelity measure has been developed (Lehmann, Jordan, Whitehill, Huynh, & Chigbu, 2012) for the clients to complete to determine if the therapist/case manager is adequately delivering SFBT. The assessment is given to the client at one randomly selected time during enrollment.

Sessions in which the assessment is administered will be video recorded. The video recordings will then be microanalyzed to further determine if fidelity has been achieved. Microanalysis dissects the session frame by frame and records results. These results are then compared to results from the fidelity measure to determine if correlation and consistency exist between the microanalyst’s percep-
tion and the client’s perception of the delivery of the SFBT. Plans are for this to be implemented in 2013.

Question 3: Outcome Evaluation

As of July 1, 2012 (fifteen months after the first youth entered the program), YODA had ninety-two clients enrolled in the program. All of the clients are youth aged seventeen to twenty-five and charged with assault of a non-intimate partner. Eighteen of the participants chose to leave the program and were rearrested or dismissed for violating the attendance policy. Fifty participants had completed the program. Data presented are for the forty-nine clients who completed the measures (one measure on one client is missing). The success rate for YODA was found to be 80 percent. Case records revealed that all clients who remained in the program until completion attended the appropriate number of sessions and all but one completed a pre-test/post-test assessment packet. Demographics, short-term outcomes, and long-term outcomes will be presented in the following sections.

Demographics. Demographic information is assessed at intake, and results are computed from the data sheet completed by each client during the initial assessment. It was found that 43 percent are Caucasian, 20 percent are Hispanic, 23 percent are African American, 12 percent are biracial, and 2 percent are Asian. Male participants comprise the majority of the sample (53.1%); females account for 46.9 percent. Client ages ranged from seventeen to twenty-five, with a mean age of nineteen. The majority of clients are eighteen when they enter YODA. Sixty-seven percent of the clients are between the ages of seventeen and nineteen. Client education varies from completion of eighth grade up to completion of some college. Nearly half (48.9%) of clients are either enrolled in twelfth grade or have completed twelfth grade, whereas 26.5 percent are enrolled in or have completed some college. The victim of the assault is primarily the mother (32.6%), followed by sister (22.4%); in spite of this, 59 percent of participants are living with their victim.

Short-Term Outcomes. Outcome data are based on the completed assessment packets at both pretest and posttest for the forty-nine clients who have completed the program and the measures. Paired sample t-tests were used to assess if changes from pretest to posttest were statistically significant.

- **MAAS:** This scale (see table 1) measures a wide range of possible problem areas; it has two cutting scores: 30 and above indicates a clinical problem, and 70 and above indicates a catastrophic issue.
- **SBI:** The SBI is a fourteen-item questionnaire rated on a five-point Likert scale (see table 2). High scores on the SBI indicate better solution builders (Smock, McCollum, & Stevenson, 2010).
- **CYRM:** The CYRM assesses for processes of resilience (see table 2). It is a twenty-eight-item questionnaire rated on a five-point Likert scale. Higher scores indicate higher levels of resilience (Ungar, 2007).
The NAS-PI (Novaco, 2003) is a two-part self-report questionnaire. It yields six scores and contains eighty-five items (see table 3):

- **Cognitive**: Determined by responses given regarding engendering thoughts that may arise as a result of personal memories or meanings.
- **Arousal**: Focuses on the physical experience of the anger response.

### Table 1  Means, Standard Deviations, and t-Test (N = 49)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pretest</th>
<th>Posttest</th>
<th>Paired t-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>Depression</td>
<td>24.34</td>
<td>16.24</td>
<td>15.37</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>23.15</td>
<td>14.08</td>
<td>16.63</td>
</tr>
<tr>
<td>Mother problems</td>
<td>33.65</td>
<td>23.78</td>
<td>18.86</td>
</tr>
<tr>
<td>Father problems</td>
<td>30.21</td>
<td>28.81</td>
<td>19.01</td>
</tr>
<tr>
<td>Personal stress</td>
<td>24.59</td>
<td>19.21</td>
<td>8.60</td>
</tr>
<tr>
<td>Friend problems</td>
<td>14.02</td>
<td>14.73</td>
<td>8.85</td>
</tr>
<tr>
<td>School problems</td>
<td>23.18</td>
<td>18.83</td>
<td>16.03</td>
</tr>
<tr>
<td>Aggression</td>
<td>22.58</td>
<td>18.05</td>
<td>9.18</td>
</tr>
<tr>
<td>Family problems</td>
<td>42.10</td>
<td>24.55</td>
<td>21.20</td>
</tr>
<tr>
<td>Suicide</td>
<td>8.89</td>
<td>15.90</td>
<td>1.39</td>
</tr>
<tr>
<td>Guilt</td>
<td>23.51</td>
<td>19.90</td>
<td>11.88</td>
</tr>
<tr>
<td>Memory loss</td>
<td>20.95</td>
<td>21.09</td>
<td>12.24</td>
</tr>
<tr>
<td>Alcohol abuse</td>
<td>9.88</td>
<td>12.66</td>
<td>4.76</td>
</tr>
<tr>
<td>Drug abuse</td>
<td>6.32</td>
<td>12.08</td>
<td>1.19</td>
</tr>
</tbody>
</table>

### Table 2  Means, Standard Deviations, and t-Test for SBI and CYRM (N = 49)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Pretest</th>
<th>Posttest</th>
<th>Paired t-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>SBI</td>
<td>59.18</td>
<td>8.67</td>
<td>65.84</td>
</tr>
<tr>
<td>CYRM</td>
<td>108.01</td>
<td>17.90</td>
<td>120.00</td>
</tr>
</tbody>
</table>

The NAS-PI (Novaco, 2003) is a two-part self-report questionnaire. It yields six scores and contains eighty-five items (see table 3):

- **Cognitive**: Determined by responses given regarding engendering thoughts that may arise as a result of personal memories or meanings.
- **Arousal**: Focuses on the physical experience of the anger response.

### Table 3  Means, Standard Deviations, and t-Test for NAS-PI

<table>
<thead>
<tr>
<th>Novaco</th>
<th>Pretest</th>
<th>Posttest</th>
<th>Paired t-test</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>Cognitive</td>
<td>45.73</td>
<td>12.50</td>
<td>36.08</td>
</tr>
<tr>
<td>Arousal</td>
<td>45.47</td>
<td>11.62</td>
<td>37.35</td>
</tr>
<tr>
<td>Behavior</td>
<td>47.27</td>
<td>11.95</td>
<td>37.59</td>
</tr>
<tr>
<td>NAS Total</td>
<td>46.12</td>
<td>12.65</td>
<td>35.55</td>
</tr>
<tr>
<td>Regulation</td>
<td>54.96</td>
<td>14.49</td>
<td>64.29</td>
</tr>
<tr>
<td>PI Total</td>
<td>44.84</td>
<td>12.07</td>
<td>36.02</td>
</tr>
</tbody>
</table>
• **Behavior**: Asks about behaviors that are problematic or indicative of violence, including impulsive reactions.

• **NAS Total**: Cognitive + Arousal + Behavior.

• **Anger regulation**: Asks about the adaptive aspects of the experience of anger in terms of the ability to evaluate and direct angry responses in a constructive manner.

• **Provocation inventory**: Provides an index of anger intensity and generality across a range of provocations.

In sum, short-term outcomes were clinically significant in a positive direction. The long-term outcome is to keep YODA participants out of court and jail. To this date, none of the YODA program completers have reoffended.

**Best Practice with Collaborative Community Programs**

Evidence-based interventions are expected to transfer to other court systems by similar collaborations. The study provided information on innovative treatments for families, as well as information to facilitate university-court collaborations.

**Innovative Treatments**

It should be noted that SFBT has not been used prior to this program with the YODA population. The three-phase approach is a unique design of assessment and treatment. Assessment/case management builds toward individual treatment for the youthful offender, and then the family is brought in for further work. To date, YODA is meeting short-term and long-term outcome goals as well as operating as intended. Clients have shown an increase in mental health, resilience, hope, and ability to build solutions. Additionally, clients have shown a decrease in aggression, along with drug and alcohol abuse.

**University-Court Collaborations**

This unique opportunity has provided a testing ground for a university-community collaboration. Of the clients who have successfully completed the program, court records indicate that none have reoffended in Tarrant County.

**Future Aims**

A future aim is to expand YODA into other areas and to continue to test YODA as an evidence-based intervention using more sophisticated analytical techniques and including comparison samples. Toward this end, a National Institute of Justice grant has been submitted for expansion of this program into Dallas County. Other program components to be expanded and studied include the teleherence component (Schoech, 2010) and the family component (Lehmann et al., 2012). The program has been presented at both national and international conferences in an effort to network with other like-minded researchers and practitioners.
References

The purpose of this study is to explore the knowledge and attitudes about autism spectrum disorders among Hispanics in the Southwest. The study also examines perceived barriers in obtaining resources, and preferences in accessing health care. Participants (N = 169) were surveyed using the Autism Awareness Survey, which was developed specifically for this research. Significant differences were found between individuals with high acculturation and low acculturation in exposure to autism, knowledge about autism, perceived barriers to obtaining resources and health care, and attitudes toward people with autism. Additionally, the findings suggest that, although the surveyed population was knowledgeable about the symptoms associated with autism, they were less knowledgeable about the etiology and course of the disorder. The research underscores the serious need for both Spanish educational resources and Spanish-speaking health care providers to address the needs of Hispanics with regard to autism, especially for individuals with low levels of acculturation.

Key words: acculturation; Hispanics; knowledge of autism; public perceptions

According to the Centers for Disease Control and Prevention (CDC), autism is a developmental disorder related to atypical biology and chemistry within the brain (Rice, 2009). Symptoms vary, but include problems with social skills such as making friends and showing empathy, as well as difficulty with verbal and nonverbal communication. Because an early, intensive, and appropriate treatment program greatly improves the outlook for most people with autism, the CDC considers it crucial that children be correctly diagnosed when they are still young, preferably before the age of three.

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Autism prevalence statistics in the United States reveal that about 1 child in every 127 of Hispanic ethnicity has an autism spectrum disorder (CDC, 2012). The prevalence of this disorder in the general population is considerably higher: one out of eighty-eight children is diagnosed with autism. It is uncertain whether Hispanic children are actually less affected by autism or whether the lack of access to appropriate health care and autism services among Hispanic families causes this disparity in diagnosis (CDC, 2012; Global Autism Public Health, 2010).

Although it is understood that the prevalence of autism spectrum disorders (ASD) is dramatically increasing, current literature does not document Hispanic understanding or awareness of these disorders. Additionally, the literature does not indicate whether Hispanics with low levels of acculturation have more difficulty accessing health care services than Hispanics with high levels of acculturation. It is possible that families do not seek treatment or care because they do not understand the symptoms or they do not have access to information concerning autism in their preferred language. Due to the paucity of literature in this area, research on this topic will contribute to the knowledge base concerning Hispanic understanding of autism and will help agencies more effectively tailor their services to meet the needs of this specific population.

Review of Literature

Although the rate of autism diagnosis for Hispanics is lower than that of the general population, the literature indicates that the lower rate of autism diagnosis for Hispanics relative to the general population results from sociocultural and economic factors, which include cultural stigma attached to diagnosis, dense population in high-poverty areas with less access to care, fear of deportation, and language complications (Bearman & Fountain, 2011; Durkin et al., 2010; Rice, 2009). It is important to note that the literature shows that Hispanics with higher socioeconomic status have the same diagnosis rate for autism as white non-Hispanics, which may indicate that the disparity in autism prevalence rates is greatly dependent on access to high-quality health care (Bearman & Fountain, 2011; Durkin et al., 2010). However, the research does not explore how an individual’s level of acculturation may affect the cultural and economic barriers to accessing health care services.

Barriers to Care

According to the literature, a variety of issues act as barriers to Hispanic populations accessing health care resources, including but not limited to Hispanic attitudes toward a system they perceive to be prejudiced, a lack of culturally and linguistically competent agencies and workers, and a lack of resources in areas of high need (Alvarado, 2005; Bearman & Fountain, 2011; Durkin et al., 2010; Flores, 1984; Flores, Abreu, Oliver, & Kastner, 1998; Graf, Blankenship, Sanchez, & Carlson, 2007; Guendelsberger, 1992; Kraemer, 2010).
Alvarado (2005) reports that Hispanic families tend to distrust professionals and authorities. The research suggests that this mistrust arises out of a fear of deportation and an aversion to being marginalized and discriminated against (Alvarado, 2005; Bearman & Fountain, 2011; Durkin et al., 2010; Flores, 1984; Graf et al., 2007; Kraemer, 2010). In particular, the study from Southern California by Bearman and Fountain substantiates this distrust. This study shows a direct correlation between heated political campaigns regarding immigration issues and lower diagnosis of ASD among Hispanic populations. Once the political fervor dies down, diagnosis numbers rise. Although the impact of political repression on the use of services by children in immigrant families is not specific to autism, this disorder may be particularly vulnerable because the diagnosis is based on behavioral symptoms (Bearman & Fountain, 2011; Mandell & Novak, 2005).

Further, inequalities in the U.S. health care system create the likelihood of underdiagnosis among children of low-income parents (Alvarado, 2005; Durkin et al., 2010; Kraemer, 2010). A study by Durkin et al. (2010) found that children diagnosed with autism spectrum disorders are less likely to reside in census block groups classified as areas of poverty, and more likely to live in block groups with higher adult educational achievement and a higher median household income. It is notable that the study also indicates that black and Hispanic children are more likely to live in areas of poverty, which suggests that these children are systematically less likely to be diagnosed with autism. The implication is that the lower overall prevalence of autism among these population groups is correlated with the lack of appropriate medical attention because areas of higher poverty are less likely to offer high-quality medical services (Durkin et al., 2010; Mandell et al., 2009).

High-poverty communities in which children with autism spectrum disorders are identified are often unprepared to meet the children’s needs (Jacobson & Mulick, 2000; Mandell & Novak, 2005; Newschaffer & Curran, 2003). Schools in wealthy sectors are able to hire professionals proficient in assessing students and to offer superior facilities that cater to the particular needs of the students (Kraemer, 2010). Schools in poor sectors generally cannot afford to offer such care. Other facilities face a similar predicament: Hospitals, clinics, and social work agencies in these poorer areas do not have the staffing or funding to offer the full spectrum of care (Alvarado, 2005; Kraemer, 2010). Alvarado and Kraemer report that Hispanics are twice as likely to report long delays in waiting rooms and unresponsive health care workers. Even if the resources are available, Hispanic families often lack the health insurance and transportation necessary to take advantage of these health care programs (Flores et al., 1998).

Many Mexican Americans report that the number one barrier to accessing health care services is the inability to communicate with health care professionals (Alvarado, 2005; Flores et al., 1998; Mandell & Novak, 2005). Although many of these Spanish-speaking individuals qualify for assistance, they often are unaware of the availability of services because they cannot communicate with those who
are knowledgeable about the programs or with the professionals on-site. Miscommunications in a hospital setting can result in adverse health consequences, which include poor medical care, misdiagnosis, and inappropriate medication and hospitalization (Flores et al., 1998).

There are many gaps in the literature pertaining to Hispanic families and ASD. One area that merits further study is whether Hispanic populations are familiar with autism and its symptoms. The literature does not address Hispanic awareness of autism, nor does it discuss whether or how people from a Hispanic background may perceive the symptoms of autism differently from members of the mainstream white, non-Hispanic culture in the United States. Ethnic minorities may be less likely to view symptoms of autism as related to a health condition and, therefore, may be less likely to seek care through public medical systems. Moreover, Hispanics may perceive autism as socially embarrassing and may be less likely to seek assistance. Additionally, the literature does not thoroughly examine whether autism prevalence is truly higher among non-Hispanics or whether non-Hispanics are simply more frequently diagnosed. There has been insufficient research comparing the prevalence rates of autism diagnosis among Hispanics and non-Hispanics of equal socioeconomic status. Finally, the literature does not address how acculturation levels of Hispanics may affect their awareness of autism. Hispanic families that are more highly acculturated may have a better understanding of autism than families that have recently immigrated to the United States. The identified sociocultural and economic barriers may be far more insurmountable for Hispanics with low levels of acculturation than for Hispanics with high levels of acculturation.

The research described in this article will examine the relationship between acculturation and autism awareness, knowledge about symptoms associated with and etiology of autism, and attitudes toward individuals with autism. Additionally, the study will seek greater understanding concerning how Hispanics perceive access to health care services.

Method

Instrumentation

The Autism Awareness Survey was constructed based in part on questions used in previous studies (for example, British Social Attitudes Survey, Staniland, 2009; Questions about Disability Survey, Grañ et al., 2007; and The Acculturation Rating Scale for Mexican Americans–Short Form, Dawson, Crano, & Burgeon, 1996), as well as questions reflective of commonly held attitudes and understandings concerning autism.

The survey is composed of fifty-three questions and addresses people’s understanding of key characteristics or behaviors associated with autism, exposure to people with autism, awareness and attitudes toward health services, and acculturation levels. Five yes-or-no questions and one fill-in-the-blank question at the beginning of the survey seek to establish people’s exposure to autism (see table 1).
The first and third sections of the survey consist of eighteen Likert scale questions (rated on a five-point scale of strongly disagree, disagree, neither agree nor disagree, agree, and strongly agree), which seek to determine perceived attitudes toward people with autism (see table 2) and perceived barriers to accessing resources and health care (see table 3). Twelve true or false questions ascertain levels of knowledge about autism (see table 4).

Table 1  Response to Items Relating to Exposure to Autism

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Have you ever heard of autism?</td>
<td>(89.3) 150 (10.7) 18</td>
<td></td>
</tr>
<tr>
<td>2. Have you ever met anyone with autism?</td>
<td>(63.7) 107 (36.3) 61</td>
<td></td>
</tr>
<tr>
<td>3. Have you ever read about autism in a magazine or newspaper?</td>
<td>(59.8) 98 (40.2) 66</td>
<td></td>
</tr>
<tr>
<td>4. Have you ever heard anyone on television talk about autism?</td>
<td>(82) 137 (18) 30</td>
<td></td>
</tr>
<tr>
<td>5. Do you know anyone with autism?</td>
<td>(57.1) 92 (42.9) 69</td>
<td></td>
</tr>
</tbody>
</table>

*Valid percentages are used in the table; one to five responses are missing for each question.

Table 2  Responses to Items Related to Perceived Attitudes toward People with Autism

<table>
<thead>
<tr>
<th>Item</th>
<th>Strongly agree</th>
<th>Disagree</th>
<th>Neither agree nor disagree</th>
<th>Agree</th>
<th>Strongly agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. People with autism are ignored by other people</td>
<td>(15.2) 25 (13.4) 22 (19.5) 32 (34.1) 56 (17.7) 29</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. People with autism are isolated from other people</td>
<td>(9.8) 16 (11.0) 18 (15.2) 25 (39.0) 64 (25.0) 41</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. People with autism stay at home</td>
<td>(11.1) 18 (35.2) 57 (24.7) 40 (24.7) 40 (4.3) 7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. People with autism are hidden from other people</td>
<td>(12.8) 21 (31.1) 51 (28.0) 46 (20.1) 44 (7.9) 13</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. People don’t know what to say to people with autism</td>
<td>(7.8) 13 (10.2) 17 (15.1) 25 (48.2) 80 (18.7) 31</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. People are comfortable around people with autism</td>
<td>(16.9) 28 (29.5) 49 (28.9) 48 (22.3) 37 (2.4) 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. People avoid interacting with people with autism</td>
<td>(6.6) 11 (17.5) 29 (33.1) 55 (31.9) 53 (10.8) 18</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. People feel sorry for people with autism</td>
<td>(12.7) 21 (16.3) 27 (16.3) 27 (36.7) 61 (18.1) 30</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. People don’t interact with people with autism because they are too different</td>
<td>(12.2) 20 (26.8) 44 (23.2) 38 (28.7) 47 (9.1) 15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. I believe that people with autism are discriminated against because of their condition</td>
<td>(14.0) 23 (14.6) 25 (20.1) 33 (29.3) 48 (22.0) 36</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Valid percentages are used in the table; three to seven responses are missing for each question.
Section four is an eleven-question acculturation rating scale that aims to establish people’s level of acculturation to mainstream, English-speaking, white, non-Hispanic culture in the United States and includes questions related to language, activity preferences, and group identity (rated on a six-point scale of none, sometimes, moderate, a lot or very often, very much, and all the time). This scale is based on the Acculturation Rating Scale for Mexican Americans–Short Form (Dawson et al., 1996), which is a standardized measure specifically geared for the Mexican American population and has strong reliability (α = .96).

Once the Autism Awareness Survey was completed, the researchers developed a Spanish version of the instrument to meet the linguistic needs of the intended population. A native-Spanish-speaking researcher completed the initial transla-
tion of the survey. Two other native-Spanish-speaking professionals then reviewed the survey, giving special attention to word choice (to incorporate local dialect) and sentence construction (to decrease the formality of the language). A forward and backward translation of the survey instrument was also completed to minimize translation errors.

Statistical Analysis

The researchers completed a primarily exploratory analysis of the data. A reliability analysis was conducted and used to create five scales. First, a scale was created to address perceived barriers to accessing resources and health care, with higher scores indicating greater perceived barriers (three items; \( \alpha = .75 \)):

- I would know where to go for help if my child were diagnosed with autism
- I would be able to find health services that really care about my family
- I would be able to get the care I need for my child

Next, a scale was created to examine preferences concerning health care services (four items; \( \alpha = .68 \)):

- I would want service professionals to speak Spanish
- I would be concerned that I would not be able to afford health care if my child were diagnosed with autism
- I would be concerned that professionals would not listen to the family’s opinion
- I would be concerned that professionals wouldn’t spend the necessary time to provide my family the help we needed

<table>
<thead>
<tr>
<th>True and false questions</th>
<th>% correct</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Most children with autism have difficulty reading facial expressions. (T)</td>
<td>65.0</td>
</tr>
<tr>
<td>2 With proper treatment, most children with autism outgrow the disorder. (F)</td>
<td>39.6</td>
</tr>
<tr>
<td>3 Children with autism often avoid eye contact. (T)</td>
<td>71.0</td>
</tr>
<tr>
<td>4 Children with autism often have unusual behavior patterns (like flapping their arms or tapping). (T)</td>
<td>79.3</td>
</tr>
<tr>
<td>5 Children with autism often talk excessively about one or two topics. (T)</td>
<td>63.3</td>
</tr>
<tr>
<td>6 Emotional trauma plays a major role in causing autism. (F)</td>
<td>53.8</td>
</tr>
<tr>
<td>7 Children with autism generally prefer predictability. (T)</td>
<td>60.4</td>
</tr>
<tr>
<td>8 Children with autism are generally attuned to other people’s feelings and emotions. (F)</td>
<td>42.0</td>
</tr>
<tr>
<td>9 Autism is caused by vaccinations. (F)</td>
<td>69.8</td>
</tr>
<tr>
<td>10 Autism is more frequently diagnosed in males than females. (T)</td>
<td>48.5</td>
</tr>
<tr>
<td>11 Children with autism tend to resist being held or touched. (T)</td>
<td>66.9</td>
</tr>
<tr>
<td>12 Autism is primarily a genetic disorder. (T)</td>
<td>36.1</td>
</tr>
</tbody>
</table>

*Correct true (T) or false (F) answers are in parentheses.
A third scale was used to investigate perceived negative attitudes toward people with autism (ten items; $\alpha = .80$). The items on this scale were modeled after a survey by Graf and colleagues (2007), entitled Questions about Disability Survey. Items on this scale included *people with autism are ignored by other people* and *people feel sorry for people with autism*.

The fourth scale examined the participant’s knowledge about the symptoms and etiology of autism (twelve items). The scale was a sum score of responses, with correct answers receiving a 1 and incorrect answers receiving a 0. Finally, the fifth scale addressed the respondent’s level of acculturation (Dawson et al., 1996) and included eleven items, $\alpha = .96$. Items on this scale include *I enjoy speaking English* and *my thinking is done in the Spanish language*. More positive scores (rating 0 or above on the scale) indicate high levels of acculturation, whereas low scores (rating below 0) indicate low levels of acculturation.

Independent *t*-tests were used to examine differences between the responses of individuals with high acculturation and those of individuals with low acculturation with respect to the variables that measure knowledge about autism, perceived negative attitudes toward people with autism, perceived barriers that prevent access to resources and health care, and preferences concerning health care services. Chi-square tests were used to compare individuals with high and low levels of acculturation concerning exposure to people with autism.

**Procedures**

The research team consisted of one researcher and three research assistants who are bilingual (Spanish and English) and one research assistant who is monolingual (Spanish). The research team created a list of public locations in a variety of areas around Tucson, Arizona, with the intention of collecting data from individuals with disparate socioeconomic, education, and acculturation levels. Some of the collection areas included grocery stores, fast food restaurants, department and outlet stores, and a local mall. Each member of the research team was responsible for several locations to cover a broad geographical area.

Inclusion criteria for the survey included age greater than eighteen and self-identification as Hispanic or Latino. The researchers asked potential participants if they spoke English or Spanish and if they would be interested in taking part in a survey designed to help social service and health care agencies offer better care to the population living in Southern Arizona. If the individual met the inclusion criteria, he or she was invited to complete the survey. Before completing the survey, participants were given an informed consent letter, as required by the Institutional Review Board. The researchers made themselves available to participants in order to answer questions, read the surveys aloud if requested, and collect the surveys. Seven participants asked the researchers to read the survey aloud. In all seven cases, the Spanish version of the survey was requested. Two participants cited poor vision and five participants cited low literacy as the reason for requesting this accommodation. After the survey was completed, the researchers held aside forty-
one surveys from people who did not meet inclusion criteria. (One was set aside because the participant did not meet the age requirement; forty were set aside because the participants did not self-identify as Hispanic or Latino.)

Results

Of the 169 surveys completed by individuals who self-identified as Hispanic, 108 (63.9%) were completed in Spanish and 61 (36.1%) were completed in English. Of those individuals with high acculturation, 58.1 percent chose to complete the survey in English, whereas, of those individuals with low acculturation, only 13.4 percent chose to complete the survey in English. The results presented below include statistics describing the demographics of the participants and statistics of items related to exposure to autism. Additionally, frequency data and significant differences between responses of individuals with high acculturation and low acculturation are presented pertaining to attitudes toward people with autism, barriers to accessing resources and health services, and knowledge about autism.

Participant Demographics

Descriptive statistics examined the age, gender, education, employment, and marital status of the participants. The sample was largely female (81.1%). The youngest participant was eighteen, whereas the oldest was seventy-nine. The mean age of participants was forty. In terms of marital status, 47.9 percent were married, 5.3 percent had a domestic partner, 32 percent were single, 7.1 percent were divorced, 5.9 percent were separated, and 1.8 percent did not respond. Levels of education ranged from completion of grades one through five to completion of graduate-level work. Forty-four percent of the participants reported having completed grade twelve or less. Of those with high acculturation, 70.9 percent had completed at least some college, as compared to those with low acculturation, of whom only 40.2 percent had completed at least some college. With regard to employment, 39.1 percent worked full time, 13.6 percent worked part time, 12.4 percent were unemployed, 30.2 percent were homemakers, and 4.7 percent did not respond to the question.

Exposure to Autism

The first section of the Autism Awareness Survey related to exposure to autism (see table 1). The overwhelming majority (89.3%) indicated that they had heard of autism, whereas only 57.1 percent reported that they personally knew someone with autism. Significantly more people reported having heard about autism on television (82%) than having read about autism in a magazine or newspaper (59.8%). In response to the question, “What percentage of people do you think get autism?” the average response was 25.7 percent of the population, which is far above the actual rate of diagnosis of 1 percent of the population.
Chi-square comparisons were performed to assess the differences in exposure to autism between individuals with high acculturation and individuals with low acculturation. Significant differences were found in the responses of those with high acculturation and low acculturation for the question pertaining to having met someone with autism. The number of people with low acculturation who had met someone with autism (56.1%) was significantly lower than for those with high acculturation (71.8%), $\chi^2(1) = 4.45, p = .04, \phi = .16$. There was also a significant difference found in responses to the question about whether they had read about autism in a magazine or newspaper. Those with low acculturation had less affirmative responses (50.6%) than those with high acculturation (67.9%), $\chi^2(1) = 5.01, p = .02, \phi = .18$. A trend toward significance was found in the comparisons of responses about personally knowing anyone with autism. Those with high acculturation reported knowing people with autism more often (64.3%) than those with low acculturation (50%), $\chi^2(1) = 3.33, p = .07, \phi = .14$. There were no significant differences between the responses of those with high acculturation and those with low acculturation to the questions about having heard of autism (89.4% vs. 89%) or hearing anyone on television talk about autism (79.8% vs. 84.1%).

Perceived Negative Attitudes

The responses in the section of the survey about perceived negative attitudes toward people with autism highlighted fairly strong views about how society interacts with people with autism (see table 2). Most notably, over 60 percent of the respondents agreed or strongly agreed that people don’t know what to say to individuals with autism (66.9%) and that people with autism are isolated from others (64%). Additionally, more than half of the respondents agreed or strongly agreed that people with autism are ignored by others (51.8%) and that people feel sorry for people with autism (54.8%). More than half of the respondents indicated that they believed that people with autism are discriminated against because of their condition (51.3%).

To determine if there were differences in perceived attitudes toward people with autism between individuals with high acculturation and those with low acculturation, the questions concerning attitudes were examined using $t$-test analysis. Significant differences were found between the responses of those with high acculturation and those with low acculturation (see figure 1). Individuals with low acculturation indicated that they perceived less negative attitudes toward people with autism ($M = 3.03, SD = 0.69$) than those with high acculturation ($M = 3.40, SD = 0.70$), $t(164) = -3.44, p = .001$.

Perceived Barriers and Preferences for Care

There were varied responses to the survey questions pertaining to perceived barriers to accessing resources and health care services (see table 3). The largest perceived barriers pertained to finances and language. More than 60 percent of
the respondents agreed or strongly agreed that, if their child were diagnosed with autism, they would be concerned that they would not be able to afford the necessary health care services (65%) and that they would want the health care professional to speak Spanish (68.5%). Additionally, 56.6 percent indicated that they would be concerned that the health care provider would not spend the time necessary to provide the family with quality care. On the other hand, over half the respondents indicated that they would know where to go for help if their child were diagnosed with autism (54.8%) and that they would feel confident that they would be able to get the care they needed for the child (71.3%).

In order to examine differences in perceived barriers to accessing resources and health care services between individuals with high acculturation and individuals with low acculturation, the questions concerning access to resources and health care were examined using t-test analysis. Significant differences were found between the responses of those with high acculturation and those with low acculturation (see figure 1). Individuals with low acculturation indicated that they perceived more barriers in accessing resources and health care services \( M = 2.70, \ SD = 1.01 \) than those with high acculturation \( M = 2.27, \ SD = 0.96 \), \( t(161) = 2.74, p = 0.07 \). On the other hand, there were no significant differences in the responses of those with low acculturation \( M = 3.65, \ SD = 0.85 \) and those with high acculturation \( M = 3.50, \ SD = 0.79 \) regarding specific preferences about health care services (see figure 1), \( t(160) = 1.16, p = .25 \).
Knowledge about Autism

Results from the true and false section of the survey demonstrated that the respondent sample had some understanding of the symptoms associated with autism (see table 4). The majority were able to identify that children with autism had difficulty reading facial expressions (65%), often avoid eye contact (71%), often have unusual behavior patterns (79.3%), talk excessively about one or two topics (63.3%), prefer predictability (60.4%), and often resist being held or touched (66.9%). However, only 42 percent of the respondents correctly indicated that children with autism are not generally attuned to other people’s feelings and emotions.

The sample responses also suggested that the etiology and course of autism is less well known among the survey participants. Many respondents (60.4%) incorrectly believed that children with autism could outgrow the disorder and that trauma plays a major role in causing autism (46.2%). Additionally, only 36.1 percent of the respondents recognized autism as a genetic disorder. It is notable, however, that 69.8 percent did correctly identify that vaccines do not cause autism.

To determine if there were differences in responses between individuals with high and low acculturation, the questions concerning knowledge were examined using t-test analysis. Significant differences were found between the responses of those with high acculturation and those with low acculturation. Individuals with low acculturation on average demonstrated less knowledge about autism ($M = 6.60, SD = 2.09$) than those with high acculturation ($M = 7.98, SD = 2.07$), $t(157) = -4.16, p = .001$.

Discussion

Researchers have found that Hispanics in the United States perceive more barriers to accessing health care than their white, non-Hispanic contemporaries (Alvarado, 2005; Bearman & Fountain, 2011; Durkin et al., 2010; Flores, 1984; Flores et al., 1998; Graf et al., 2007; Guendelsberger, 1992; Kraemer, 2010). The results of this study build on past research by delineating significant differences in the perceived barriers to care between Hispanics with low acculturation and Hispanics with high acculturation. The findings are not surprising, but this study clearly demonstrates that Hispanics with low acculturation perceive more barriers to accessing health care than those with high acculturation. Speculatively, it could be that Hispanics with high acculturation perceive fewer barriers to care because they can communicate more confidently in English with health care professionals and have higher English literacy, meaning that they can access publicly disseminated literature and information more easily.

This research additionally contributes information on the previously unexamined topic of Hispanics’ level of exposure to autism. Hispanics with low acculturation reported significantly less exposure to autism than Hispanics with high acculturation in their responses to the questions pertaining to having met someone with autism, having read about autism, and personally knowing someone
with autism. Interestingly, there were no significant differences in the responses about having heard of autism. This may indicate that some information concerning the disorder has effectively circulated to the Hispanic population. On the other hand, the lack of direct contact with people with autism and the lack of exposure to written material concerning autism may indicate that Hispanics with low acculturation have only a cursory understanding of autism, and that there needs to be more effort in offering education about the specifics of the disorder.

This supposition is supported by the data addressing knowledge about autism. Hispanics with low acculturation knew significantly less about autism than those with high acculturation. Although all the respondents had fairly accurate understanding of the symptoms associated with autism, they had less knowledge about the etiology and course of the disorder. More specifically, close to 60 percent of the survey participants inaccurately believed that those with autism would eventually outgrow the disorder; only 36.1 percent knew that autism is a primarily genetic disorder, and 46.2 percent believed that trauma plays a large role in causing autism. This lack of knowledge concerning the etiology of autism may be indicative of a larger problem concerning the issue of culpability associated with autism. In other words, people feel that the parents of a child with autism must have done something wrong in their parenting to somehow cause the disorder. This perception of culpability is problematic, not only because it is incorrect, but also because it connects feelings of shame and guilt to autism such that families may be less likely to seek help because they feel that society will blame them for the problem.

The findings of this research correspond to and affirm the assertions of Alvarado, Mandell and Novak, and others that language is the number one barrier that keeps Hispanics from accessing health care services. Even though this study was conducted in a city close to the Mexican-American border where high levels of multicultural awareness and outreach would be assumed, there remain great disparities in the accessibility of resources between people who have fluency in the English language and those who do not. Moreover, this study again confirms the findings of Jacobson and Mulick, Mandell and Novak, and Newschaffer and Curran that the cost of health care is one of the primary barriers keeping people from accessing the health services they need.

Some limitations are evident with this study. First, the researchers used a sample of convenience, which is a nonprobability approach; therefore, the responses may not be truly representative of the target population. Additionally, the small number of participants limits the external validity and generalizability of the study. Another limitation of the study is that the survey instrument was newly developed and therefore could be lacking validity. A final limitation of the research is that the Spanish translation of the survey may not use the most appropriate dialect for the population surveyed, which may affect the participants’ understanding of the questions and therefore influence the responses. To minimize this limitation, researchers did forward and backward translations of the survey and several native Spanish speakers collaborated to ensure the best possible word choice.
Best Practices for Working with Families with Autism

Although previous studies have examined perceived barriers that keep Hispanics from accessing health care, the strength of the research presented in this article is that, in addition to confirming the findings from prior studies, it also addresses previously unexamined topics such as Hispanics’ exposure to autism and knowledge about the symptoms and etiology of autism, and it differentiates between Hispanics with high and low levels of acculturation. This exploratory study can act as a foundation for further research, and it highlights the importance of continued investigation concerning autism and the Hispanic population.

The implications of this research for social work and health care practitioners are far-reaching. Once again, it has been demonstrated that the primary barriers keeping Hispanic families from accessing health care services are language and finances—the same barriers that researchers have identified for this population for the last twenty years (Alvarado, 2005; Bearman & Fountain, 2011; Durkin et al., 2010; Flores, 1984; Flores et al., 1998; Guendelsberger, 1992; Kraemer, 2010). It seems that there has been little progress in the development of culturally appropriate and cost-efficient services. The cost of health care has been the topic of national debate, yet there has been no tangible movement to reduce the cost of health services, particularly for the uninsured and underinsured. Additionally, with the upcoming, highly politicized changes to the diagnostic criteria for autism spectrum disorders within the Diagnostic and Statistical Manual for Mental Disorders (American Psychiatric Association, 2000), many families who currently receive support through the Department of Developmental Disabilities may cease to qualify for assistance, leaving the financial burden of care entirely on the family. This research again highlights the uncertainty felt by the general public and the need for professionals to engage in national dialogue and advocacy for the marginalized populations in our communities. This study supports the actions of practitioners as they consider the broader implications of their work and underscores the need for advocacy in addressing social problems.

The other primary barrier to care pertains to language, that is, the lack of Spanish-speaking health care professionals and the lack of Spanish information and literature concerning autism. There are clear implications for mezzo-level social work practice; in particular, health care programs need to broaden services that address the specific cultural needs within their communities. In the Southwest, this means making health care services equally accessible to English- and Spanish-speaking populations. Although it seems that this community is generally aware of autism as a concept, education about autism, specifically about issues concerning culpability, is clearly necessary. Without addressing the stigma of the disorder, vast numbers of those with autism spectrum disorders are unlikely to receive the care they need during the prime treatment years, and will reach adulthood without the skills to effectively engage with the world around them.
This research should remind health and education professionals of the unique needs of the diverse populations within this country, which must be met with equitable and appropriate care.

References


Promotion of Holistic Development in University Students: A Credit-Bearing Course on Leadership and Intrapersonal Development

Daniel T. L. Shek

There is a need to reexamine how universities can promote holistic and balanced development of university students. Based on the positive youth development approach, it is argued that promotion of psychosocial competencies and positive mental health attributes such as resilience, emotional competence, self-understanding, and interpersonal skills is an important strategy to facilitate holistic development of university students in Hong Kong. A credit-bearing course entitled Tomorrow’s Leaders was developed at The Hong Kong Polytechnic University and piloted twice in response to this requirement. Findings based on various evaluation strategies, including objective and subjective outcome evaluations, process evaluation, and qualitative evaluation consistently showed that this course was able to promote the psychosocial competencies and positive mental health of the students.

Key words: Chinese adolescents; formal curriculum; positive youth development; psychosocial competencies; university students

Developmental Problems in University Students and the Role of Universities

A survey of the literature showed that university students face many developmental issues. Shek and Wong (2011) reviewed developmental issues such as mental health problems, substance abuse, and egocentric behavior of university students.

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students. Several phenomena were revealed by the review. First, there were mental health issues confronting university students. For example, Blanco et al. (2008) found that the prevalence rates for alcohol use and personality disorders in university students were 20.4 and 17.7 percent, respectively. As Mowbray et al. (2006) pointed out, “averaging across a number of studies, it appears that approximately 12–18% of students on college campuses have a diagnosable mental disorder” (p. 227). Suicide was the second leading cause of death among college students in the United States after homicides and accidents (Barrios, Everett, Simon, & Brener, 2000).

Second, there was a gradual drop in empathy and rising narcissistic personality characteristics among university students. For example, studies revealed that there was an overall increase in narcissism across the cohorts of university students (Twenge & Foster, 2008; Twenge, Konrath, Foster, Campbell, & Bushman, 2008). There were also research findings showing that university students have become more self-focused and financially oriented, but less engaged in social responsibility and civic participation. In a recent New York Times article titled “Students Are Different Now,” Bips (2010) asserted that “students now are less mature and often not ready for the responsibility of being in college . . . many students today lack the resilience and are unable to summon strategies to cope . . . many students are often not prepared to be young ‘adults’ with all the responsibilities of life.”

With particular reference to Hong Kong, Shek (2010) highlighted several phenomena regarding the development of university students in Hong Kong. First, research findings show that the mental health of university students is a concern. For example, Wong, Cheung, Chan, Ma, and Tang (2006) showed that the rates of psychological morbidity in first-year postsecondary (tertiary) education students in Hong Kong were high. In a study conducted by the Hong Kong Tertiary Institutions Health Care Working Group (2007), roughly half of the respondents displayed excessive anxiety problems. In fact, there are findings indicating that roughly one-fifth of young people in Hong Kong have various mental health concerns (Shek, Ma, & Sun, 2011).

In another recent review of developmental issues in university students, Shek and Cheung (in press) highlighted that there are several issues that deserve attention. First, there are behavioral and lifestyle issues in university students in Hong Kong. Findings showed that alcoholism among university students in Hong Kong gradually worsens throughout their university lives. Additional evidence showed that viewing pornography on the Internet was prevalent among male university students in Hong Kong. Moreover, university students encountered sleeping problems: 68.6 percent of students had insomnia and 40 percent rated their sleep quality as poor. Finally, research showed that dating violence in Hong Kong university students was more prevalent than reported in other countries.

Mental health issues in university students also deserve attention. Chan, Tiwari, Leung, Ho, and Cerulli (2007) found that the rate of suicidal ideation
among a university student sample was 41 percent, which was higher than the percentage reported in the Western literature. Regarding depression, Song et al. (2008) compared Hong Kong students with Beijing students and found that more Hong Kong students suffered from depressive symptoms. University students had personal goal and self-confidence problems, and they showed materialistic and pragmatic values. Finally, there were signs of egocentrism and lack of civic responsibilities in university students.

With reference to the above-mentioned problems, universities have an obvious responsibility to help students to develop holistically. It has been suggested that contemporary universities are unable to help students develop in a holistic manner. In the past two decades, books criticizing higher education have been published. In his book entitled *The Closing of the American Mind*, Bloom (1987) pointed out that the decline in emphasis on humanities, overemphasis on moral relativism and postmodernism, and disconnection between contemporary students and spiritual and cultural roots (especially those in the Great Books) in contemporary universities have adversely affected the total development of students. In his book entitled *The University in Ruins*, Readings (1997) pointed out that the changing nature of universities has transited from the preservation of national culture to quantitative but empty benchmarks on excellence. Criticisms of contemporary universities can also be found in Wilshire’s book *The Moral Collapse of the University* (1990). His view is that academic professionalism and careerism have been overemphasized and that education, as well as the needs of the teachers and students, has been underemphasized.

In his book *Our Underachieving Colleges*, former Harvard president Derek Bok (2006) examined learning in undergraduate education. He concluded that students must catch up on critical thinking, quantitative skills, and moral reasoning to become well-informed citizens. In another book, *Excellence without a Soul*, Harry Lewis, former dean and professor of Harvard University, argued that the fundamental purpose of the university has been forgotten and its mission lost (2006). Lewis opined that general education courses lacked vision and mission, and that students could not gain autonomy, resilience, and a sense of responsibility from university education. He also warned of the predominance of money as the driving force for education, decision making, and consumer satisfaction. In short, one of Lewis’s key messages is that universities fail to nurture the holistic development of university students.

In a special issue focusing on contemporary tertiary education, Dalton and Crosby (2006) argued that the inner lives of university students are grossly neglected in university education and that university education programs fail to help students to “make internal connections to the defining beliefs and purposes in their lives . . . since they do not reach that part of students’ lives where things really matter” (p. 1). Astin and Sax (1998) also pointed out that there was an overemphasis on intellectual outcomes but negligence toward holistic development in university students.
The Quest for Holistic Development in University Students

Traditional mainstream adolescent developmental theories (e.g., Freudian theories) commonly focus on the developmental problems of adolescents. In response to such theories, which emphasize adolescent pathologies, theorists in the fields of positive psychology and positive youth development (PYD) have argued that it is important to look at the bright side and the potentials of young people. According to Damon (2004), in contrast to approaches that focus on youth developmental issues such as depression and substance abuse, positive youth development emphasizes the talents, strengths, interests, and future potentials of children and adolescents. It also emphasizes the principle that “problem-free is not fully prepared” (Pittman, 1991) and developmental assets such as psychosocial competencies are important in children and adolescents.

A survey of the literature shows that various PYD models propose different developmental assets or psychosocial competencies. Benson (1997) highlighted the importance to adolescents of developing forty developmental assets, including social competence (e.g., planning and decision making, interpersonal competence, resistance skills, and peaceful conflict resolution) and positive identity (e.g., sense of purpose, self-esteem, and positive view of personal future). Weissberg and O’Brien (2004) proposed that it is important to promote social-emotional competencies, such as self-awareness, social awareness, self-management, relationship skills, and responsible actions, to be nurtured in young people. Graczyk et al. (2000) similarly argued that the promotion of social and emotional learning (SEL) in adolescents is important. In the context of higher education, Bok (2006) asserted that university students should be nurtured to develop psychosocial skills, including communication, critical thinking, moral reasoning, preparation for citizenship, living with diversity, living in a global society, and preparation for work.

The concept of developmental assets such as psychosocial competence is closely related to the concept of mental health or psychological well-being. According to Ryan and Deci (2001), psychological well-being is defined as “optimal psychological functioning and experience” (p. 142). The importance of the positive dimension of mental health (i.e., not just absence of psychological problems) is also highlighted by the World Health Organization (WHO; 2011), which defines mental health as

a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. . . . The positive dimension of mental health is stressed in WHO’s definition of health as contained in its constitution: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”

Obviously, developmental assets such as psychosocial competencies are integral components of the positive dimension of mental health.
Development of a Course on Tomorrow’s Leaders for Hong Kong University

Under the new four-year undergraduate curriculum at the Hong Kong Polytechnic University, students admitted in 2012 will be required to complete a requirement in leadership and intrapersonal development. A course entitled Tomorrow’s Leaders was developed to help students fulfill this requirement. It is expected that, after taking this course, students will accomplish the following learning outcomes:

1. understand and integrate theories, research, and concepts on the basic qualities (particularly intrapersonal and interpersonal qualities) of effective leaders in the Chinese context;
2. develop self-awareness and self-understanding;
3. acquire interpersonal skills;
4. develop self-reflection skills in their learning; and
5. recognize the importance of an active pursuit of knowledge as it relates to intrapersonal and interpersonal leadership qualities.

Several positive youth development constructs, including self-understanding; resilience; cognitive, social, emotional, and moral competence; spirituality; positive identity; interpersonal relationships; and self-leadership are included in this course. The course syllabus is shown in Table 1 (Shek, 2012).

Table 1  Syllabus for the Course Tomorrow’s Leaders

<table>
<thead>
<tr>
<th>Topic</th>
<th>Subject Content</th>
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| 1     | An overview of the personal attributes of effective leaders: role of self-understanding and interpersonal relationship qualities.  
| 2     | Self-understanding: personality traits conducive to successful leadership.  
| 3     | Emotional competence: awareness and understanding of emotions, emotional quotient (EQ), role of emotional management in effective leadership, and mental health.  
| 4     | Cognitive competence: different types of thinking, higher order thinking, experiential learning, role of cognitive competence in effective leadership, and effective leaders as teachers.  
<table>
<thead>
<tr>
<th>Topic</th>
<th>Subject Content</th>
</tr>
</thead>
</table>
| 5     | Resilience: stresses faced by adolescents, life adversities, coping with life stresses, adversity quotient (AQ), and role of resilience in effective leadership.  
| 6     | Spirituality: meaning in life and adolescent development, spirituality and mental health, role of spirituality in effective leadership, and servant leadership.  
| 7     | Ethics and morality: moral issues and moral competence, role of ethics and morality in effective leadership, integrity and responsibility and effective leadership.  
| 8     | Social competence: basic social competence skills, ability to build up positive human relationships, role of social competence in effective leadership, and egocentric mentality as a block to effective leadership.  
| 10    | Interpersonal communication: theories, concepts, and skills of interpersonal communication, and role of communication skills in effective leadership.  
| 11    | Interpersonal conflict; role of conflict resolution in effective leadership, team building, relationship quality, and effective leadership.  
| 12    | Personal integrity and sense of responsibility in effective leaders; egocentrism in university students.  
| 13    | Self-leadership, mental health, and effective leadership.  
Evaluation of Tomorrow’s Leaders

Tomorrow’s Leaders was offered to four classes of students in the 2011–12 school year. In Pilot Study 1, 268 students participated in the course. In Pilot Study 2, 195 students enrolled in four classes. Systematic evaluation was performed using various evaluation mechanisms, including objective outcome evaluation, post-lecture and post-course subjective outcome evaluation, process evaluation, and qualitative evaluation. The evaluation findings are presented in the following sections.

Objective Outcome Evaluation

In Pilot Study 1, pre-test and post-test data utilizing the Chinese Positive Youth Development Scale (CPYDS) were collected from fifty students taking the course. The CPYDS is a validated instrument that assesses various aspects of positive youth development, including bonding; resilience; cognitive, emotional, behavioral, moral, and social competence; self-determination; self-efficacy; positive identity; spirituality; prosocial norms; and prosocial involvement. Relevant domains of the CPYDS were used in this study. Results showed that participants had significant increases in scores in the domains of emotional, cognitive, and behavioral competence; self-determination; and positive identity. They also had significant increases in several composite scores (Shek & Sun, 2012e).

In Pilot Study 2, a quasi-experimental study with an experimental group (N = 195) and a control group (N = 71) was conducted to examine the effectiveness of the course. The two groups were comparable in terms of gender ratio, age, and family background characteristics. Analyses of covariance, controlling for pre-test differences between the two groups, showed that the experimental group generally exhibited higher levels of psychosocial competence in terms of a composite variable including resilience; social, emotional, cognitive, and behavioral competence; self-determination; self-efficacy; and beliefs in the future. The study suggests that this course can promote critical thinking, interpersonal competence, problem solving, lifelong learning, and ethical leadership in Chinese university students in Hong Kong (Shek, Sun, Tsien-Wong, Cheng, & Yim, in press).

Subjective Outcome Evaluation (Post-Lecture Evaluation)

To evaluate their perceptions of the lectures, students were invited to respond to a twelve-item post-lecture questionnaire after each lecture (except the last lecture) in Pilot Study 1. A total of 2,039 post-lecture subjective outcome evaluation forms were collected following lectures 1 through 13. The post-lecture evaluation questionnaire was found to possess good psychometric properties. Results showed that the students generally had positive perceptions of the lecture content, class atmosphere, and teacher attributes. With reference to the global evaluation of the
subject, 93 and 90 percent of students gave positive evaluations of the teacher and subject, respectively. Subject, class, and teacher attributes were found to be predictive of the overall satisfaction with the lecture and the teacher (Shek, 2012).

In Pilot Study 2, students were similarly invited to respond to a twelve-item post-lecture questionnaire after the first thirteen lectures (N = 195 students with 2,012 questionnaires collected). Results showed that students generally had positive perceptions of the subject, class, and teacher attributes, and the overall evaluation was very positive. More than 93 percent of the respondents had a positive global evaluation of the subject and the teacher. Through factor analyses, three factors were abstracted from the scale (subject attributes, class attributes, and teacher attributes). The total scale and subscales were internally consistent. It was also found that subject, class, and teacher attributes were significant predictors of perceived benefits of the subject (Shek & Sun, in press-b).

Subjective Outcome Evaluation (Post-Course Evaluation)

In Pilot Study 1, subjective outcome evaluation data based on a validated instrument were collected from 189 students after completion of the course. The students generally had positive perceptions of the program and instructors, with more than 90 percent of the participants indicating that they were satisfied with the program and that they perceived the program was helpful to them in the domains of holistic development and leadership. For example, 94 percent of the students felt that the subject had helped them to achieve self-reflection, and 93 percent commented that the subject promoted their overall development. Significant correlations among perceived quality of the program, perceived quality of instructors, and perceived program benefits were found (Shek & Sun, 2012d).

In Pilot Study 2, 195 students responded to the thirty-seven-item Subjective Outcome Evaluation Scale (SOES) after completion of the course. Results showed that students generally had positive perceptions of the program and instructors, with more than 90 percent of the participants indicating that they were satisfied with the program. Almost all participants felt that the subject had helped them develop their intrapersonal and interpersonal competence. In both pilot studies, factor analyses showed that three factors (course, instructor, and benefits) were abstracted from the scale. The total scale and the subscales were found to be internally consistent (Shek & Sun, in press-a).

Process Evaluation

In Pilot Study 1, process evaluation was carried out for fourteen lectures to understand the quality of the program implementation. Based on systematic observations by two observers, results showed that the average level of program adherence was high (85.71%), with high ratings given to student interest, classroom control, use of interactive delivery method, use of strategies to enhance student motivation, opportunity for reflection, degree of achievement of the objec-
tives, quality of preparation, overall implementation quality, and success of implementation. Various aspects of the program implementation contributed to the high quality and success of the program (Shek & Sun, 2012c).

In the second piloting exercise, process evaluation was carried out for nineteen lectures, with each lecture observed by two independent observers. Results showed that interrater reliability was generally high. Regarding ratings for the quality of program implementation, results showed that quality of implementation as assessed by the two observers was generally high. In addition, both observers generally regarded the program implementation as successful. High program fidelity (average degree of program adherence = 94.9%) was also found. Classroom management, time management, and achievement of the teaching unit’s objectives were significant predictors of overall quality and success of the program (Shek & Sun, in press-c).

Qualitative Evaluation (Personal Reflection)

In Pilot Study 1, students were invited to use qualitative descriptors and metaphors to describe their experiences in the course. Based on the reflections of 189 students, results showed that most participants used positive descriptors (such as self-understanding, interesting, motivating, meaningful, and enlightening) and positive metaphors (such as meaningful tours, compass, star, and superstar) to describe the course. Several scholarship holders were also invited to write down their personal reflections. Results showed that the students liked the course, and they identified many positive attributes of the course. They also appreciated the instructors, and they felt that the course contributed to various aspects of their development (Shek & Sun, 2012f).

In Pilot Study 2, three qualitative studies based on the reflections of the participants were conducted. In the first study, students were invited to use three descriptors and a metaphor to describe their experiences at the end of the course (Shek, in press). Based on the reflections of 143 students, results showed that 94.4 percent of the descriptors used by informants were positive (e.g., helpful to development, useful/helpful, reflective, inspiring, and impressive). For the metaphors used to describe the subject, 92.7 percent were positive (e.g., enjoyable, meaningful, interesting, interactive, or relaxing course; path to future; breakthrough; milestone; and turning point).

In the second study, students were invited to write personal reflections about the subject. Based on the reflections of 104 students, data were separately analyzed by two independent raters. Reliability analyses revealed that the coding of reflections had high intra- and interrater reliability. Results showed that the informants were generally positive about the subject and lecturers, and that they perceived that the subject promoted their overall development in various domains.

Finally, five recipients of Wofoo Foundation Scholarships were invited to write reflective journals regarding their experiences in taking this course. The students
believed there was a need for this course, and they felt that the course was beneficial to their development. Additionally, they pointed out that they liked the course and instructors, and they identified many positive attributes of the course and its implementation. Respondents also perceived the course to be beneficial to their development. Some of the narratives are included below:

- “I learned a lot from this GE course. We built up friendships and shared different points of view through discussion. In the lectures, the lecturer allowed us to interact and communicate with classmates. We thought and reflected on our own experiences of our life. Now, Tomorrow’s Leaders to me is not only a noun, but also something we could achieve in the future.”
- “In my major, there are only lectures and tutorials. After the lecturers finished what they wanted to say, they left. But in Tomorrow’s Leaders there were many interactions, which shocked me at the very beginning. Nearly everyone has to share what they think and feel during the lesson. This is something I can never encounter if I haven’t taken this course. Also, the most interesting part was the worksheet. These few pieces of paper can help me find my truth and know about myself. I have the deepest feeling when I was filling the worksheet about my strengths, weaknesses and ideal-self. I would like to find out the answers.”
- “The lectures that I like most are ‘Self-understanding’ and ‘Resilience.’ For ‘Self-understanding,’ it provided a chance for us to rethink ourselves. I think it was a valuable opportunity to understanding our strengths and weaknesses. After understanding ourselves, it is a chance to let us accept and strive for change. Then, I believe that it is easier to be a good leader and communicate with others after the change. For ‘Resilience,’ I learned that we can convert difficulties into opportunities. Now in my mind, difficulties are just time to make decisions and time to prove that I have the ability to solve problems. Last but not least, I liked the in-class activities, videos, and stories provided by the instructor. It got me involved in the class and to cooperate with different people. And also, it is valuable to meet other people from different programs, such as engineering and social work. It is good to understand them and know more about their values, which are very different from mine.”

Qualitative Evaluation (Focus Group Interviews)

In Pilot Study 1, five focus groups (N = 23 students) were conducted to understand the feelings and views of the students taking the course. Results showed that students generally had positive perceptions of the course content, the class, and the lecturers, and almost all students felt that the course could promote their reflection and self-understanding. All students also held the view that there was a need to have this course in their university study (Shek & Sun, 2012b).
In Pilot Study 2, twenty-three randomly selected students participated in four focus group interviews. The students generally felt that the subject was very helpful to their development and that there was a strong need to offer this course. They also enjoyed the course very much. Some related narratives are as follows:

- “The course was interactive. It was well-designed with clear structure of which you could pace with the rundown of the lecture.”
- “I liked the ‘Stars’ of the videos which had a modeling effect on me, especially on the self-development and personal growth.”
- “I thought that the course should be organized for the university students at an earlier stage so that they could know more about the formation of personality and different competences. . . . All of these had good match with the framework of positive youth development concept.”
- “After the lecture on emotional competence, I always reminded myself to be tolerant of my family. Besides, you might have problem in working with others if you could not handle your emotion.”
- “Before I took the course, . . . I looked at things from my perspective. I thought about myself first—it was your fault but not my fault. I am a perfectionist. I do not like other people intruding in my life and I am very stubborn. In particular, I always have quarrels with my mum and I do not understand her feelings. In the past, I simply ignored her and thought it was her business if she worried about me. . . . but now I will stand in my mom’s perspective to look at things. I think our relationship has improved. My mum said that our relationship had improved. In the past, we would stop talking when we were unhappy. Now, we would communicate and I would understand her feelings.”

Best Practice for Youth Development

This article has outlined the development of a course entitled Tomorrow’s Leaders for students to fulfill the leadership and intrapersonal development requirement of the four-year undergraduate curriculum at the Hong Kong Polytechnic University. The course was piloted twice, with the use of a wide range of evaluation strategies. Overall, the evaluation findings are overwhelmingly positive. With specific reference to objective outcome evaluation, students showed positive changes after taking the course, and the positive changes were more pronounced in students in the experimental group than those in the control group.

With reference to the nonexperimental evaluation findings, students generally had positive perceptions of the course and the instructors, and they agreed that the program could promote their psychosocial competence in areas such as resilience, positive identity, and overall positive development. Shek and Wong (2011) pointed out that adolescent developmental issues would not disappear overnight, and that existing strategies to cope with the problem are not consistent
with the basic principles of public health. A review of the literature shows that positive youth development programs are very popular in high school settings (Catalano et al., 2012). Surprisingly, validated and systematic positive youth development programs are rare in higher education. The findings suggest that the use of a credit-bearing course to promote the holistic development of university students is a promising approach (Shek et al., 2012).

These two pilot studies and the related evaluation further reinforce the importance of nurturing developmental assets such as psychosocial competence in promoting holistic development and the positive component of mental health in young people. Actually, Tomorrow’s Leaders can be regarded as a university version of the Project P.A.T.H.S initiative in Hong Kong. To promote holistic development among Hong Kong adolescents, the Hong Kong Jockey Club Charities Trust launched a project entitled P.A.T.H.S to Adulthood: A Jockey Club Youth Enhancement Scheme (Project P.A.T.H.S.), with an aggregated earmarked grant of HK$750 million. To date, more than 200,000 secondary school students from more than 280 secondary schools have joined the program. Triangulation of various types of evaluation data clearly showed that the project was able to promote positive development and reduce problem behavior in grade seven to grade nine students (Shek & Sun, 2012a).

Of course, there are several limitations of the two pilot studies. First, although a quasi-experimental design was used in the second pilot study, it is important to use a true experimental design to evaluate the program. In particular, the use of randomized clinical trials and independent groups of researchers at several sites would be helpful. Second, because the current findings are basically cross-sectional or short-term, there is a need to conduct longitudinal studies. This is important because there is a need to assess the impact of the program in real life settings. Third, involvement of observers observing the students taking this course would provide an additional perspective in understanding the program’s effect. Finally, to enhance the generalizability of the findings, the subject should be offered in other settings involving different types of students.

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Reducing Health Disparities for People with Serious Mental Illness: Development and Feasibility of a Peer Health Navigation Intervention

John S. Brekke, Elizabeth Siantz, Rohini Pahwa, Erin Kelly, Louise Tallen, and Anthony Fulginiti

People with serious mental illness die, on average, twenty-five years earlier than those in the population without a serious mental illness. This disparity is largely due to treatable medical conditions that remain unaddressed due to factors at the client, treatment, provider, clinic, and system levels of health and mental health service delivery. This article describes the development, initial implementation, and feasibility of the Bridge, a peer-staffed care linkage model situated in a mental health clinic that addresses barriers at multiple levels of service delivery by connecting clients to physical health services and developing client skills that result in self-management of health care. The Bridge was developed collaboratively with interventionists, clinic staff, and mental health peers and relies largely on an in vivo approach.

Key words: health; health disparities; health navigation; intervention; serious mental illness

People living with serious mental illness in the United States die, on average, twenty-five years earlier than those without a serious mental illness, largely due to preventable medical conditions and suboptimal medical care (Parks, Svendsen, Singer, & Foti, 2006). Studies have found a higher incidence of certain physical disorders, such as diabetes (Dickerson et al., 2006; Lester, Titter, & Sorohan, 2005), obesity (Parks et al., 2006), high cholesterol or dyslipidemia (Dalmau, Bergman, & Brismar, 1997), metabolic and cardiovascular problems (Brunero & Lamont, 2010; Deakin et al., 2010), and cancer (Brown, 1998), among people...
with serious mental illness. When combined with a serious mental illness, physical illness can lead to other health conditions (Dickerson et al., 2005) and to a quality of life lower than that of both the general population and individuals with mental illness alone (Desai, Rosenheck, Druss, & Pearlin, 2002; Dickerson et al., 2008). These negative health consequences can affect other recovery goals such as housing, vocational training, and education (Bazelon Center for Mental Health Law [BCMHL], 2004).

Individuals with serious mental illness also face numerous barriers to access and use of health care services needed to prevent and manage chronic diseases at multiple levels of the service delivery system (De Hert et al., 2011; Druss, Rask, & Katon, 2008). At the system level, the chasm between the health and mental health care systems impedes access to care in both systems and reduces coordination of services (Miller, Druss, Dombrowski, & Rosenheck, 2003). Environmental barriers include difficulties in finding a specialist, long waits in clinics, transportation difficulties, geographical distance, and cost (Dickerson et al., 2003;Jeste, Gladso, Lindamer, & Lacro, 1996). Provider-level barriers for people with serious mental illness include limited training of mental health professionals in attending to their physical health concerns (Brown, 1998), limited training of primary care physicians in working with people with serious mental illness (Leigh, Stewart, & Mallios, 2006), and the stigma endured during encounters with health providers (Goldberg et al., 2007). At the individual level, additional barriers may result from mistrust of the system, lack of knowledge and resources, and behavioral or cognitive challenges in understanding and accessing services, along with educational, cultural, and language hurdles (Bradford, Coleman, & Cunningham, 2007; Cohen & Krauss, 2003; Dickey, Normand, Weiss, Drake, & Azeni, 2002).

The high incidence of comorbid diseases among people with serious mental illness contributes to the high cost of health care for those who receive specialty mental health services (BCMHL, 2004), leading to increasing demands for solutions, nationally and internationally (Hedberg & Skärsäter, 2009; Kane, 2009; Maj, 2009; Shattell, Donnelly, Scheyett, & Cuddeback, 2011). The integration of health and mental health services is a means to address the fragmentation of health and mental health service systems (Anderson & Knickman, 2001; Druss et al., 2008; Goldberg, 1999). This article will discuss the conceptual model, development, and feasibility of an innovative community-based health navigator intervention for people living with serious mental illness.

Models for Integrating Services

The Bazelon Center for Mental Health Law (2004) has identified the following models for integrating health and mental health services for individuals with serious mental illness: (1) embedding of health care providers within mental health programs, (2) full-service health and mental health delivery programs housed in the same agency, and (3) collaboration between independent health and mental health providers. The first two models involve co-situated care, and the third is a
care linkage model. These approaches address different barriers to care. Although co-situated approaches would appear to address more barriers, they require significant change in both health care policy and the structure and financing of service delivery (Goldberg, 1999). For example, although co-situated service programs show some impact, they are still challenged by separate funding streams for health and mental health services. Another barrier to integration is the difference in reimbursement plans for health and mental health services (BCMHL, 2004). Even with Medicaid, individuals with serious mental illness are served through fee-for-service arrangements, whereas physical health is addressed via managed care services (Goldberg, 1999). Moreover, integrating care contracts does not necessarily result in more integrated and efficient services (Laws, Gabriel, & McFarland, 2002; Stroul, Pires, & Armstrong, 2001; Vogel, 2001).

The third model, care linkage, improves collaboration between independent health and mental health providers and could be implemented in the context of many existing financing and service structure arrangements. One randomized study has shown increased utilization of primary care service by individuals with serious mental illness, increased preventative care visits, and better health outcomes when separate health and mental health services are coordinated by a nurse case manager (Druss, von Esenwein, et al., 2010). Although care linkage does not require co-situated health and mental health care, the use of highly paid professionals may introduce other cost considerations.

**Care Linkage and Peer Providers**

A promising alternative to care linkage provided by professionals is the use of peer providers to deliver these services (New Freedom Commission on Mental Health, 2003). Peer providers bring their own experience of living with a mental illness to assist clients with serious mental illness. Peers are one of the most rapidly growing segments of the mental health workforce in the United States (Druss, Zhao, et al., 2010), and peer-run interventions are becoming prominent in the recovery literature (Rosenick & Rosenheck, 2008; Solomon, 2004). Peers can be trained to work in a variety of settings to promote recovery and wellness (Cook, 2005; Davidson et al., 1999; Davidson, Chinman, Sells, & Rowe, 2006; Rosenick & Rosenheck, 2008; Solomon, 2004), and potentially offer more cost-effective services than other options (Battaglia, Roloff, Posner, & Freund, 2007; Jandorf et al., 2006; Steinberg et al., 2006). Furthermore, this peer provider option can offer training and employment opportunities to persons with serious mental illness and provide them with a stronger role and voice within these systems, a key goal of the Recovery Movement.

Peer interventions build on the experience and sensitivities of peers to focus on practical issues of access and utilization of health services. For example, individuals with a history of cancer have been used to help women with breast cancer access services (Darnell, 2007; Dohan & Schrag, 2005). Similarly, HIV/AIDS
services have applied this model to reduce barriers to service utilization (Bradford et al., 2007), and such models are thought to be an effective strategy for addressing obstacles to accessing health care services. At present, only one randomized pilot trial, in which trained peers led manualized group psychoeducation classes on chronic disease management for participants with serious mental illness, has been completed (Druss, Zhao, et al., 2010). Compared to participants who received treatment as usual, participants who completed the course showed higher rates of utilizing primary care services (68.4% vs. 51.9%), more patient engagement in self-managing their health and health care, and higher quality of physical health. These results, although promising, may also suggest that patients may require significantly more assistance to see substantial improvements in well-being.

Given the potential benefits of a care linkage model with peer providers, the authors developed and implemented an intensive, individualized, peer health navigator intervention to facilitate access to physical health care for people diagnosed with serious mental illness who are engaged in the publicly funded mental health system in Los Angeles.

Theoretical Framework for Peer Health Navigation

Improving the physical health of people living with serious mental illness is a complex challenge, resulting from numerous factors at the levels of the individual, the provider, the health care system, and the broader geographic and sociopolitical environment. A sound conceptual framework is important for organizing the multiple factors that contribute to the use of health services and the physical health status of people living with serious mental illness, and can provide a road map for addressing factors to be targeted by an intervention.

The conceptual model underlying this intervention tailors Gelberg, Andersen, and Leake’s (2000) Behavioral Model of Health Service Use for Vulnerable Populations (BMHSUVP) for those with serious mental illness. Gelberg and colleagues posit that health services usage is determined by a combination of predisposing characteristics (demographic, social structure, and health beliefs), enabling resources (personal/family and community), need for care (perceived and evaluated), and personal health care habits (diet, exercise, and self-care). Importantly, this model includes not only factors that lead to health care utilization, but also factors that influence the effectiveness of those services. To tailor this model for those with serious mental illness, a series of focus groups and interviews was conducted with clients, staff, and administrators from health care and mental health care agencies. Based on the information obtained in these interviews, it became apparent that the BMHSUVP model omits some important factors that suppress health service utilization among those with serious mental illness—namely severe psychiatric symptoms, stigma, and system bifurcation. The adapted theoretical model is shown in figure 1.
Figure 1  Health Behavior and Outcome Model for the Seriously Mentally Ill

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<td>1. Health &amp; wellness</td>
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<td>2. Quality of life</td>
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The model’s predisposing domain includes participant demographics such as age, gender, and marital status; health beliefs including values concerning health and illness; attitudes toward health services and knowledge of disease; factors related to social structure including ethnicity, level of education, employment status, social networks, occupation, religion, acculturation, immigration status, literacy, living conditions, victimization, and psychological resources (e.g., mastery, coping, self-esteem, cognitive ability, and substance abuse). Even if services are accessed, clients with serious mental illness may be predisposed to negative experiences with physicians as symptoms of their disorder, and cognitive deficits can make communication more difficult and stressful (Berren, Santiago, Zent, & Carbone, 1999).

The enabling domain includes personal and community characteristics required for the health care interaction to take place (Gelberg et al., 2000). The proposed model includes personal and family resources such as access to a regular source of care, insurance, income, social support, perceived barriers to care, self-help skills, ability to negotiate the system, and community resources such as establishing residence and availability of health services, case management, transportation, telephone, and other information sources.

The need domain includes self-assessment or professional assessment that health services are required to treat health conditions specific to an adult living with serious mental illness. Clients’ perceptions and clinicians’ evaluations of their clients’ physical health status may be influenced by the presence of serious mental illness (Gelberg et al., 2000). Physical health treatment and preventive care such as cervical screenings, mammograms, and immunizations (Carney, Allen, & Doebbeling, 2002; Druss, Rosenheck, Desai, & Perlin, 2002) may be given secondary priority relative to care for active psychiatric symptoms, maintaining stable housing, and financial insecurity (BCMHL, 2004).

Personal health behaviors play an important role in service needs (Gelberg et al., 2000). Diet, exercise habits, self-care habits, and substance use can have powerful influences on health status (Compton, Daumit, & Druss, 2006). Even if health habits are not poor, increased morbidity and mortality associated with serious mental illness can be traced, in part, to second-generation antipsychotic medications currently used to treat this condition. Studies have linked weight gain, dyslipidemia, diabetes, insulin resistance, and metabolic syndromes to these medications (Gianfrancesco, Grogg, Mahmoud, Wang, & Nasrallah, 2002; Hippisley-Cox, Vinogradova, Coupland, & Parker, 2007; Kreyenbuhl, 1999). Clients may be reluctant to seek out medical care due to concerns that they will be judged or blamed by their physicians for their self-care habits, motivational deficits, and low self-esteem (Dickerson et al., 2006). Moreover, clients who have difficulties in these domains are particularly likely to have difficulty adhering to treatment regimes or following a physician’s instructions.

Stigma has a pervasive influence on the receipt of health care among those with serious mental illness. Stigma refers to imputed personal characteristics that identify persons as being undesirably different from normal, and may result in
negative self-attributions as well as devaluation by others (Link & Phelan, 2001). When the stigma is mental illness, negative attitudes can lead to avoidance and discrimination on the grounds of perceived unacceptability or inferiority. The consequences of stigma can include decreased life opportunities, loss of independent functioning, and decreased use of physical health services among people living with serious mental illness (BCMHL, 2004). Moreover, recognizing oneself as a member of the devalued group can have negative effects on one’s self-concept (Link, 1987; Link & Phelan, 2001; Scheff, 1994) and lead to fear of discrimination and feelings of shame. Physical health providers are not immune to stigmatizing attitudes and behaviors toward individuals with serious mental illness (Goldberg et al., 2007). These attitudes may be rooted in the fear of unpredictable behavior and concern with regard to an individual’s noncompliance with treatment. Some primary care providers report concerns that people with serious mental illness may become bizarre, agitated, disorganized, or even violent in their waiting rooms (BCMHL, 2004). These negative attitudes can cause individuals living with serious mental illness to receive poor quality of care from the physical health community (Goldberg et al., 2007).

System bifurcation is the separation of physical and mental health services, which poses a serious issue for those with chronic mental and physical health issues. At a system level, at least four types of separation between mental and physical health care may exacerbate the problems for persons with serious mental illness:

1. geographic, or lack of colocated medical and mental health services;
2. financial, including but not limited to separate funding streams for medical and mental health services;
3. organizational, or difficulty in sharing information and expertise across these systems; and
4. cultural, or provider focus on particular symptoms or disorders rather than on the persons with those problems (Druss & Newcomer, 2007).

Bifurcation discourages people with a mental illness from accessing and utilizing services (Lieberman & Coburn, 1986). Current insurance policies reinforce this bifurcation because neither Medicare nor Medicaid pays for two services on the same visit. The Los Angeles County Department of Health Services has suggested that the cost of treating a person with serious mental illness can be ten times that of treating a client without mental illness in a public health clinic because clinics are paid a flat fee regardless of case complexity. This provides little incentive for doctors or clinics to treat those with serious mental illness. Mental health professionals are unable to provide health services, as physical health care is beyond their scope of practice or training and is not reimbursed by mental health funding streams (Brown, 1998). Hence, even colocated services require multiple visits and pose structural barriers to adequate care, and in addition to the fiscal divide, the separation of the professional cultures of physical and mental
health systems can cause mutual mistrust and rivalry (BCMHL, 2004). Differences between physical and mental health care provision can also exist in terms of information storage and sharing, software compatibility, privacy rules, and professional standards.

This understanding of the multifaceted challenges of integrating health and mental health care for the population with serious mental illness led to the development of the Bridge peer health navigator intervention.

**The Bridge: A Peer Health Navigator Intervention**

The Bridge health navigator intervention was developed using a collaborative approach including the members of the research team, service providers, and peers. The intervention was based on the model, presented above, of the barriers that lead to problematic health access, utilization, and outcomes for people living with serious mental illness. The model addresses system bifurcation and practitioner issues, and is designed to assist clients regardless of their symptom severity or functional level. The use of peer intervention can help ameliorate stigma for clients, as peer experiences with mental illness may provide a common ground to build rapport, an essential component of this type of intervention. The Bridge intervention moderates the impact of the factors that impede both service utilization and health outcomes by strengthening the enabling factors and ameliorating the suppressing factors. The four components of the intervention are assessment and planning, coordinated linkages, consumer education, and cognitive-behavioral strategies. A central goal of the Bridge is to give clients the skills and experience necessary to self-manage their health care activities to the greatest degree possible after the intervention ends.

**Assessing and Planning**

In order to plan what assistance is needed, the navigator takes the client through a thorough assessment of his or her health status, current use of health services, and experience with accessing and using health services, as well as barriers encountered. This process results in a collaborative health navigation plan, which includes the client’s health care and wellness goals (Mueser et al., 2006). A step-by-step strategy is then developed to guide the goal-directed activity and to provide a basis for monitoring progress. This activity increases clients’ awareness of their health care needs and their history of health care service use, which increases their motivation to participate in navigation and self-management strategies.

**Coordinated Linkages**

Based on an integrated care linkage model (BCMHL, 2004), coordinated linkages consist of several activities that assist clients as they navigate the health care system, including helping them make appointments, communicate with a range of
medical care providers, and ensure follow-up care; handling pharmacy and specialty care issues; and ensuring adherence to medical treatment plans. This model was drawn partly from patient navigation interventions developed for people with cancer and people with HIV (Battaglia et al., 2007; Bradford et al., 2007; Darnell, 2007; Dohan & Schrag, 2005; Jeste et al., 1996; Steinberg et al., 2006). Peer navigator experiences, with both their mental illness and their navigation of physical health and mental health services, make them uniquely sensitive to and aware of challenges their peers face. The method is also based on the principles of Assertive Community Treatment (Stein & Test, 1980; Test et al., 1991), in that an in vivo approach to linkage and training activities is stressed. Compared to models that predominantly use a classroom training approach, (e.g., Goldberg et al., 2013), the Bridge features an in vivo approach that develops self-management skills in real-world health care settings. The in vivo approach is important because these real-world health care settings are ideal for teaching and learning self-management skills that are sustainable.

Consumer Education

The third intervention component is consumer education, which is based on principles of patient education (Prohaska & Lorig, 2000). Patient education is theoretically rooted in the health belief model, in which an individual’s response to illness is rooted in his or her beliefs about health and health care. Hence, providing knowledge to alter health beliefs can lead to better subjective perceptions of health and better decisions about illness and its management (Goldman & Quinn, 1988; Prohaska & Lorig, 2000). For the current intervention, the consumer education component includes education about the health care system, how to partner with medical providers, treatment compliance, self-advocacy, appropriate interaction skills, and health and wellness issues (such as regular health care, diet, and exercise), as well as education about health benefits and entitlements.

Cognitive-Behavioral Strategies

The fourth intervention component is the use of cognitive-behavioral strategies to support behavior change and maintenance with regard to health care utilization, and is based on cognitive-behavioral and social learning theory (Dobson & Hamilton, 2002). Central to the intervention is a method for guiding the behavioral work, which is expressed explicitly and succinctly as for them, with them, by them. Using behavioral strategies of modeling, role playing, coaching, and fading, peer navigators enhance client skill development, using a systematic process that entails gradually shifting navigation activities to the client (fading) with the aim of maximizing the client’s management of his or her health care to the greatest extent possible.

As an example, making a medical appointment by phone can be challenging. At first, the navigator makes the appointment with the client watching and lis-
tending on speaker phone (for them, or modeling). The next time, the client makes the call with the navigator present as a coach, or as the receptionist in a role play (with them, or coaching). Finally, the navigator fades and lets the client make the phone call independently (by them) while continuing to act as a reinforcer, supporter, or collaborative problem solver if complications arise. Although the authors prefer in vivo coaching and learning, role playing can also be done if clients have sufficient skill. These strategies are complemented by user-friendly self-instructional and self-help cognitive-behavioral strategy guides for the peer navigator. This training method is used for all skill building aspects of the intervention and becomes the foundation for self-management.

In addition to these four components, the intervention also addresses screening and engagement, intervention target points, the intervention timeline, and outcomes.

Screening and Client Engagement

The Bridge intervention is based on appropriate screening and engagement. The authors have developed a six-item screening tool that targets current health problems and health service use. The tool is designed so that an inclusionary response on any one of the six items indicates the need for health navigation. The screen can be administered in a self-report or interview format (in person or by phone). It has been used by health navigators, by case managers, and by staff as part of agency intake forms. Once a positive screen occurs, the navigator meets with the client (ideally in person) and uses an engagement script that details the navigator intervention, the roles of the navigator and the client, the activities that will occur, and the timeline. One agency has used orientation groups to screen and engage clients.

Intervention Target Points

In practice, there are eight challenge points, identified as critical junctures by prior research and focus groups, at which peer navigators may intervene to facilitate successful health care utilization. Figure 2 presents these points for intervention as well as the navigator role at each point. As can be seen, they range from client awareness of health care needs, through resource location, to follow-up care.

Intervention Timeline

The Bridge is implemented in two phases. Phase one is characterized by frequent in-person contact between the peer health navigator and the client. This is an intensive four-month phase during which the navigator engages and helps the client complete an initial assessment, collaborates with the client to develop health and wellness goals and create a navigation plan, works with the client toward
Figure 2  Bridge Health Navigator Intervention

Consumer challenge points to successful health care outcomes

1. Work with service coordinators and mental health providers to assess consumer need for navigation.
2. Conduct health care service screening with consumers.
3. Help with insurance benefits as necessary.

1. Conduct health and wellness assessments with consumers.
2. Work with consumers to set health and wellness goals and the means to achieve those goals.
3. Provide health education tailored to consumer's goals.

1. Find providers and/or health clinics.
2. Develop relationships with providers and clinics.
3. Find insurance and/or benefits information.

1. Assist with making appointments (role play and in vivo).
2. Coach consumer in making appointments.

1. Provide appointment reminders.
2. Assist with and coach regarding transportation needs.

1. Help with provider forms.
2. Model interactions with medical personnel (role play and in vivo).
3. Coach interactions with staff and patients (in vivo).
4. Act as stigma buffer.

1. Assist with treatment compliance, treatment plan, follow-up or specialty care, and prescriptions.
achieving the goals, helps the client navigate through the health care system, and provides active health education and skill building to shape and reinforce positive behavior and move the client toward more independence. An in vivo navigation approach is preferred for modeling and coaching, although this depends on client preference and skill. This means that navigators routinely accompany clients on doctor, pharmacy, and lab visits in order to build their competence and independence, and to help with the transition to self-management.

Phase two is a two-month step-down phase in which clients’ health activities become increasingly more independent. In phase two, the health navigator connects with the client via phone or in person once a week or as needed to check on his or her progress; help troubleshoot emerging health-care-related issues; and provide support for the client to facilitate progress toward established goals, revise goals, or set new goals. The length of phase two depends on the needs of the client as some clients require step-down support for longer than others.

Although a timetable has been offered for the intervention, it is a general guideline and subject to variation based on the intensity of client need. The authors have found that individualization of both phases is critical, as clients progress at different rates in learning the skills for autonomous health navigation and self-management.

Outcomes

Outcomes targeted by the Bridge intervention have been classified as proximal or distal. Proximal health outcomes include increased use of ambulatory and outpatient care, decreased usage of emergency room and urgent care health services, improved health status, increased health care self-efficacy, greater satisfaction with health care, and higher health-related quality of life. Distal outcomes include better general life satisfaction, improved functional outcomes, and higher self-esteem.

Feasibility Test of the Bridge

Clinic Sites

The Bridge peer health navigator intervention was implemented at two outpatient mental health clinics in Los Angeles. Both sites are part of a large contract provider called Pacific Clinics that serves 3,500 clients annually and has large numbers of clients in need of assistance with coordinating health care services. The sites were selected because of their willingness and capacity to participate in implementing this pilot intervention. The clients were enrolled in full-service partnerships that targeted the most functionally impaired and highest users of mental health services, those with histories of homelessness, or those most in need of engagement in intensive mental health services. The intervention featured low caseloads (20:1) and was based on an Assertive Community Treatment approach (Gilmer, Stefancic, Manning, Ettner, & Tsemberis, 2010).
Peer Navigator Qualifications

Because the peer navigator is a crucial component of this intervention, members of the research team and service providers reviewed the qualifications required to be a successful navigator. Several local agencies offer a comprehensive peer mental health worker training program that combines ten weeks of classroom instruction with six weeks of intensive internship at a mental health agency. It was agreed that peer health navigators should participate in an official training program to learn the skills necessary for working in a mental health clinic setting. Other mutually approved qualifications for a peer navigator were good communication skills, flexibility, ability to work well in a variety of settings, capacity to develop rapport with peers, and comfort in communicating with mental health and medical professionals.

Navigator Training

Peer health navigator training was initially conducted at one of the participating sites. The navigator was placed at the site and worked with different teams. He spent two months shadowing clinic nurses, team leaders, and service providers to get a sense of the operation, workflow, and ethos of the clinic. After this two-month period, the navigator began working with clients to pilot test the assessment tools and began testing the navigator model. During this time, he received in-depth training with the research team about the health navigator model and the theory supporting it, background on understanding the scope of the problem, setting boundaries, avoiding dual relationships, setting up a supervision plan, dealing with stress on the job, and becoming integrated into the staff culture of the clinic.

Manual Development

Using information gathered from the needs assessment combined with the stage model of manual development (Carroll & Nuro, 2002), the authors have manualized the Bridge intervention. The stage model proposes three different stages for manual development (Carroll & Nuro, 2002; Carroll & Rounsaville, 2008). The advantage of this model is that it leads to a manual that is well tested in a variety of settings and with different populations. A drawback is the length of time needed to move from bench to clinic, which contributes to a disconnect between research and practice that needs to be addressed (Dobson & Hamilton, 2002; Moras, 2002). Thus, the authors used a modified version of the stage model, which emphasizes working closely and continuously with practitioners to ensure that the manual is applicable to the real world and to allow it to be disseminated more quickly (Moras, 2002). To do this, a manual development working group was created, including members of the research team, clinic staff, and the health navigator. This working group method allowed the authors to receive continuous feedback on the manual contents, and resulted in ongoing refinement and improved utility in a real-world setting.
The manual includes detailed instructions, scripts, and forms for screening, engagement, assessment, goal setting, planning for medical visits (physician, lab, or pharmacy), post-visit review, and monitoring progress. It also explicates the for them, with them, by them training method and offers client education material.

**Fidelity and Monitoring**

The authors have developed protocols for establishing and maintaining fidelity to the Bridge, as well as strategies for monitoring the extent of implementation at an agency. The fidelity tool consists of rating the navigator’s competence in accomplishing the critical elements of the intervention. This evaluation is based on in vivo observation, verbal case descriptions, and record review. The extent of implementation is monitored via a software program that requires the navigator to list both client contacts and contacts on behalf of the client, as well as the location, length, and topic of each contact.

**Results from Pilot Data**

Preliminary data on the feasibility, outcomes, and implementation of the Bridge have been obtained from seven clients who received the intervention during this early developmental phase. Concerning outcomes, data have been received from four clients who completed baseline and follow-up assessments after six months of the intervention. These four clients showed positive changes in the total number of current health problems (baseline \(M = 6.5, SD = 0.7\); follow-up \(M = 4.0, SD = 0.8\); Mann-Whitney \(z = -2.4, p < .03\)) and an increase in the number of health screenings in the previous six months (baseline \(M = 1.75, SD = 1.00\), follow-up \(M = 4.25, SD = 1.9\); Mann-Whitney \(z = 2.1, p < .06\)). The number of medical hospital admissions began low and stayed low, as did the number of emergency room visits for physical problems. There was a decline in the number of outpatient visits to primary care providers in the previous six months (baseline \(M = 6.5, SD = 4.6\); follow-up \(M = 3.3, SD = 3.4\)) that was not statistically significant. According to the navigator, this reduction was due to better follow-up care procedures that reduced visits for the same health problems over time. Based on these highly preliminary data, there is some suggestion that the intervention could be related to improved health status and more appropriate use of outpatient services.

Pilot data on the quantity of client contacts were also analyzed. Of the seven fully engaged clients, the average contacts made with or on their behalf were 2.3 per week, with a range of 1.4 to 2.8 contacts per week. Eighty percent of the contacts were with the client, and 20 percent were with another person on behalf of the client. These contacts spread somewhat evenly between in-person (60%) and phone contacts (40%). Based on field notes kept by the navigator, the duration of the contacts ranged from under five minutes to over four hours. The navigator reported that he moved to the step-down phase with all clients, during which the contacts decreased by over 75 percent as clients transitioned to more self-management of their health care.
The range of health-related issues among pilot clients was enormous. Six of seven clients had not had any routine care from a primary care physician in several years. Most identified their psychiatrist as their primary medical care doctor. Only one individual had had an eye exam in the previous five years. Only one client had a regular dentist. One individual had ongoing foot lesions that resulted in repeated hospitalizations due to inadequate treatment follow-up. Most clients used the hospital as their routine health care provider. The navigator secured health benefits for one undocumented Latino and accompanied most clients on doctor visits. During these visits issues ranged from communication problems with nurses and doctors to difficulties handling the waiting room and exam room experiences. There were also frequent problems with treatment compliance that resulted in ongoing and increasingly serious health problems and overuse of emergency services. One individual was too anxious to take public transportation to the medical clinic, so the navigator first accompanied her and sat next to her on the bus; on subsequent trips he sat several seats behind her, and then he drove behind the bus as she rode alone, all to encourage independence through reduced navigator presence.

Best Practice for Work with Persons with Severe Mental Illness

There were many navigator contacts to ensure follow-up care and treatment compliance. Pharmacy interactions and managing multiple medications were found to be common difficulties for clients. Pharmacy personnel were pleased to work with the navigator as they reported challenges in working with individuals with serious mental illness. Health care physicians and nurses were generally welcoming to the navigator and most often allowed him into the examining room. Once they had worked with the navigator, physicians actively engaged his services and felt he improved the effectiveness of the medical visit.

Because the work can be stressful, supervision and support of the peer navigator is a crucial aspect of this intervention. To address this, the peer health navigator met weekly, or as needed, with the project manager to debrief, talk about what was working and not working, and discuss any troubling situations. The health navigator also participated in weekly team meetings to discuss navigation-related issues with the project team.

Agency Integration

The authors have found that working closely with mental health agency staff is critical to adequately integrating peer health navigation into the agency clinical model. For example, staff suggested that the peer health navigator be included in team meetings, and that goals and treatment plans be shared (considering compliance issues) so that coordination and integration could be achieved. Other forms of inclusion and communication have developed over time that facilitate the integration of health navigator services. If mental health agencies have not previously integrated peers into their approach, professional staff are required to take on additional work.
Next Steps

The purpose of this article was to describe the development, implementation, and feasibility of a peer health navigator intervention called the Bridge. The authors developed the Bridge peer health navigator intervention for many reasons. Several service models have been advocated for dealing with the physical health of those with serious mental illnesses, yet models of care that integrate care through co-situation of services require multiple structural and financial changes to the existing health care system. A care linkage model, such as the Bridge, improves collaboration between independent health and mental health providers, and can be used in the context of many existing financing and service structure arrangements. The use of peer health navigators is an emerging best practice for addressing health needs of people living with serious mental illness. There is accumulating evidence that peer-based services can improve outcomes in health and in other aspects of recovery among people living with serious mental illness, and are also cost effective (Rosenick & Rosenheck, 2008).

The results from the feasibility work reported here are encouraging. The authors are currently analyzing data from a small randomized trial \((n = 24)\) of the Bridge intervention, and are refining the treatment manual. They are also working on an agency implementation and sustainability protocol, which will be manualized to deal with both administrative and intervention integration issues at the staff level, and they have developed protocols for training new peer health navigators. Nonpeer paraprofessionals and professionals have recently been trained in the Bridge intervention, but the use of professionals has proven difficult due to cost considerations. Finally, the Bridge intervention was developed using a population with serious mental illness that was very functionally impaired and living in an urban area. As the effectiveness of this intervention is investigated further, it will be important to consider the degree to which the intensity of the intervention and its in vivo approach are required for other less challenged populations and settings.

References


Implementation of evidence-based practices (EBPs) and emerging best practices is an important component of providing effective mental health services. If EBPs are not implemented properly, their efficacy is reduced. Implementation efforts are in vain if programs cannot sustain the EBP after initial startup or after achieving fidelity. Therefore, sustainability is an essential element of implementation. This article details a conceptual framework for the development of the EBP Sustainability Index, a scale being piloted at the University of Kansas that helps measure whether programs are at risk of discontinuing an implemented EBP. Forewarning about possible discontinuance allows consultants, staff, and administrators to develop plans to ensure sustainability rather than de-adoption.

**Key words:** evidence-based practice; framework; implementation; sustainability

Sustainability is essential to adequate implementation of evidence-based practices (EBPs) in mental health. If EBPs are not sustained, the positive outcomes associated with the mental health practice will likely diminish. Implementation science refers to the study of elements influencing the distribution, implementation, and sustainability of EBPs. Fortunately, significant progress has been made in developing frameworks and strategies for adequate implementation of an EBP at start-up (McHugo et al., 2007). However, knowledge about how to sustain an EBP over time is lacking. Issues such as financial backing, supervisory and staffing problems, organizational structure, and incompatible policies all influence whether an EBP remains in place.

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To address this issue, the University of Kansas School of Social Welfare is piloting an EBP Sustainability Index (SI). The SI is used to determine whether an EBP is at risk of being discontinued. This article will describe the background context leading to development of the SI, an operational definition of sustainability, and the conceptual underpinnings of each assessment item.

**Background**

Effective implementation and maintenance of mental health EBPs are primary concerns for social work and many other human service fields (Aarons, Hurlburt, & Horwitz, 2011; Bellamy, Bledsoe, & Traube, 2006; Farkas, Gagne, Anthony, & Chamberlin, 2005; Gotham, 2004; McHugh & Barlow, 2010; McNeese & Thyer, 2008; Proctor et al., 2009). Empirical support undergirds evidence-based and emerging best practices to verify that they provide effective outcomes and services. However, there is also increasing evidence that service improvement is as much influenced by the process of implementation as it is by the practices that are chosen for implementation (Drake, Bond, & Essock, 2009). Conducting training is not sufficient to teach the complex skills that are often required for EBPs (Fixsen, Blase, Naoom, & Wallace, 2009). This finding has been replicated in many fields including health care (Grol & Grimshaw, 1999) and mental health (Drake et al., 2009), and in systematic reviews of implementation efforts across a variety of fields (Naoom, Blase, Friedman, & Wallace, 2005). Since the 1970s, research has indicated that the *train and hope* approach to implementation (i.e., conducting a training and then hoping that skills are retained or that a model is implemented; Stokes & Baer, 1977) is not effective.

In the human services domain, EBP implementation is generally considered to be more complex than in other domains "because they [the EBPs] are delivered through the actions of individuals and organizations, which exist within complex, multi-layered social contexts" (Aarons et al., 2011, p. 5). Therefore, multicomponent implementation strategies are needed to address the challenges of effective implementation (Fixsen et al., 2009; Glisson & Schoenwald, 2005; Grimshaw et al., 2001; Grol & Grimshaw, 1999).

Over the last twelve years, the University of Kansas School of Social Welfare has collaborated with Dartmouth College and other organizations throughout the United States to complete the largest study to date of the implementation of EBPs for individuals with psychiatric disabilities (Bond, Drake, McHugo, Rapp, & Whitley, 2009; Drake et al., 2001; McHugo et al., 2007; Torrey et al., 2001; Torrey, Lynde, & Gorman, 2005). In this project, termed the National EBP Project, researchers developed and then tested a comprehensive EBP implementation approach that included the following features (Torrey, Finnerty, Evans, & Wyzik, 2003):

- consultation to the state mental health authority
- consultation to community mental health center administrators
- a kickoff presentation to the provider organization
- provision of the EBP tool kit to the organization
Fidelity monitoring included two steps:

1. fidelity assessments based on daylong site visits by a pair of independent fidelity assessors who, guided by fidelity scale criteria, conduct structured interviews, observe team meetings and interventions, and review medical records; and
2. fidelity review meetings with agency leaders in which assessors give oral and written feedback on quality of implementation (Bond et al., 2009).

In Kansas, five mental health evidence-based or emerging best practices were implemented using this National EBP Project implementation approach:

2. Integrated Dual Disorder Treatment (Wieder & Kruszynski, 2007)
3. Strengths Model Case Management (Rapp & Goscha, 2011)
4. Family Pyscho-education (Polio, North, & Osborne, 2002)
5. Supported Education (Manthey, 2011; Mowbray et al., 2005)

Additional efforts are underway to use the national EBP implementation approach for additional practices: supported housing (Grant & Westhues, 2010), illness management and recovery (Salyers, Rollins, McGuire, & Gearhart, 2009), and CommonGround shared decision making (Deegan, 2007).

At the national level, this implementation model was tested at more than fifty sites across eight states. At each site at least one EBP was implemented. Each site was followed for a two-year period using a combination of qualitative and quantitative methodologies. Outcomes were assessed at baseline and at six-month intervals for two years using EBP fidelity scales and other measures. None of the sites attained high fidelity at baseline; however, most sites increased fidelity scores during the first year and attained high fidelity scores at or within two years (McHugo et al., 2007).

Data from the national EBP implementation project have led to more than fifty articles published in peer-reviewed journals. These include articles that report on the overall implementation outcomes across EBPs (Bond et al., 2009; McHugo et al., 2007; Rapp, Goscha, & Carlson, 2010) and on findings for specific models. These articles reveal a wide range of accomplishments including successful implementation and the associated results that each EBP was intended to achieve.

Although the overall findings from the National EBP Project have been encouraging, some broad studies noted barriers to successful implementation and sustainability (e.g., Rapp et al., 2008; Rapp et al., 2009). In addition, many
researchers studying individual EBPs noted potential sustainability concerns that were consistent across practices. For instance, it was found that outcome tracking and clear feedback loops were important for the implementation of Integrated Dual Disorder Treatment (Chandler, 2009), Supported Employment (Marshall, Rapp, Becker, & Bond, 2008), and Assertive Community Treatment (Bjorklund, Monroe-DeVita, Reed, Toulon, & Morse, 2009).

In addition, in one relevant mixed methods study, both qualitative and quantitative findings suggested that there were at least five warning signs that may indicate that an organization may de-adopt a practice (Massatti, Sweeney, Panzano, & Roth, 2008):

1. lack of financial resources
2. indications that external agents do not support the organization’s implementation effort
3. problems related to attracting and retaining qualified staff
4. indications that the practice does not fit well either with employee knowledge and skills or with the organization’s mission and treatment philosophy
5. reports that the practice is neither easy to implement nor seen as a permanent part of the organization’s regular service offerings

Similar themes were repeated and recognized by other researchers (e.g., Blasinsky, Goldman, & Unutzer, 2006; Jansen, Van Den Bosch, & Volberda, 2005; Rapp et al., 2010). Although there are scales such as the General Organizational Index (Substance Abuse and Mental Health Services Administration, 2002) that help assess an organization’s readiness for EBP implementation, there are no scales yet developed that focus on a program’s ability to sustain a practice.

In order to address these sustainability issues, researchers at the University of Kansas School of Social Welfare created the EBP Sustainability Index. Items on the sustainability index were developed by assessing national EBP studies, reviewing the implementation and sustainability literature, and receiving feedback from consultants and trainers who helped implement EBPs in the field.

**Operationalizing Sustainability**

In order to clearly demarcate the difference between implementation and sustainability, it is important to clearly define the two terms. Wiltsey-Stirman (2010) conducted a systematic review of sustainability that included forty studies across many fields of human service. It was found that definitions diverged greatly and many researchers did not operationalize sustainability at all. Implementation is defined as helping a program meet the standards for high fidelity to an EBP model. Implementation usually lasts between one and two years, and typically involves structural changes, staff skill development, and modification of organizational processes to support the practice. Most programs will need significant on-site consultation and training during the first year of implementation. Consultation and
training activities tend to taper off during the second year of implementation, and are often focused on refining staff skills and solidifying supports within the agency to continue the practice.

On the other hand, sustainability can be interpreted as maintaining an EBP over a long period of time. The sustainability stage occurs after initial consultation/technical assistance has ended or has been greatly curtailed. A program will usually enter a sustainability stage two years after initial start-up or after practice fidelity has been achieved. After the second year, fidelity assessments decrease from once every six months to once per year and consultation is truncated. It is at this time that sustainability begins. Appropriate and effective implementation of an EBP can be time consuming and expensive.

Because social work and other human service arenas often face problems with sustainability that can lead to de-adoption (Massatti et al., 2008), it is important to identify methods to sustain EBPs that do not require the intensive efforts that occur during initial implementation. It is hoped that, through noninvasive assessment, the SI will provide specific information that can lead to cost-effective and targeted interventions that enable EBPs to be sustained.

**Conceptual Underpinnings of the Sustainability Index**

There are two primary ways in which a program may fail to sustain an EBP: EBP drift and EBP de-adoption. Even when the initial implementation is successful, programs have a tendency to drift away from EBP fidelity (e.g., Bond, 1991). Drifting away from model fidelity is not simply discontinuing an EBP; it is a natural phenomenon that occurs when programs slowly start to change their practice over time. The reasons for drift can be diverse; examples include cost cutting; changes in policy from local, state, or federal lawmakers; or reverting to previous ways of conducting service. Examples of EBPs that have experienced drift and its associated reduction in effectiveness include Assertive Community Treatment (ACT) and the Individual Placement and Support (IPS) employment model. In both cases, when the program moved away from high fidelity, the model became less effective (e.g., Bond, 1991; Bond, 2007; Godfrey, 2010; Rosenheck & Mares, 2007; Schneider et al., 2009).

Programmatic drift can be assessed by conducting annual fidelity assessments of the EBP that has been implemented. Corrective actions can then be taken to ensure adherence to high-quality standards. Unfortunately, some organizations do not continue conducting fidelity reviews (annually or otherwise) after the initial period of implementation. In addition, most fidelity scales assess for internal programmatic structures/skills specific to an EBP rather than for external influences that may result in EBP discontinuance. It is anticipated that the sustainability index will provide insight into both EBP drift and EBP discontinuation. It assesses six broad domains: finances, staffing, policies, structure, quality improvement, supervision, and staff skills. Table 1 describes some of the underlying conceptual underpinnings for the SI.
# Best Practices in Mental Health

## Table 1: Conceptual Underpinnings of the SI and Corresponding Assessment

<table>
<thead>
<tr>
<th>Item</th>
<th>Conceptual underpinning</th>
<th>SI assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finances</td>
<td>A primary reason for difficulty in sustaining is inadequate sources of funding.</td>
<td>The SI assesses whether there have been perceived or real financial concerns within the past six months and whether the agency can continue to support the EBP. The SI also assesses whether there is confidence that the organization will be able to find resources to continue the EBP in the future despite financial constraints.</td>
</tr>
<tr>
<td>Staffing</td>
<td>Adequate staffing is an essential component of continued EBP maintenance (e.g., Massatti et al., 2008; Wieder &amp; Kruszynski, 2007). Significant turnover at key agency positions can be detrimental to an EBP (Aaron, Sommerfeld, Hecht, Silovský, &amp; Chaffin, 2009).</td>
<td>The SI assesses whether there has been frontline staff or supervisory or upper-level administration turnover in the past six months.</td>
</tr>
<tr>
<td>Policies</td>
<td>Several studies have noted the importance of state and federal level policies and support, as well as more local cross-system coordination policies in order to achieve adequate implementation (Isett et al., 2007; Magnabosco, 2006; Van de Ven &amp; Chu, 2000). Internal policies are also important influences on EBP maintenance.</td>
<td>The SI assesses both internal and external policy changes over the past six months. In the case of internal policies, the SI attempts to determine if conflicting policies exist or have been newly developed. Any changes in policy that may conflict with service delivery through the EBP are assessed.</td>
</tr>
<tr>
<td>Structure</td>
<td>Many studies have indicated that ensuring compatible organizational structures is imperative to ensure that a practice is adequately sustained (Isett et al., 2007; Magnabosco, 2006), including mechanisms to keep the EBP on the organizational agenda and having an EBP champion.</td>
<td>The SI documents several aspects of organizational structure. Any organizational or structural changes that conflict with the EBP are assessed. The SI also assesses whether there are mechanisms in place to keep the EBP on the organizational agenda and well rooted in the organization's infrastructure. The SI also determines if there is an EBP champion on staff with specific responsibility to support the continuation of the EBP.</td>
</tr>
<tr>
<td>Quality improvement</td>
<td>There is a wealth of evidence indicating that continued quality improvement through training, consultation/technical assistance, feedback loops, and fidelity reviews is important when implementing and sustaining an EBP (e.g., Bond, McHugo, Becker, Rapp, &amp; Whitley, 2008; Marshall et al., 2008; Marty, Rapp, McHugo, &amp; Whitley, 2008).</td>
<td>The SI assesses whether outcomes are tracked, shared, distributed, and discussed with staff members. The SI also assesses whether specific actions are taken to improve client outcomes. Annual fidelity reviews provide a means for tracking an EBP's quality. The SI assesses whether or not recommendations from the last fidelity review have been enacted.</td>
</tr>
<tr>
<td>Supervision</td>
<td>There is increasing recognition in the EBP literature of the role of the supervisor in increasing the ability for practitioners to master the skills needed within a particular EBP (Becker et al., 2007; Blakely &amp; Dzidzic, 2007; Fisen et al., 2009; Marshall et al., 2008). There is also evidence that, when supervisors and other leaders systematically endorse and support an EBP, it is likely to sustain longer (e.g., Solberg et al., 2000).</td>
<td>The SI assesses three important supervisory behaviors that relate to improving practice skills of an EBP. This includes reviewing EBP tools completed by individual staff, providing field mentoring, and giving staff specific feedback on use of EBP tools and methods. The SI assesses not only the occurrence of these behaviors but their frequency of occurrence.</td>
</tr>
<tr>
<td>Staff skills</td>
<td>Even when organizational structures are in place to support an EBP, the specific skills associated with an EBP may still be lacking (e.g., Henschel, Kolko, Baumann, &amp; Davis, 2010; Moser, Deluca, Bond, &amp; Rollins, 2004). Additional support needs to be in place to ensure that supervisors, frontline staff, and others in the organization have the skills to implement the practice (Rapp et al., 2009).</td>
<td>The SI assesses what percentage of staff members are proficient using EBP skills, tools, and/or methods (based on the EBP's fidelity criteria). It assesses whether team members have received training related to the EBP over the past six months. It also assesses the amount of consultation received by the team or supervisors in the past six months.</td>
</tr>
</tbody>
</table>
Sustaining Best Practices

Although the SI has not yet been validated, it is currently being piloted at sites implementing evidence-based practices and emerging best practices in Kansas. It will continue to be revised based on piloting research. The SI is assessed by the EBP consultant and trainer during regularly scheduled fidelity reviews using information obtained from organizational leadership, supervisors, frontline staff, and written agency materials. It is considered an additional body of information, along with the fidelity review report, for organization leadership to use when making decisions related to the EBP.

Conceptually the SI was developed to assess concerns that have already been discovered and articulated in the peer-reviewed implementation science literature. It is meant to be nonintrusive and to point to targeted interventions that help to warn of potential drift and/or discontinuation. It can be considered a preventative measure that helps create cost-effective plans for maintaining innovative and evidence-based practices to improve the lives of the people social workers serve. If these practices are not sustained, individuals may be harmed when helpful services are discontinued midstream. Ensuring the continuation of beneficial EBPs helps safeguard continuity of services and the outcomes that individuals both want and need.

References


## Appendix A: EBP Sustainability Index

1. **Finances**

<table>
<thead>
<tr>
<th>1a) There have been perceived or real financial concerns over the agency being able to support the EBP within the last six months</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>High level of financial concerns reported within the past six months about being able to support EBP</td>
<td>[1 \text{a)} ]</td>
<td>[1 \text{b)} ]</td>
<td>[2 \text{a)} ]</td>
<td>[2 \text{b)} ]</td>
<td>[3 \text{a)} ]</td>
</tr>
<tr>
<td>Moderate level of financial concerns within the past six months about being able to support EBP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low level of financial concerns within the last six months about being able to support EBP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No reported financial concerns within the last six months about being able to support EBP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1b) Confidence that agency will find resources to continue the EBP or agency has made commitment to continue despite financial constraints

<table>
<thead>
<tr>
<th>Agency does not believe they will be able to find resources to continue the EBP</th>
<th>Agency has high level of concern about finding resources to continue the EBP</th>
<th>Agency has moderate concerns about finding resources to continue the EBP</th>
<th>Agency has moderate confidence they will find resources to continue the EBP or commitment to continue in spite of financial constraints or there are no financial concerns</th>
<th>Agency is highly confident they will find resources to continue the EBP or agency has made commitment to continue in spite of financial constraints or there are no financial concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–24% staff retention</td>
<td>25–49% staff retention</td>
<td>50–74% staff retention</td>
<td>75–99% staff retention</td>
<td>100% staff retention</td>
</tr>
<tr>
<td>Supervisor position is currently vacant</td>
<td>Supervisor position has not been filled, but interviews are currently being conducted</td>
<td>Supervisor has been hired, but has not yet received training in EBP</td>
<td>Supervisor is receiving training in EBP, but has not yet achieved proficiency in EBP</td>
<td>No turnover at supervisor level or new supervisor has achieved proficiency in EBP</td>
</tr>
</tbody>
</table>
There has been turnover at key upper administration positions in the past six months

<table>
<thead>
<tr>
<th>2c)</th>
<th>There has been turnover at the upper administration level and there are high levels of concern that it may compromise the sustainability of the EBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Policies</td>
<td>Agency policies have been developed or retained that will keep the agency from achieving high fidelity</td>
</tr>
<tr>
<td>3a)</td>
<td>There have been internal agency policies developed in the past six months that conflict with EBP or conflicting internal policies remain in place</td>
</tr>
<tr>
<td>3b)</td>
<td>There have been external policies developed within the past six months that conflict with the EBP or existing policies remain in place that impede the EBP</td>
</tr>
<tr>
<td>4. Structure</td>
<td>Structural barriers exist that will keep the agency from achieving high fidelity</td>
</tr>
</tbody>
</table>

There have been turnover at key upper administration positions and there are moderate levels of concern it may compromise the sustainability of the EBP

<table>
<thead>
<tr>
<th>2c)</th>
<th>There has been turnover at the upper administration level, but it is unclear as to the impact on the EBP</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Policies</td>
<td>Agency policies have been developed or retained that will challenge the agency’s efforts to achieve high fidelity</td>
</tr>
<tr>
<td>3a)</td>
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<tr>
<td>3b)</td>
<td>There have been external policies developed within the past six months that conflict with the EBP or existing policies remain in place that impede the EBP</td>
</tr>
<tr>
<td>4. Structure</td>
<td>Structural barriers exist that present a moderate level of challenge to the agency’s efforts to achieve high fidelity</td>
</tr>
</tbody>
</table>

There has been turnover at key upper administration positions, but there are low levels of concern that the EBP will be compromised because of this

<table>
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<tr>
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<tr>
<td>3b)</td>
<td>There have been external policies developed within the past six months that conflict with the EBP or existing policies remain in place that impede the EBP</td>
</tr>
<tr>
<td>4. Structure</td>
<td>Structural barriers exist that present a low level of challenge to the agency’s efforts to achieve high fidelity</td>
</tr>
</tbody>
</table>

No turnover at key upper administration positions or position has been filled and it is clear the EBP will not be compromised because of this

<table>
<thead>
<tr>
<th>2c)</th>
<th>No turnover at key upper administration positions or position has been filled and it is clear the EBP will not be compromised because of this</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Policies</td>
<td>No conflicting policies have been developed or conflicting policies have been removed</td>
</tr>
<tr>
<td>3a)</td>
<td>No conflicting policies have been developed in the past six months that conflict with EBP or conflicting internal policies remain in place</td>
</tr>
<tr>
<td>3b)</td>
<td>No conflicting policies have been developed or previously conflicting policies have been removed or revised to support the EBP</td>
</tr>
<tr>
<td>4. Structure</td>
<td>No structural barriers exist to impede high fidelity</td>
</tr>
</tbody>
</table>
Appendix A—(Continued)

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4b) Mechanism in place to keep EBP on the organizational agenda</strong></td>
<td>No strategies exist to keep EBP on organizational agenda</td>
<td>At least one strategy is in place to keep EBP on organizational agenda</td>
<td>At least two strategies are in place to keep EBP on organizational agenda</td>
<td>At least three strategies are in place to keep EBP on organizational agenda</td>
</tr>
<tr>
<td><strong>4c) Presence of EBP champion with specific functions to support continuation of EBP</strong></td>
<td>No EBP champion present</td>
<td>EBP champion present, but with no power to influence decisions made related to EBP sustainability</td>
<td>EBP champion present, but only indirect influence on decisions made related to EBP sustainability</td>
<td>EBP champion present with moderate power to influence key decisions related to EBP sustainability</td>
</tr>
<tr>
<td><strong>5. Quality Improvement</strong></td>
<td><strong>5a) Recommendations from last fidelity review that have been enacted</strong></td>
<td>None of the recommendations have been enacted</td>
<td>A few of the recommendations have been enacted, but critical recommendations have not yet been addressed</td>
<td>Most of the recommendations have been enacted with discussion occurring on the others</td>
</tr>
<tr>
<td></td>
<td><strong>5b) Frequency that specific actions are taken to improve client outcomes from reviewing data with staff</strong></td>
<td>Never</td>
<td>Actions are taken occasionally, but not in any systematic manner</td>
<td></td>
</tr>
<tr>
<td><strong>6. Supervisor</strong></td>
<td><strong>6a) Frequency that supervisor reviews tools with staff</strong></td>
<td>Supervisor spends less than 30 minutes per week reviewing EBP tools</td>
<td>Supervisor spends 30–59 minutes per week reviewing EBP tools</td>
<td>Supervisor spends 60–89 minutes per week reviewing EBP tools</td>
</tr>
<tr>
<td>6b) Frequency that supervisor gives feedback to staff</td>
<td>6c) Frequency that field mentoring occurs</td>
<td>7. Staff Skills</td>
<td></td>
<td></td>
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<td>----------------------------------------------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Supervisor spends less than 30 minutes per week giving specific feedback on skills/tools related to the EBP</td>
<td>Supervisor spends less than 30 minutes per week providing field mentoring</td>
<td>25% or less of staff are proficient with EBP tools and methods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisor spends 30–59 minutes per week giving specific feedback on skills/tools related to the EBP</td>
<td>Supervisor spends 30–59 minutes per week providing field mentoring</td>
<td>26–50% of staff are proficient with EBP tools and methods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisor spends 60–89 minutes per week giving specific feedback on skills/tools related to the EBP</td>
<td>Supervisor spends 60–89 minutes per week providing field mentoring</td>
<td>51–74% of staff are proficient with EBP tools and methods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisor spends 90–119 minutes per week giving specific feedback on skills/tools related to the EBP</td>
<td>Supervisor spends 90–119 minutes per week providing field mentoring</td>
<td>75–99% of staff are proficient with EBP tools and methods</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supervisor spends at least two hours per week giving specific feedback on skills/tools related to the EBP</td>
<td>Supervisor spends at least two hours per week providing field mentoring</td>
<td>100% of staff are proficient with EBP tools and methods</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The profession of social work has codified the use of research-informed or evidence-based practice as both a basic educational competency and an expectation of ethical practice. Although there is debate as to what constitutes evidence, manualized treatments that have undergone rigorous empirical scrutiny are considered by many to be the gold standard for evidence-based or empirically supported treatment (EST). Disseminating ESTs into the real world requires that clinicians learn and use the treatment manual. Although the challenges of implementing ESTs across systems or agencies are well documented, little is known about the experiences of individual clinicians who attempt to learn and implement a manualized treatment in a community mental health setting. The purpose of this article is to discuss one clinician’s experience using a treatment manual, to identify benefits and challenges, and to provide recommendations to practitioners and treatment development researchers about developing and using treatment manuals in the real world.

Key words: adolescent; community mental health; evidence-based practice; family therapy; treatment manual

The profession of social work has codified the use of research-informed/evidence-based practice as both a basic educational competency (Council on Social Work Education, 2008) and an expectation of ethical practice (National Association of Social Workers, 2008). Although there is debate as to what constitutes evidence (see Drisko & Grady, 2012) and what factors contribute to the best client outcomes (cf. Addis & Cardemil, 2005; Duncan & Miller, 2005), treatments that have been validated in well-controlled studies in which participants are randomly assigned to different treatment conditions have long been considered the gold
standard for clinical practice. These treatments are referred to as empirically supported treatments (ESTs), evidence-based therapies (EBTs), empirically validated therapies (EVTs), or less precisely, evidence-based practices (EBPs).

In order for an intervention to be empirically tested, the developers must specify the conceptual, procedural, and structural boundaries of a treatment (i.e., what is being done and why it is being done; Addis & Cardemil, 2005; Henggeler & Schoenwald, 2002). This information is contained in a treatment manual. The treatment manual has been a basic component of psychotherapy research since the 1960s (Duncan, Nicol, & Ager, 2004). Since the 1990s, it has been either celebrated as a tool for disseminating ESTs and improving clinical practice or vilified as imposing an impersonal and impractical treatment that does not reflect real-world problems (Godley, White, Diamond, Passetti, & Titus, 2001). Although treatment manuals are only one component of an EST, the most common form of learning about and becoming trained in ESTs is by reading these manuals (Herschell, Kolko, Baumann, Abigail, & Davis, 2010).

The challenges of widespread implementation of manualized treatments are well documented (Chorpita, Becker, & Daleiden, 2007; Godley et al., 2001; LeCroy, 2008). Some of the challenges are philosophical, such as clinician distrust of treatments developed in the lab, or beliefs that client outcomes have less to do with specific interventions and more to do with therapist effects and the therapeutic relationship. Other challenges are pragmatic, such as the quality and detail of the dissemination plan, time required to be certified in an EST, and cost effectiveness of implementing an EST compared to that of continuing to provide treatment-as-usual. Even when those barriers have been overcome, implementation challenges arise at every level of the service delivery system:

Variables influencing treatment fidelity, including the quality of the treatment manual, can be conceptualized from a social ecological framework. Practitioners are embedded in quality assurance systems (e.g., manuals, supervision), which are embedded within organizations, which are embedded within community contexts. Variables at each level of analysis influence practitioner behavior and, in many cases, can undermine the intents of the best conceived treatment manual. (Henggeler & Schoenwald, 2002, p. 419)

The Institute of Medicine (2001) estimated that, once a treatment has an evidence base, it takes seventeen years for the intervention to make its way into clinical practice. Recognizing the need to reduce the time and increase the number of mental health providers trained in ESTs, public health authorities have recently allocated over $2 billion dollars to improve dissemination efforts and to develop best practices for disseminating ESTs (see McHugh & Barlow, 2010, for a review).

**Therapist Experiences Using Treatment Manuals**

Although the challenges of deploying an EST system-wide are daunting, the challenges faced by a sole practitioner attempting to use a treatment manual in a
community mental health setting may be greater. If a practitioner follows professional standards (Council on Social Work Education, 2008; National Association of Social Workers, 2008) and, through a process of determining the best intervention for the client (e.g., Parrish & Rubin, 2011), decides that the best treatment is an EST, he or she will be faced with a number of questions (Chorpita et al., 2007):

- Can the manual be accessed, and if so, are there financial or other barriers to obtaining it? Northey and Hodgson (2008) reported that the costs of implementing manualized treatment for couples or families ranged from approximately $1,000 for Emotion-Focused Couple Therapy to $30,000 for multisystemic therapy (MST). If an agency is able to implement MST for $30,000 and save $100,000 on more intensive services, then it is good value for the money. For the independent practitioner, however, purchasing a $40 to $60 treatment manual is an easy and affordable way of becoming familiar with a treatment.

- Will knowledge, skills, time, and agency support be available to implement the EST? If, for example, the clinician finds that Dialectical Behavior Therapy (DBT) offers the most empirical support for a self-harming client who has a diagnosis of borderline personality disorder, he or she will soon find that DBT is actually a multicomponent treatment that assumes an integrated system of care among a team of providers. Alternately, if a clinician is in an outpatient setting, and a manual has been developed for group therapy in an inpatient or partial hospitalization program, there may be challenges in establishing groups, finding space, or overcoming other structural factors that would complicate the implementation of the manual.

- Even if the practitioner is able to find a manual intended for the client and agency setting, how will he or she determine whether the client’s outcomes result from the treatment prescribed in the manual or from other factors? Even in the most rigorous randomized clinical trial in which therapists are trained to fidelity and receive regular supervision, not all clients improve. Furthermore, there are those who argue that treatment outcomes have more to do with nonspecific or common factors than with the techniques and procedure included in the treatment manual (Duncan & Miller, 2005).

In addition to the practical challenges of finding and implementing a treatment manual, the clinician will discover that very little has been written by practitioners with regard to their experience in implementing a manual-based treatment (Stegall & Nangle, 2005). Although there is a large body of literature that discusses dissemination of ESTs, only one study has evaluated clinicians’ experiences in implementing such a treatment (Godley et al., 2001).

Godley et al. (2001) examined interviews with nineteen therapists and case managers who used manualized approaches to treatment of cannabis abuse during a large randomized field experiment. The authors concluded that nearly all of these therapists and case managers had positive experiences with the treatment
manuals. They reported that manuals were easy to use, provided useful structure, helped the clinician to focus treatment, and allowed for creativity and flexibility. Challenges to working with the manualized treatment include managing behavioral problems not addressed in the manuals, adapting complex or inappropriately advanced material, establishing guidelines for working with parents even when they are not included in the manual, and maintaining children’s focus when teaching specific skills. The clinicians discussed the importance of clinical supervision in implementing the manual-guided treatments. The authors concluded that, despite clinicians’ positive experience with the treatment, clinician feedback is essential in improving the value and utility of the treatment manual.

To contribute to the knowledge base about implementing manualized treatments, this article will describe the experience of a clinical social worker attempting to implement Problem-Solving Communication Training (PSCT; Robin, Bedway, & Gilroy, 1994) in a community mental health agency. This article is neither a clinical case study, which seeks to provide an exemplar for treating a problem, nor an evaluation of a specific treatment, which seeks to demonstrate the effectiveness of one approach relative to another. This article is more similar to autoethnography (Sparkes, 2000), in that it provides a context—the specifics of the case and the focus of the treatment—in order to focus on the first author’s (JBS’s) experience using a treatment manual in a community setting. By critically evaluating this experience, the authors hope to help clinicians make more informed decisions about whether to obtain and use treatment manuals and to help treatment development researchers produce manuals that are more user friendly.

Intervention

Summary of Problem-Solving Communication Training

Problem-Solving Communication Training was one of ten treatment manuals included in LeCroy’s (1994) Handbook of Child and Adolescent Treatment Manuals. The treatment manual provided a theoretical overview, defined key terms, and recommended training procedures (including supervision). Robin, Bedway, and Gilroy (1994) described PSCT as a highly directive, twelve-session, behavioral family systems intervention intended to resolve parent-adolescent conflict. The treatment manual focused on teaching problem-solving skills, improving communication skills, and addressing cognitive distortions.

Problem-Solving Communication Training is a four-phase treatment: engagement (sessions 1 through 3), skill building (sessions 4 through 7), conflict resolution (sessions 8 through 10), and termination (sessions 11 and 12). For each session, the authors specified the goals, provided details about how to achieve the goals, included sample dialogue and suggested wording for introducing concepts or topics, recommended or included goal-specific measures or homework, and gave instructions on how to end the session. Additionally, the authors provided a context for using the treatment manual. They advised the reader that not all families would need all of the modules included in the manual, and that the manual
could not cover every variation of parent-adolescent conflict. They also specified that the manual was intended for trained clinicians who were familiar with family systems work. Consistent with these requirements, the clinician who implemented PSCT is a licensed clinical social worker who has extensive experience working with families. As a bonus, he taught the PSCT treatment manual discussed in this article in a master’s-level clinical social work practice course.

The following is a brief summary of the presenting problem and description of the treatment, identifying the session goals and what worked and did not work, followed by a discussion of the clinician’s experience in each session. The case study concludes with detailed recommendations for clinicians, treatment development researchers, and educators. The personal pronoun I has been used throughout the case study to indicate that only one author (JBS) delivered the treatment.

Presenting Problem

Ms. D. self-referred to the agency to request services for herself and her fourteen-year-old son Craig. During the intake phone call, Ms. D described her family life as “one big argument.” She reported feeling very stressed, noting that she was a single parent, held two part-time minimum-wage jobs, and was responsible for taking care of her ailing mother. She stated that she blamed herself for her son’s problems: “If I could spend more time with him he wouldn’t be so angry.” Ms. D described her son as bright and a good student. He had few friends and participated in no extracurricular activities, “unless you think of video games as extracurricular.” She stated that he had no psychiatric diagnoses, was not on medications, and had no known medical problems. She reported that Craig refused to comply with parental requests. She stated, “He tells me what to do—it is almost like he wants to be the one in charge.”

Decision to Use the PSCT Treatment Manual

Ms. D described parent-child conflict and problems with the family structure (i.e., son taking on an executive role). I was familiar with PSCT because I had taught it in a graduate-level clinical practice social work course as a way of demonstrating problem-solving skills and providing students with an example of a treatment manual. The problems that the mother described were consistent with the treatment manual. I was eager to apply an empirically supported treatment and put into practice something that I had used with my students.

Overview of Treatment

I met with the family for a total of thirteen sessions. The first five sessions addressed the material in the treatment manual and resulted in some reduction in conflict and some improvement in problem-solving skills. Between the fifth and sixth session, Ms. D’s mother died. The focus of treatment shifted to individual bereavement counseling for Ms. D for the six weeks following her mother’s death. We ended services with two family sessions.
Implementing the Treatment Manual in the Real World

Phase I. Engagement, Session 1: Build Rapport

**PSCT goals.** PSCT goals for this session are to establish rapport with the family; identify deficits in problem-solving skills, cognitive distortions, and family structure problems; establish a shared view of the family problem; and motivate the family to participate in treatment. Materials needed are the Review of Negative Communication handout and the Unreasonable Beliefs handout (included in the manual), as well as a self-report questionnaire for homework (not included in the manual).

**What worked.** The treatment manual provided helpful sample dialogue to demonstrate what a model discussion about problem-solving skills looked like, and gave questions to assess for deficits in communication skills. Because the manual had a specific theoretical foundation, including questions that were theoretically consistent was very helpful. The family had difficulty identifying skill deficits, and the manual helped to navigate the clinical waters.

**What did not work.** The biggest challenges in session 1 were maintaining rapport while trying to follow the details of the manual, adopting the expert tone, and using the required handouts.

The need to follow the manual made it hard to establish rapport with the family. The manual provided a specific order for addressing issues and specific language with which to describe the process to the family. Although I had taught this treatment manual in clinical practice elective, I was not familiar enough with it to conduct the session without referring to the text. This had the paradoxical effect of interfering with the first goal: to establish rapport with the family.

Taking the expert role was counter to my training as a solution-focused therapist. Throughout the treatment, I was expected to define problems, have the family choose from preselected options, and frame both the problem (deficits in communication skills and distorted cognitions) and the solution. In order to be faithful to the model, I found myself questioning my clinical choices and fighting against the tone and direction of the manual.

Handouts were difficult to use. Neither handout was included in session 1; instead, they were located in sessions 5 and 8, respectively. The handouts were not intended to be stand-alone, ready-to-use documents. In order for the handouts to be useful, I could either retype them or try to enlarge them on the copy machine; neither was a practical option given my time constraints and unreliable copy machine. The third handout, the homework assignment, was not included in the manual.

Phase I. Engagement, Session 2: Individual/Family Assessment

**PSCT goals.** Goals for this session are to establish rapport with the adolescent, assess psychopathology and cognitive functioning, obtain a developmental history, and assess marital interaction and family impact of adolescent-parent conflict.
What worked. The treatment manual provided an outline of topics to include in the adolescent and adult interview and gave examples of rapport-building statements. Because the content was not prescriptive, I was able to use my existing clinical skills to establish rapport with the adolescent and parent.

What did not work. The biggest challenges in session 2 were assessing for psychopathology and cognitive functioning, having individual sessions with the child and parent, and collecting self-report measures from session 1. Although one of the goals of the session was assessing for psychopathology and cognitive functioning, the manual stated that “a detailed discussion of such assessment goes beyond this manual. Consult Mash and Terdal (1988)” (p. 100). The expectation that I would have the time or resources to access this book was unreasonable. The manual did not clarify whether the treatment should be modified if clients present with deficits in cognitive functioning or psychopathology.

The individual session with Ms. D conflicted with two agency policies:

1. I could not have an individual session with Ms. D because agency policy prohibited children from being left alone in the waiting room.
2. We agreed to have the session over the phone, which violated agency policy because I could not bill for therapy by phone.

The treatment manual advised that, if the parent/child did not complete the self-report measures in between sessions, he or she should complete them while sitting in the waiting room. However, because the self-report measure was not included in the manual, and because the child was not allowed to be in the waiting room alone, I never collected this information. This omission proved to be problematic in later sessions.

Phase 1. Engagement, Session 3: Contracting and Preparation for Change

PSCT goals. Goals for this session are to establish treatment goals, determine the extent to which the family needs training in each component, and inform the family of the therapist’s conceptualization of their problems. Materials needed consist of the Agreement for Action (AfA) form (included in the manual).

What worked. The AfA specified the targets of treatment. In theory, this made it easier to maintain treatment fidelity.

What did not work. The biggest challenges in session 3 were using the AfA and taking an expert stance with the family. There were three problems with the AfA:

1. It was not formatted for copying. The hour I spent retyping the form helped me to become familiar with it, but was time that could have been spent catching up on paperwork or having a billable session.
2. The AfA was a one-size-fits-all list of problems that served as the PSCT treatment plan. I could not use it as a treatment plan, however, because our agency required personalized treatment plans that include information not on the AfA.

3. The family disliked the AfA because some of the action steps did not apply to them.

In part because of my solution-focused training, I was uncomfortable framing the problem for the family and telling them what to do differently. It is likely that the family’s distrust of the AfA was in part a reflection of my own discomfort.

Phase II. Skill Building, Session 4: Problem-Solving Training

**PSCT goals.** Goals for this session are to present and teach problem solving, teach the family to use a problem-solving worksheet, and give the family a successful experience resolving a meaningful disagreement. Materials are limited to the problem-solving worksheet (included).

**What worked.** The child and parent responded well to the structure of the problem-solving model. I was familiar with problem solving, so the content in the manual was value-added to my existing skills. The worksheet was appropriate for copying.

**What did not work.** The problem-solving session was supposed to revolve around an issue that the family identified on the session 1 Issues Checklist. Because I never assigned it, we spent ten minutes figuring out which issue we were going to talk about. This limited the amount of time we had to problem solve. The family was compliant, but the problem solving seemed sterile and academic. I was concerned that there was something else going on that we were not talking about, but did not feel comfortable deviating from the manual.

Phase II. Skill Building, Session 5: Communication Training

**PSCT goals.** The goals for this session are to increase family members’ awareness of their negative communication habits and their effect on the parent-child relationship, identify the most important negative communication habit, teach positive communication, and assign positive communication homework. Materials needed consisted of the Negative Communication handout (provided).

**What worked.** The manual included a handout suitable for copying. The family was very engaged with the content. They found the discussion of their negative communication to be very entertaining. I had a great deal of experience addressing problematic communication, so I was very comfortable with the clinical territory.
What did not work. In this session, there was nothing that did not work. We were able to address all of the content in the session, and it was favorably received by the family. I finally felt that I had found my groove with the treatment manual and the family was responding appropriately.

Intrusions of the Real World into the Manualized Treatment

Sessions 6 through 12

Between sessions 5 and 6, Ms. D’s mother died. After the funeral, Ms. D reported that her son had been rude and disrespectful. She reported feeling angry and frustrated with his behavior and her lack of control as a parent, as well as overwhelming sadness. To their credit, the authors of PSCT provided instruction on how clinicians could address crises. They defined crisis as a breakdown in communication skills, failure to implement an agreed-upon solution, or a situation in which emotions were running high.

This intrusion of the real world seemed to be a perfect opportunity to apply the PSCT intervention, especially because Ms. D was finally willing to hold her son accountable for his actions. However, it quickly became apparent that teaching problem-solving skills was far less important than recognizing Ms. D’s need to process the loss of her mother. Therefore the focus of treatment changed from parent-child conflict to bereavement. After six weeks of individual treatment, Ms. D started working with a grief and loss counselor. Although I was willing to continue to work with the family, they were no longer interested in services. The parent-child conflict that had been the focus of treatment had disappeared. Consequently, the PSCT intervention was no longer appropriate.

Session 13. Termination

PSCT goals. The goals for this session are to review treatment goals and progress and prepare the family for continued application of skills.

What worked. The termination plan described in the manual was very similar to my usual termination session. Ms. D and Craig shared a laugh when we reviewed their conflicts from the beginning of services. Although they were now few and far between, the changes appeared to be more a function of shifting family dynamics than the skills we addressed in the PSCT intervention.

What did not work. The manual recommends spacing sessions two to three weeks apart. Although the family was willing to do this, the agency’s requirement that I fill all available slots with clients meant that I could not leave a two-week gap between termination sessions.

Best Practice with Manualized Interventions

One of the most basic questions that drive practitioners and intervention researchers is how clinicians can best help their clients. A compelling answer is to
implement ESTs, which are grounded in theory; have well-defined targets of treatment; have withstood scrutiny from clients, clinicians, the developer, and other researchers; and have demonstrated efficacy in reducing symptoms and improving functioning. Some have argued that it is unethical not to deliver an EST if one exists that matches a client’s presenting problem(s) (Myers & Thyer, 1997). However, for the clinician whose experience was described in this article, the anticipated benefit of the EST was outweighed by the numerous challenges he faced in implementing the treatment manual, including incompatibility with agency structure and billing requirements, unreasonable expectations of the clinician’s knowledge and skills, and incomplete documentation. Although some of the agency-level challenges would certainly be addressed in a system-wide adoption of an EST (McHugh & Barlow, 2010), for independent clinicians, these challenges make successful implementation of a treatment manual in a community setting unrealistic.

Benefits of Using the Treatment Manual

If independent clinicians are not likely to deliver manualized treatments to fidelity, is there a benefit to using a treatment manual in the community? LeCroy (2008) argues that clinicians should have the access and opportunity to use treatment manuals because, unlike research articles that report on the treatment that has been found to be more effective, treatment manuals actually describe what the treatment looks like and how to deliver it. This information increases the likelihood that clinicians will be able to deliver well-conceptualized and effective treatments to clients who present with a variety of issues (LeCroy, 2008). Consistent with LeCroy and the findings by Godley et al. (2001), the treatment manual provided the clinician with a useful structure, helped to focus his treatment, and helped him to learn new treatment techniques. As a community clinician responsible for treating clients who presented with a variety of psychosocial problems, many of whom bounced from crisis to crisis, the clinician was accustomed to taking an eclectic approach that revolved around putting out fires. Although the structure of the manual was challenging, it provided a welcome stability and focus to treatment. The PSCT manual provided a theoretically grounded framework for conceptualizing problems, and helped the clinician to think about what his treatment would look like over the course of many weeks, rather than just one at a time. Because he wanted to provide the best services for his clients, following the manual provided reassurance that he was doing right by them. The inclusion of dialogue and examples to demonstrate the process of teaching communication skills helped him to learn a technique that was applicable beyond the treatment manual. The inclusion of a section on crisis management was excellent. Treatment manuals that ignore crises fail to acknowledge the experience of most clients in clinical settings.

Challenges of Using the Treatment Manual

As noted earlier, the failure to transfer ESTs from the lab to the field is well documented. This is problematic from a public health perspective because ESTs are seen as a primary component of high-quality health care. Public health agencies
in the United States recently allocated $2 billion to improve dissemination efforts (McHugh & Barlow, 2010). In part this is because the most widely used model of disseminating ESTs to community mental health clinicians—reading treatment manuals—has been found insufficient to produce sustained, long-lasting change in practitioner knowledge and skill (Herschell et al., 2010). Because manualized treatments are so difficult to learn and deliver with fidelity, some have argued that sole practitioners should not attempt to use treatment manuals (Henggeler & Schoenwald, 2002). Despite the benefits described above, the challenges associated with implementing the PSCT significantly outweighed the benefits. The remainder of the article will list these challenges and provide recommendations for clinicians and treatment development researchers.

**Lack of Access**

It is nearly impossible to find out which manualized treatments exist and which manuals are available; if more than one manual addresses the same problem, there is no system to determine which manual is most appropriate. The clinician happened to be familiar with PSCT because he had used it as a teaching tool in an MSW program. Without that very rare circumstance, he would never have thought to use a treatment manual.

The following recommendations may help to address the challenges that have been identified:

1. Clinicians should become familiar with compendia of treatment manuals (e.g., Barlow, 2007; LeCroy, 2008) so that they can connect client need with existing ESTs.
2. Research articles should list the name of the treatment manual used in the clinical trial; they should also indicate whether the manual is available, and under what circumstances it can be obtained. This will make it easier for clinicians to be informed consumers. Social media and social networking can be used to provide resources for clinicians. Examples include podcasts to provide a “treatment manual on tape” experience; a YouTube channel with short videos demonstrating key components of the treatment; and a Facebook or Google+ site where clinicians using the manual can find a support community, get updates on treatment-specific publications and information on background readings, and learn about upcoming trainings and other resources. Existing dissemination networks, such as the National Center for Child Traumatic Stress (2007), should be made available to solo community practitioners, rather than systematically excluding them. Self-directed training, workshops, consultation, and supervision have all been found to improve a therapist’s knowledge of and skill with an EST beyond what can be acquired simply by reading a treatment manual (Herschell et al., 2010).

**Incompatibility with Agency Structure**

The treatment manual used in the case study did not conform to agency regulations regarding intake, assessment, or treatment plan development. It assumed
that the decision to use the manual had been made prior to meeting the family. Although this fits clinical research protocols in which therapists treat only clients who meet criteria specified by the manual, it does not work in community practice, in which clients are assigned to clinicians who have an opening, rather than to clinicians who provide a specific type of treatment. It will never be certain that a treatment manual will fit a new client’s problems.

Following are some suggestions for dealing with these issues:

1. Clinicians should determine whether the treatment manual is compatible with agency requirements for populations served (e.g., adults, parents, or children), modalities (e.g., individual, couple, family, and group therapy), and diagnoses or psychosocial problems (e.g., is the clinician allowed to provide services to someone who does not meet criteria for a diagnosis?). The clinician found that the PSCT treatment manual used in the case study targeted family problems, not an individual diagnosis. If his agency had mandated that treatment follow specific diagnoses rather than problem areas (e.g., problem-solving and communication training), he would not have been able to use PSCT.

2. Treatment manuals should spell out in simple language indications and contraindications for using the treatment with specific psychosocial problems and/or diagnoses, populations, and practice settings. In clinical trials, inclusion and exclusion criteria are managed by the research team, not the clinical team. This information needs to be included in the treatment manual. Information about successful implementation in a community setting (i.e., effectiveness trial) should also be included. It should be assumed that the treatment manual will be used after intake and assessment, rather than from the beginning of treatment. Although clinical trials are set up so that only clients who meet criteria for the treatment are consented into the study, decisions in community practice are made after clients enter the system. The treatment manual should specify whether it is appropriate for use in agencies or organizations whose staff does not have mental health training (e.g., child welfare systems), or in agencies that use a recovery model or are consumer-led programs (Hardiman, Theriot, & Hodges, 2005).

Financial Unatenability

The treatment manual did not consider agency expectations for clinician billable hours. Not only did the clinician have to provide services that were not billable, but he could not bill for the hours per week he spent reviewing the manual, making handouts, and preparing for the session. Because he still had to meet his billable hours, the time spent on the manual was essentially an in-kind donation to the agency. This is an unrealistic expectation.

Following are recommendations for dealing with this challenge:

1. Clinicians should determine if the treatment is billable before committing to the treatment. It is unlikely that the treatment manual can be implemented
with less than one hour of preparation for each hour in session with the client. This could include discussing the manual with a supervisor or a peer supervision group, reviewing the material in advance of the session, and identifying what worked and what did not work after the session.

2. It is important to identify the type of funding streams that will reimburse for the EST. Treatment manuals should clearly identify CPT codes that correspond to sessions. If there are no known funding streams, or if the treatment does not correspond to existing CPT codes, the manual should clarify that. When face-to-face billable hours are the primary way that agencies evaluate clinician productivity, unbilled time required by most manuals (e.g., intensive clinical supervision, fidelity checks through video review and adherence checklists, and clinician training to competency) is likely to be discouraged by the agency, or resisted by the clinician unless he or she can be credited with the time needed to learn the manual (Henggeler & Schoenwald, 2002).

Unreasonable Expectations of Clinician’s Skills and Knowledge

The treatment manual assumed that the clinician had knowledge of key components of therapy, or that the clinician would be able to get additional instruction, training, and/or supervision. A widely cited barrier to implementation of ESTs in community practice is the need for extensive training (Henggeler & Schoenwald, 2002). In the PSCT manual used in the case study, the authors wrote that the treatment was intended for a clinician or advanced student (Robin et al., 1994, p. 92). Two pages later, however, they stated that the procedure outlined in the manual required prior experience with families and adolescents, and that supervision is needed for effective implementation. Even if the clinician had had the time and money to hire an additional supervisor (which he did not), it may have been unrealistic to assume that he would find one with experience in PSCT.

Following are recommendations for dealing with these issues:

1. Clinicians should review the manual to determine whether their clinical training and theoretical orientation/practice framework will enable them to effectively deliver the intervention. Matching a treatment manual to the clinician’s practice framework will increase the clinician’s belief in the value of the manual and his or her confidence in the treatment provided. Although the majority of clinicians identify as eclectic, it is likely that most have one or two dominant practice perspectives (e.g., they focus on affect, behaviors, or cognitions; emphasize the roots of a problem, either interpersonal or cognitive, or emphasize current functioning). The clinician in this article found himself fighting against the expectation that the PSCT therapist would take an expert role, formulate the problem for the family, and prescribe solutions. He learned that unlearning how to be solution focused was just as hard as learning PSCT (Palmer-Olson, 2007, cited in Sandberg & Knestel, 2011).
2. Treatment manuals should be designed with the intention that most clinicians will have the skills necessary to use them. A multimillion-dollar study that produces a detailed theoretically grounded and empirically tested treatment approach is only as valuable as a graduate student’s term paper if neither can be used by clinicians. Although the standard protocol in treatment development is to fully evaluate the treatment in a lab setting prior to testing it in the community, Chorpita (2002) and others have argued for including community feedback as early as possible in the process. Once the treatment protocol has been drafted and used in a pilot study, feedback from community-based clinicians should be obtained as quickly as possible, using either individuals or focus groups. Questions that should be included are

- Are treatment goals consistent with agency mandate?
- Does the order of the treatment make sense?
- Is there sufficient explanation?
- How could the treatment manual be made more user friendly?

If the feedback is that the manual is too structured, too complicated, or too confusing, treatment development researchers owe it to clinicians and their clients to make it easier to use. There could be two treatment manuals, one for research studies and one for the community, both of which emphasize the same active ingredients. If the researcher starts with the assumption that community practitioners will not have access to time or funds to become certified in a treatment, or to treatment-certified supervisors, then they can incorporate into the community version of the manual more clinical instruction, including case studies, sample dialogue, and examples of what not to do. The manual would then serve as both a guide and a resource, rather than a prescription for treatment (Escudero, 2012).

Incomplete Documentation

The treatment manual used in the case study did not include handouts that were suitable for copying, and in one case did not include an essential homework assignment. The best devised dissemination plan (e.g., McHugh & Barlow, 2010) will fail if the treatment manual is written with the researcher, not the clinician, in mind. (Note that the second edition of LeCroy’s (2008) Handbook of Evidence-Based Treatment Manuals for Children and Adolescents includes more reproducible handouts and is much more user friendly than the first edition, where the clinician found the PSCT treatment manual.) Suggestions for improvement include the following:

1. Clinicians should review the treatment manual for missing components (e.g., assigned homework) or handouts that are not suitable for copying.
2. Researchers should ensure that all required materials are in ready-to-use formats (e.g., clean handouts that can be photocopied) or should include reference to a website where clinicians can download the documents. Exist-
ing psychometric properties include detailed scoring and interpretation instructions for outcome measures. If the outcome measures are not included in the manual, there should be an explanation (e.g., the materials are restricted by copyright or need to be purchased separately). Researchers should know that most independent practitioners will not have the time or resources to obtain additional measures. If the treatment manual cannot include the measures used in the research, the authors should include proxy measures that enable clinicians to gather comparable and useful outcome data.

Conclusion

Although the treatment with Ms. D and her son was not a textbook example of successful manualized intervention, the experience of trying to implement the manual was clinically useful and shed light on some of the strengths and limitations of trying to implement a treatment manual in a community mental health setting. Until researchers develop manuals specifically for clinicians—and the systems within which they must provide services—these manuals will not be a conduit through which to disseminate ESTs. Clinicians who decide to use a treatment manual should know that, despite the popular notion that these manuals can be implemented off the shelf, all will have to be modified to fit client need and agency policies and procedures. Although modification will likely mean that the clinician is not delivering the treatment with fidelity, being trained to deliver the treatment with fidelity is unrealistic for most community clinicians.

Adopting and implementing a treatment manual is not the only way to answer the question of how a clinician can best help clients. However, if clinicians are made aware of the benefits and challenges associated with implementation and they are willing to provide feedback to the authors of the treatment manual, and if researchers are willing to make the needed modifications, then well-written and easily accessible treatment manuals can become a valuable tool in the effort to provide the best services possible to clients (LeCroy, 2008).

References


Book Reviews

**Character Formation and Identity in Adolescence: Clinical and Developmental Issues**
Randolph L. Lucente
Lyceum Books, Chicago, 2012
Reviewed by Jed Metzger

*Character Formation and Identity in Adolescence* provides an integrated approach to adolescent development and the various depth-oriented psychoanalytic psychotherapies. Scholarly and well organized, this book interweaves case vignettes with theoretical exploration across the adolescent developmental process. Lucente has an advanced understanding of adolescent development as well as Freudian psychologies of ego, object, and self.

The clarity and depth of this book make it an invaluable resource for practitioners providing depth-oriented psychoanalytic psychotherapy. Each chapter makes an important contribution. The book requires a comprehensive knowledge of development and classical treatment, and therefore will be most useful to either doctoral-level students or experienced practitioners. Additionally, although Lucente states that the text is offered to bridge classical psychoanalytic psychotherapy with postmodern approaches, this reviewer found that the theoretical and case illustration remained strongly structural.

Chapter 1 focuses on adolescent development and the clinical process. The material is presented from a classical perspective, and is detailed and well researched. The treatment approaches mirror the developmental thinking, with emphasis on insight-oriented intervention. The chapter is organized around

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identity formation, the development of an ego ideal, and character formation and concludes with an interesting discussion of intersubjectivity.

Chapter 2, “Narcissism, Character Formation, and Separation-individuation,” begins by framing these concerns against an ego psychological understanding, but quickly moves to introduce self psychology. The integration of the neurobiology of the adolescent developmental process is described, followed by a lengthy case presentation illustrating the aforementioned concepts and perspectives.

Chapter 3 takes on splitting, differentiation, and identity. Lucente uses object relations theory and ego psychology to frame the therapeutic and developmental issues. There is an interesting discussion on how transference unfolds, with a variety of perspectives offered. Lucente ultimately rejects the Freudian assessment of the transference, favoring a more ego mastery understanding.

Chapter 4 discusses affect regulation and the true self. Here the case and theoretical presentations are put forward from an intersubjective lens. As the chapter title attests, there is a strong application of British object relations theory. The final chapter presents evidence in support of the book’s approach. A wheel of awareness model is offered to build an evidence base for this form of clinical inquiry.

In sum, this is a well-researched and well-written book. It will be most useful for advanced practitioners or doctoral students who work from a classical model. Although, as mentioned earlier, the book does not seem to bridge into postmodern approaches, as Lucente suggests, it would be interesting to see whether a postmodern approach could in fact be integrated into the classical structural approaches.

Citizenship Social Work with Older People
Malcolm Payne
Lyceum Books, Chicago, 2012
208 pages (paperback), $36.95, ISBN 978-1-935871-08-8
Reviewed by Jason Dauenhauer

Malcolm Payne’s book *Citizenship Social Work with Older People* encourages readers to be mindful of the value and importance of aging adults in a global society. The author argues that elders are not afforded the same rights as younger people with regard to active participation and engagement in social relationships. This negative perspective toward aging is fostered by economic development theories in which elders are no longer seen as productive, contributing members of society. The author’s purpose for writing this book is to promote critical and creative social work skills related to older people in many parts of the world. To enhance the book’s utility, he has included links to a variety of supplemental Internet resources in addition to traditional peer-reviewed scholarly resources.

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The first chapter provides an overview of aging issues while grounding the reader in the author’s principles of citizenship social work—fostering social participation of all people and promoting societal responsibility for citizens. Readers are encouraged to examine the powerful effects of attitudes toward aging and how these attitudes translate into social policy and practices. This is reinforced by including numerous short case examples, contrasting the experiences of older adults who are the same chronological age, yet have significantly different life experiences, as well as exercises to promote reflection. Most importantly, the strengths and weaknesses of aging-related theory are described while keeping the reader focused on social work’s responsibility to recognize the balance of individual, cultural, and large-scale economic social factors that influence the behavior of older adults.

Chapter 2 describes the increasing trend of service integration for older adults that focuses on holistic social work practice to promote independence and dignity within and across service systems. Numerous case examples highlight methods of service integration and the role of social workers who promote age-proof individualized care coordination within communities and service systems. Social work students and seasoned practitioners alike will be reminded of the importance of their role as advocates and agents of change, helping elders to remain engaged as contributors to society and not relegated to what the author terms “health care and social care ghettos.” The author provides clear definitions of and distinctions between social care and social work within diverse settings. Many useful resources are provided as well as examples of different systems of service provision for older adults in various countries.

Chapter 3 focuses on social work skills with older people, providing a good overview of the social work assessment and intervention process and highlighting case scenarios that are common and relevant (e.g., grief/loss, grandparent care giving, sexual orientation, and falls). The following two chapters highlight critical social work practice and creativity. The author justifies the need for social work providers to think critically when engaging with elders, their families, and providers to assess needs and identify solutions. He encourages practitioners to avoid and/or and to move toward and/also—a very simple, but meaningful way to avoid limitations imposed by structured policies and practices. He also asserts the need for social workers to promote creative outlets for older adults in various settings and provides examples.

The latter portion of the book focuses on groups and macro-practice with older adults followed by aging-specific topics that relate to social exclusion. The final chapter emphasizes the inequalities faced by older adults with different life experiences, health issues, economic resources, and education. Importantly, the author connects these issues to ageism and the role of social work practitioners to advocate for social and economic justice and fairness with regard to the provision of services. Strategies for safeguarding vulnerable older adults (e.g., elders at risk of abuse) and special considerations for end-of-life and bereavement issues are included.
In summary, Citizenship Social Work with Older People provides current information and strategies for social workers who are increasingly engaged in service provision for older adults in many industrialized parts of the world, especially the European Union, the United Kingdom, and the United States. The central theme of citizenship social work, with a focus on aging, is grounded in the ethics of the social work.

This compendium can be used as a text for a social work practice course on aging, or as a supplemental text for a service-learning course. It reinforces many of the gero-competencies established by the Council on Social Work Education, and describes current Internet-based resources that provide a global perspective on social work and aging. Students will be inspired by the author’s passion for training a future generation of social workers who are critically and creatively mindful that older people have a right, and society has a responsibility, to keep this population meaningfully engaged within the community.

Advocacy Practice for Social Justice, 2nd Edition
Richard Hoefer
Lyceum Books, Chicago, 2012
256 pages (paperback), $39.95, ISBN 978-1-935871-07-1
Reviewed by Pamela Viggiani

The second edition of Advocacy Practice for Social Justice presents a strong case for including advocacy at all levels of social work practice. Hoefer provides a straightforward and easily readable guide to help students and professionals think about and incorporate advocacy into their practice. He reminds students and practitioners that social work has both a strong history and a current mandate to advocate for social justice. Hoefer grounds his argument for including advocacy in social work practice firmly in the profession’s value base and its ethics. He argues that, when social workers’ values are considered by policy makers, the result is “greater social justice across the country and perhaps even in the world” (p. 23).

This book takes the reader from an understanding of advocacy and social justice and its primacy in social work to a model of how to incorporate advocacy into everyday practice. Eight of the ten chapters lay out a logical model for social work advocacy. Chapter 1 presents Hoefer’s unified model for advocacy practice for comparison with the generalist social work model. His six-step model pairs nicely with the generalist model of engagement through follow-up.

Each step of Hoefer’s model is fully explicated in chapters 3 through 8. His thoughtful pairing of his advocacy model with the generalist model allows social workers to understand the model as part of good practice rather than as a specialized practice area.

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The remaining two chapters provide grounding for advocacy. Chapter 9 provides a basic argument for social workers to strive for social justice and to use advocacy to obtain that end. Chapter 10 offers a short overview of the history of social work’s advocacy efforts throughout the twentieth century and into the first decade of the twenty-first century, while calling for the continuation of advocacy in social work today. Hoefer reiterates that his book’s major thrust is to present “advocacy as a problem-solving practice technique with steps similar to other practice techniques” that “can and should be used in many situations and places . . . in dealing with client problems at micro-, mezzo-, and macrolevels” (p. 211).

Hoefer’s utilization of case study illustrates the application of his advocacy model. In the first chapter, for example, he takes a micro-level case and shows how the advocacy model would work to effectively relieve both the client’s short- and long-term problems by addressing clinical and social justice concerns. Hoefer also includes tables and graphics that compare, highlight important points, and simplify complex concepts. Although his discussion questions and exercises at the end of each chapter may be too basic for many, the annotated references at the end of each chapter will allow readers to broaden and deepen their knowledge of topics discussed in the chapters.

Overall, Advocacy Practice for Social Justice is a useful guide for social work practitioners and students. The straightforward and readable format is likely to attract readers and keep their attention. For an instructor, it is a useful text in that it views advocacy as a part of ethical social work at micro-, mezzo-, and macrolevels of practice and easily incorporates advocacy strategies across the practice curriculum. Hoefer furthers social work’s primary mission, to “enhance human well-being and help meet the basic human needs of all people, with particular attention to the needs and empowerment of people who are vulnerable, oppressed, and living in poverty” (Code of Ethics of the National Association of Social Workers, 1996, http://www.socialworkers.org/pubs/code/code.asp).
The purpose of this article is to provide reviews of some of the key websites on a topic germane to the current issue of Best Practices in Mental Health. Because a number of articles in this issue concern youth, sites on attention deficit hyperactivity disorders (ADHD) were selected. Sites will be organized by government, general, and membership organizations.

Government Websites

Centers for Disease Control and Prevention: http://www.cdc.gov/ncbddd/adhd/

The Centers for Disease Control and Prevention (CDC) website on ADHD is very user friendly, and will appeal to the general public. Pictures and icons make navigating the site very easy. With an apparent goal of educating the public about ADHD, this site provides research, data, and statistics, recommended articles, and avenues for accessing more information including conferences and workshops. This site provides a personal touch with stories from people living with ADHD.

Mayo Clinic: http://www.mayoclinic.com/health/adhd/D800275

The Mayo Clinic site on ADHD provides a basic but helpful overview of the disorder. It provides information on symptoms, causes, risk factors, complications, diagnosis, and treatment. Additionally, the site includes pages on lifestyle and home remedies and alternative treatments, which provide tips for managing symptoms outside of medication management. This site would be appropriate for those looking to gain a basic understanding of ADHD.

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Like the Mayo Clinic website, the National Institute of Mental Health (NIMH) ADHD site provides basic, easy-to-read information about ADHD; however, NIMH extends beyond symptom, diagnosis, and treatment to discuss co-occurring disorders, strategies for working with schools, and information about adult ADHD. Information from NIMH is also available in print, which makes it a useful tool for health and mental health providers, as well as schools and support centers.


This website outlines causes, risk factors, symptoms, and treatment for ADHD. It contains information helpful to both parents and practitioners, as well as initial steps for diagnosing ADHD in children. The Signs and Tests section outlines the criteria for diagnosing ADHD, which is particularly helpful because ADHD is often misdiagnosed or undiagnosed. The Treatment section addresses various treatment methodologies including medication and behavior therapy.

General Websites
Shire US Inc.: http://www.adhdandyou.com/

This easy-to-navigate website provides targeted information for individuals with ADHD, their parents/families, and professionals. Each section contains information relevant to a particular group, with a focus on managing the disorder. There is an extensive resource section with tools and information. The site is updated regularly with new information.

National Resource Center on AD/HD: http://www.help4adhd.org/

Funded by the CDC and sponsored by Children and Adults with Attention Deficit Disorder, this website offers information on the science behind ADHD, along with resources and support. Targeting individuals (or their families) with ADHD, this site covers topics from dealing with the educational, legal, and insurance systems to practical concerns regarding workplace issues and maintaining social relationships. The information is provided through a variety of methods including webinars, podcasts, and a live help line.

Membership Websites
Attention Deficit Disorder Association (ADDA): http://www.add.org/

The ADDA is a membership association that provides information and resources for adults with ADHD. The site provides little information about the disorder itself, but offers updates on legislation and advocacy opportunities, and information about support groups, as well as scholarship information for college students. Much of the website is easily accessible; however, newsletters and webinars are for members only.
Children and Adults with Attention Deficit/Hyperactivity Disorder (CHADD):  
http://www.chadd.org/  

The CHADD organization website is one of the more comprehensive and accessible, offering information about ADHD in children, teens, and young adults, as well as adults. It outlines information about symptoms, diagnosis, treatment, and coexisting disorders; resources including local support groups, research, and a professional directory; and information about conferences and trainings. With the exception of information directed toward the organization’s members, the website is easy to navigate and gives links to additional information and assistance through the National Resource Center on ADHD.

The Attention Deficit Disorder (ADD)/ADHD Support Site:  
http://www.attentiondeficit-add-adhd.com/  

This site provides basic, summarized information on a wide range of topics. Topics include overviews of child and adult ADHD; information about potential side effects of commonly prescribed medications; research and literature on the disorder; and information on nutrition and ADHD, school resources, and summer camps for children with ADHD. Much of the website is focused on medication side effects, nutrition, and literature.
Best Practices at Your Finger Tips
An Easy-to-Use Text with Ready-to-Implement Approaches

“Best Practices in Community Mental Health offers a broad and well-researched overview of the contemporary issues facing the community mental health field and its consumers. Each chapter is authored by well-known writers and researchers in their field.”
—Rick Trammell, Argosy University, Hawaii

Each chapter features:
- Background information and theory
- Steps for implementation
- Review of available evidence
- Glossary of terms
- Suggestions for further reading

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Are We There Yet? Ensuring Quality Best Practices
Vikki L. Vandiver

2013 paperback, 332 pages,
ISBN 978-1-935871-04-0, $49.95
New from Lyceum Books

The Recovery Philosophy and Direct Social Work Practice

“The book is a handbook on social work’s natural compatibility with recovery perspectives on mental illness. It is timely, packed with the knowledge and practices necessary for clinical social workers to function successfully within the recovery approach and, above all, speaks to students and practitioners about their role in relation to consumers. I think this book is excellent.”

—Daniel Salhani,
University of British Columbia, Okanagan

Joseph Walsh’s new book gives a clear, practice-oriented approach to social work using the recovery philosophy. The book provides in-depth examples of recovery practice with persons who have schizophrenia, depression, bipolar disorder, and autism spectrum disorders. The recovery philosophy offers clients a path to wellness, hope, self-direction, and social inclusion, and gives social workers a new way to serve and empower their clients.

Features

- A practice-based approach, with content on the dynamics of the social worker/consumer relationship and clinical endings in recovery work
- History and definitions of several models of recovery
- Summaries and discussion questions following each chapter

Scan QR code to see full description, and the expanded table of contents!

Self Care for Social Workers by Way of the Kitchen

BSW and MSW students have a lot on their plate, but unfortunately that doesn’t always include healthy meals. This two-year cooking guide can help any social work student (or professor) incorporate tasty, healthy meals into their busy lives. With recipes contributed from over fifty social work educators, Corcoran’s cookbook adds a lot more flavor and fun to the idea of self care!


Best Practices in the Classroom Environment

Whether you are a graduate student or a tenure-track professor, this book will help you identify your teaching strengths and provide you with the tools to successfully share and build knowledge within the classroom setting.


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