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2016

A Process Evaluation of the Creation of the Mind-Body Care Curriculum for a Child and Adolescent Partial Hospitalization Program

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A Process Evaluation of the Creation of the Mind-Body Care Curriculum for a Child and
Adolescent Partial Hospitalization Program

By

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MSW Clinical Research Paper

Presented to the Faculty of the
School of Social Work
University of St. Thomas and St. Catherine University
St. Paul, Minnesota

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Abstract

This study is a process evaluation of a planning committee adding structure to a partial hospitalization program's curriculum. The purpose of this study was to evaluate the planning process to provide recommendations or indications of changes that can be made in planning for other programs. The data collected consisted of committee meeting agendas, notes and minutes, and committee member interviews. The findings revealed major themes of program structure, logistics and operations, and evidenced-based. In discussion this study met its' purpose, and gives lessons learned from the committee and implications for social work practice, policy, and research.

Acknowledgements

No amount of words can express how thankful I am for all who have helped me along this journey. I'd like to acknowledge my parents, who after eighteen years of supporting my education, have never failed to stand by my side in my pursuit for knowledge. My three younger siblings have inspired me to be a more positive role model and continue pursuing my dreams. To my research committee members, Courtney, Anastasia, and Andrea, without your guidance throughout this study I do not believe I would've been able to complete it. I would also like to acknowledge my peers, classmates and friends, who truly have supported me in every way. Thank you for always picking me up when I was down, telling me I could finish when I felt as though I could not. I would also like to acknowledge my coworkers, you have all supported my education in ways I did not even know you could. As I said, these short words could never express my gratitude for each person in my life. But a special thanks to a friend who motivated me to go to graduate school when I thought it was beyond my reach, thank you for teaching me to be passionate and driven in my learning, and for inspiring me to never forget the value in learning something new each day. I carry this lesson around with me everywhere I go and it has helped me get to where I am today.

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A Process Evaluation of the Creation of the Mind-Body Care Curriculum for a Child and
Adolescent Partial Hospitalization Program

This study is a process evaluation of a partial hospitalization program's

development of a curriculum, which implements complementary and alternative

medicines (CAM). It is important to be oriented to the general nature of partial

hospitalization programs and complementary and alternative medicines (CAM) to gain

understanding of this study's information. The CAM-Based Curriculum in this study was

developed for a partial hospital program for children ages five through 18 years, suffering

with mental health concerns. The general terms related to this research are overviewed in

this introduction and provide substance to this process evaluation.

A partial hospitalization program is a mental health program, which is often a

transitional program from a short-term inpatient hospitalization program (Grandello,

Granello, & Lee, 1999). Additionally, a partial hospitalization program's treatment

intensity is greater than that of outpatient or day treatment programs (Brown, 2004). The

term "day hospital" has also been used also been used by Neuhas (2005) to describe a

partial hospitalization program's treatment modality. The treatment modality is typically

provided through psychosocial approaches such as group therapy (Neuhaus, 2005). The

Neuhas (2005) article suggests partial hospitalization programs' treatment approaches are

interventions of "psychoeducation, self-assessment, behavioral coping, self-care, and

interpersonal connections" skills (Neuhaus, 2005, p. 8). Psychoeducation, in this article,

refers to diagnosis information, treatment options, and education on health lifestyle

choices or risk factors to their health. The purpose of psychoeducation is to provide

"factual information" (Neuhaus, 2005 p. 8). Self-assessment refers to skill acquisition of

healthy alternatives to help detect or raise awareness to potential problems one may encounter. Behavioral coping/self-care approaches use these skills to make behavioral changes and improve self-care skills within patients' typical daily living environment. Interpersonal connections approaches utilize the group setting of partial hospitalization programming to implement practical strategies of assertiveness, how to ask for help, conflict negotiation, and anger management. According to Neuhaus (2005), the primary objective for day hospitals is reported to be acute stabilization.

The partial hospitalization, or "day hospital," treatment model is often confused with day treatment programs. A day treatment program is a mental health program that is long-term and significant overall functional recovery is the primary objective for patients (Neuhaus, 2005). Neuhaus (2005) reported day treatment programs are provided on a longer-term basis than that of day hospital programs. These programs also operate on group therapy and psychosocial treatment modalities (Neuhaus, 2005), which is similar to day hospitals (partial hospitalizations). This may be a reason why the day treatment modality is often confused with partial hospitalization programs. The current group therapy and psychosocial treatment approaches, typically found in both partial hospital and day treatment programs are considered "conventional" medical approaches, and there are more calls from consumers for alternative medicines (Wyatt & Post-White, 2005).

In general, there are two types of medical treatment systems: conventional and alternative. Conventional medicine includes the following three care levels: behavioral/parenting, psychotherapies, and pharmalogical interventions (Kohen, 2010). Historically, alternative medicine has encompassed what is considered the other care systems (Culbert, Olness, & Vohra, 2010), mostly all other approaches not within

tradition medicine practices. However, more recently the US federal government and other institutions have coined a broader term for these care systems, 'complementary and alternative medicine' or 'CAM' (Culbert et al., 2010, p. ix). The term CAM embodies many complementary and integrative therapies /techniques, make up these other care systems.

One care system approach of CAM is mind-body therapy. Many of the complementary therapies embrace elements of mind-body therapy concepts. Some of these practices include guided imagery, meditation, mindfulness-based stress reduction, yoga, biofeedback, or hypnotherapy (Culbert et al., 2010). An integrative therapy approach attempts to use these different techniques in various conjunctions-to acquire a healing balance for best care using the recognition of mind, body, spirit, and sociocultural contexts (Culbert et al., 2010). Mind-body medicine attempts to influence physical functions that may be directly affecting an individual's health through the patient's understanding of the general and personal interactions of the mind and body (Culbert & Olness, 2010). Mind-body medicine has been otherwise described by Mcclafferty (2011), as the intentional support of positive thoughts or emotions for the purpose of enhancing overall health. The main goal in mind-body approaches is to create a state of calm, positive focus for the individuals' receiving treatment (Mcclafferty, 2011). Mind-body therapies were the main influences for the planning committee in this study. This planning committee consists of a group of multidiscipline professionals, who intend to integrate mind-body therapies into the current conventional/traditional medicine approaches in partial hospitalization curriculums common today.

Purpose Statement

The purpose of this study was to examine and evaluate the process of the planning

committee in the creation of the Mind-Body Care Curriculum for a current partial

hospitalization program. The Mind-Body Care Curriculum's purpose was to provide

structure to the current conventional treatment model through the implementation of

mind-body skills to a partial hospitalization program's current curriculum. This study

examined the process of the committee using individual interviews and evaluation of

meeting notes and minutes. This study will allow for easier implementation for other

partial hospitalization programs and highlights changes that could improve the

.

curriculum's implementation. This study has implications for partial hospitalization

programs' micro (individual, staff, or family units), mezzo (program), and macro

(organization) levels of application.

Literature Review

This literature review had two main concepts: partial hospitalization programs

(PHP) and introduction to CAM (complementary and alternative medicine). In reviewing

partial hospitalization programs, it begins with historical research or studies of programs,

and then the current state of partial hospitalization programs will be discussed. This

literature review's introduction into CAM practices has been divided into an overview of

mind-body medicine, and then the prevalence and outcomes of these approaches.

Partial Hospitalization

   Historical. Partial hospitalization programs trace back nearly a century. In an

article published in 1981, Neuhas indicated the first partial hospitalization program was

documented in 1937. It began in the early 1930's, in Moscow, Russia, and was started by

psychiatrist Dzhagarow. Reportedly, the documentation showed the treatment modality was "useful and acceptable" (Neffinger, 1981, p. 265). In 1947, Cameron reported of the Western world's first partial hospitalization program, at Allan Memorial Institute of Psychiatry in Montreal, Canada. For partial hospital programs available during the time period after 1946, research studies were scarce. Information presented at the American Psychiatric Association Conference in 1958 indicated that only eight partial hospitalization programs existed in the United States by 1958 (Moneypenny, 1982). This statistic may point to the reason for the lack of available research during the time between 1946 and the 1960s.

In an article published by Neffinger (1981), it was reported that although partial hospitalization modalities were in existence before, "it was not used in or even recognized in any significant way until the late 1950s and early 1960s" (p. 265). The study criticized mental health professionals for being bystanders to the failures to educate other colleagues and politicians on partial hospitalization programs' effectiveness/efficiency after the early 1930s (Neffinger, 1981). Likely, more information about the specifics of treatment intensity and modalities would have been beneficial for helping other professionals understand partial programming.

Beginning in the 1960s, more literature was published on partial hospitalization programs. Some program factors from historic publications are important to illustrate. The length of time patients remained in partial programs was one factor throughout the literature that varied amongst studies. Moneypenny (1982) reported on a 1966 study in which patients averaged an eight-week stay. Another study of a partial hospitalization program was conducted from 1980 to 1982 and it showed that participants averaged eight

to 12 weeks for their length of stay in an adolescent program (Kettlewell, Jones, & Jones, 1985). Lastly, a report published in 1987 evaluated a child and adolescent program that had an average treatment length of ten weeks (Zimmerman, 1987). These three studies vary within an eight to 12-week treatment period. A program studied by Neffinger (1981) showed a much shorter average length, which points to the confusion of the "length of stay" which is still typical for partial hospitalization programs.

This shorter partial hospitalization program's overview was published in 1981, and it indicated that a "day hospital" program is on average two to four weeks in length (Neffinger, 1981). This article by Neffinger (1981) indicated a few partial hospitalization programs that were operating at two to four times shorter, in comparison to the average length of partial hospital program treatments shown in older research reports. It appeared overall, however, that the average treatment time was about eight weeks. This conclusion is further evidenced by the early 1990's design for "short-term" programs that, as reported, were structured to be six weeks to four months (Neuhaus, 2005).

There were a few important factors shown in the literature concerning partial hospitalization programs, which related to staff working within partial hospitals in the 1980s. For instance, Kettlewell et al. (1985) conducted a study between 1980 and 1982 of a community mental health center's partial hospitalization program. It involved five full-time and one part-time employee that operated their program. These employees included "a program coordinator, two social workers, a part-time child psychiatrist, a mental health technician, and one full-time secretary" (Kettlewell et al., 1985, p. 140). This program overview stated that twelve adolescents attended the partial hospital program daily. According to a 1981 study, partial programming provides an advantage for staff.

The partial programming makes scheduling easier due to the more typical five-day

workweek schedule (Neffinger, 1981). This schedule compared to inpatient

hospitalization schedules, which require overnight and weekday shifts. This is considered

a strength of the partial hospitalization's program structure.

The intensity of patients' symptoms and conditions can be determined by ranking

them on a continuum of acuity versus chronicity (Neffinger, 1981). Treatment intensity

levels help in understanding the types of patients admitted to partial hospitalization

programs and the rationale for their admission. Kettlewell et al. (1985) reported that a

patient's symptom intensity considered "acute" to be a candidate for partial

hospitalization. The basic treatment goal is to offer massive and intensive interventions

aimed to "stabilize [the] acute episode[s]" (Neffinger, 1981, p. 263) experienced by the

patients admitted in partial hospitalization programs. An episode describes a time in an

individual's life where they are experiencing mental health symptoms that disable or

inhibit them from functioning optimally in their typical environment. The long-term goal

is to "eliminate or minimize future episodes" (Neffinger, 1981, p. 263). The partial

hospitalization treatment model allows patients to remain in some of the environments

they may be functioning well in while receiving mental health treatment (Neffinger,

1981). For example, part-time jobs or evening/weekend activities. During the program,

patients receive various services. The research shows that patients receive varying

services based on the program they are in. However, most of these programs follow

conventional, or "traditional," models of treatment.

Neffinger's 1981 article pointed to the need for a psychopharmacological

modality to be included in partial hospitalization programs. Typically,

psychopharmacological treatment is provided by a psychiatrist. This early conventional modality aids in medical mental stabilization through medications. Virtually all reported hospitalization programs also consist of group therapy work. Moneypenny (1982) reported that a 1977 study, concerning the aims of therapeutic communities, showed that "specific, educationally oriented groups tailored to patient needs" (p. 34) was an effective form of treatment. The groups were structured around social skills and re-learning daily living tasks (Moneypenny, 1982).

Group therapy is an ideal modality when the target population is youth. According to Kettlewell et al. (1985), adolescents are heavily influenced by peer groups which may help foster positive changes in teens. The groups participating in the 1985 study took part in combinations of "psychoeducational (communication skills, coping skills, mental health concepts, etc.), insight-oriented (group therapy, psychodrama), and activity therapy (field trips, cooking, etc.)" (Kettlewell et al, p. 140). The Kettlewell et al. (1985) group treatment therapies are comparable to the Neffinger (1981) article's second treatment modality: "supportive therapy" for partial hospitalization programs. Each patient in the 1985 article identified three to five target areas of which their treatment would focus around (Kettlewell et al., 1985).

Past research studies have shown improvements in patient functioning because of partial hospitalization programs and the advantages of the programming approach. One example that supports the argument patients' gain improvements in functioning after partial hospitalization is from a previously referenced, in 1980 to 1982 of an eight to 12 week program (Kettlewell et al., 1985). The Kettlewell et al. (1985) article reported that patients showed improvements in areas of targeted emotions (anger, anxiety, and

depression), school functioning, and within patients' peer relationships. Neffinger (1981)

demonstrated that the advantages of this approach included: patients could remain living

with family outside of the program; outpatient treatment held less stigma than inpatient

for some individuals; and the ability for "gradual tapering off of treatment frequency and

intensity" (p. 265). It also outlined a few disadvantages to partial hospital programs,

including: being easier to drop out of programming (versus inpatient treatment

programs); problems with current living arrangements and transportation; programming

could interfere with full-time school or employment; and patients seeking one-on-one

work could be disappointed with the group work approach (Neffinger, 1981). Kettlewell

et al. (1985) showed that the partial hospital treatment modality was promising and

encouraging, however the modality reportedly needed to be further substantiated.

The historical research overviewed in this study began in the 1930s with the first

program in Moscow and then spanned up to the 1990s, by which time thousands of

partial hospitalization programs existed. The "short-term" length of stays examined

determined the average partial hospital stay was approximated to be around eight weeks.

Neuhaus (2005) reported that "though such lengths of stay were a breakthrough at that

time for P[artial] H[ospitalization], those stays would be considered long term by current

standards in the United States" (p. 3). Partial programs' development was pushed by the

desire to explore effective, less expensive "alternatives to inpatient programs" (Neffinger,

1981, p. 265). Throughout the partial hospitalization program's existence, it has

reportedly established itself as a standard of the mental health service industry

(Kettlewell et al., 1985). Historical research has provided some framework for partial

hospital programs but have called for the established need of continued quality

assessment of partial hospitalization programs.

Current State of Partial Hospitalization Programs. It is important to examine

the current impacts on partial hospitalization programs. Also well as partial

hospitalization program's working values that operate around. In an article written by

Neuhas (2005), he described seven contextual variables that may affect partial

hospitalization program structures and approaches. These seven variables include: types

of patients, theoretical orientation, treatment objectives, treatment intensity, setting

(private vs. public), and payers of service (insurance). These contexts are meaningful

to further examine how partial hospitalization programs have operated in recent years.

The type of patients treated within the partial hospitalization program and the

variation within these types can heavily influence a program's structure. An adult partial

hospitalization program study published by Grandenillo et al. (1999) identified patients'

primary diagnoses as follows: psychotic disorders, major depression, bipolar disorder,

anxiety disorders, dysthymia, alcohol and substance abuse, and depressive disorders

(NOS). The variations of primary diagnoses overviewed by Grandenillo et al. (1999)

showed the need for flexible treatment approaches based upon the patients' diagnoses and

needs at any present time. This need for flexibility is further backed up by an inpatient

study of patients and nurses' hospital experiences, which reported that patients expressed

that "group therapy did not address their illness" (Shattell, Andes, & Thomas, 2007, p.

246). Therefore, types of patients admitted into partial hospitalization programs are

important to consider when providing treatment modalities, especially group therapy

modalities.   Variation in treatment objectives is a significant in partial hospitalization

programs. There are calls from managed care providers, as well as the general public, for

partial hospital programs to demonstrate their effectiveness and provide empirical

evidence (Granello, D. et al., 1999). One method of measurement for individually

assigned treatment objectives could be assessed from admission to discharge. And if

possible assigned objectives should to be evaluated overtime to determine sustainability,

and address/focus on the reduction of the severity of symptoms (Granello, D. et al.,

1999). Treatment objectives should reflect individual diagnoses in how partial

hospitalization programs approach treatment. The results of the 1999 adult partial

hospital program study showed improvements for patients diagnosed with any depressive

disorder, anxiety disorder, and/or chemical dependency diagnoses. However, there was

not as much improvement shown for patients with psychosis and bipolar disorder

(Granello, D. et al., 1999). Bateman and Fonagy (1999) report results of the effectiveness

of partial hospitalization for treating individuals with Borderline Personality Disorder.

This study shows partial hospitalization programs showed improvements in depressive

symptoms and social/interpersonal functioning, and also decreases in suicidal

idealization/self-injurious behaviors and inpatient stays (Bateman & Fonagy, 1999).

Given this, it is important to consider differences in diagnosis and patients' individual

presenting symptoms when creating treatment objectives.

Treatment intensity refers to the level of intensity in which treatment is provided

in partial hospitalization programs. The program's intensity is heavily influenced by

the amount of time patients are allowed to remain in the program. Granello et al. (1999)

published a study that overviewed a partial hospitalization program for chemically

dependent adults. The patients in the program received five hours of group therapy

services and one medication check-in per day, then, they receive one hour per week of individual therapy. The average length of stay was determined to be 15 days (Granello et al., 1999). A different study from 1985 described two "short-term PH programs" that averaged a one-week length of stay (Neuhaus, 2005). This short-term partial program was designed for individuals with borderline personality disorder and has a dialectical behavioral therapy approach. It is designed that after the one-week stay patients were expected to transition to an outpatient program to further learn and practice these dialectical behavioral therapy techniques (Neuhaus, 2005). These studies support the depiction that historically lengths of stay in partial hospitalization programs have been longer, but more recently the lengths of stay have been shortening. It is necessary to consider how to create realistic goals that can be completed in a given timeframe.

A major context that influences a partial hospitalization program's structure that is important to expand on is payers of service or insurance requirements for the billing of partial hospital program services. Providers must provide payers of service a diagnosis, a written justification of the individual's need for partial hospitalization, and a preliminary plan for care in the form of an evaluation or certification from an authorized mental health professional, who possess the appropriate licensure (Brown, 2004). Additional partial hospitalization program's requirements to payers of service as reported by Brown (2004) include: a daily diagnosis; six hours of services per day (providers must ensure patients documentation for three services per day –one of which must be psychotherapy, and then any combination of occupational/activity therapy; education; or training can constitute the other two services); and all sessions are required to be, at least, 45 minutes in length.

Additionally, in regards to the of payers of service, the pressures of managed care providers pose many challenges for participants in partial hospitalization programs. In Neuhaus' 2005 study, participants report one challenge that current partial hospitalization programs face, related to managed-care contract changes (Neuhaus, 2005). For example, changes can elicit gaps, such as during transitions to new managed care providers, or moving to another state and waiting for state insurance coverage approval. Another impact of payers of service are reported to create barriers such as unreliable or low reimbursement rates for patients has been indicated to impact partial programs. A study of patient and nurses' satisfactions reported that both parties believe insurance coverage contributes to shorter lengths of stay in hospitalization programs (Shattell et al., 2007). (Cunningham, Mckenzie, & Taylor, 2006). Additionally, Neuhaus (2005) stated managed care companies apply pressure on programs, compressing programs' time frames. Such pressure can impact programs even to the extent of closing programs, these closures are reportedly due to being "not financially viable in the current market place" (Neuhaus, 2005, p. 2). The current literature's information of financial viability is not congruent with the historical research. In an historical article previously overviewed, it stated to have financial benefits of partial hospitalization programs and reduction of costs comparable to the more costly full inpatient hospitalization (Neffinger, 1981). The contextual variable of payers of service also impacts the other six contexts outlined by Neuhaus (2005), because the requirements for the payment for services are complex and providers can be unreliable which impacts treatment directly.

As discussed, there is a great range within the seven different contexts, in which partial hospitalization programs may potentially exist. Fixed and flexible program values

are helpful guidelines for partial hospitalization programs' that take into consideration the

variations in the contexts. In 2006, Neuhaus published an article that gave light as to how

partial hospitalization programs vary within the contexts they are applied. Neuhaus'

article discussed ten "fixed values" which should be instilled across all contexts, and a

number of "flexible values" for how the "fixed values" can be applied within various

contexts. Fixed values within this study are said to be instrumental in establishing

priorities, aids in decision making, and creates flexible organization that is proactive

within the environment. The ten fixed values provide concrete foundations for programs

to build off of, these include:

Table 1

Ten Fixed Values in a Partial Hospitalization Program

Fixed Value Number	Fixed Value
One	A pragmatic skills-training approach optimizes the ways in which short-term PH treatment matches the various needs of patients to improve their functioning.
Two	Collaboration between patients and staff is necessary, which is optimized by a treatment contract guiding priorities and evaluating progress.
Three	Interventions are adapted from evidence-based cognitive-behavioral approaches.
Four	Treatment is a learning process, and a patient's skill acquisition is enhanced by a stage model.
Five	Patients are duly informed of their diagnoses and supported with psychoeducation and information about the treatments available.

Six	Aftercare planning evolves from psychoeducation and skills training to facilitate continued use of skills and coordination with outpatient treaters.
Seven	Program structure is predictable yet flexible.
Eight	Program leadership is oriented to solution-focused and proactive management decisions.
Nine	Accountability according to one's role is apparent at all levels of the organization; staff are trained in the skills-based approach and adhere to the program's mission.
Ten	An effective psychosocial treatment milieu promotes mutually respectful interpersonal connections among and between staff and patients alike.

Note this table was retrieved from Neuhaus (2005).

This literature review has presented research related to partial hospitalization programs in regards to their contexts and values. The following contextual variables were overviewed to impact the partial hospitalization program's delivery: types of patients, theoretical orientation, treatment objectives, treatment intensity, setting (private vs. public), payers of service (insurance). These are important values to consider when implementing a partial hospitalization program; considerations of the "fixed values" and their respective flexible operational suggestions are crucial. This partial hospitalization program literature review showed the variations in which a program can be implemented, these factors are important to the overall model of partial hospitalization.

Introduction to CAM

CAM has conceptual roots tracing back to a form of "dualism" where Descartes argued that the mind controls the body, but the body can influence one's rational mind (Kohen, 2010). Since "antiquity" meditative techniques have been utilized by various cultures (Sibinga & Kemper, 2010). Additionally, imagery practices have historical roots throughout cultures as healing traditions (Culbert & Olness, 2010). More specifically, guided imagery comes from Jungian analytic tradition and is based on cognitive perspectives (Johnson, 1999). Also found in Culbert et al. (2010), yoga is considered an ancient Indian practice. More recently the term biofeedback was first documented in the late 1960s during an experiment and children's use of biofeedback began in the 1970s (Kohen, 2010). In the 1980s, psychosomatic communicating networks were beginning to be identified by molecular biologists (Kohen, 2010). These biologists studied not only the brain but the endocrine and immune systems as well, more specifically endorphins and other peptides that communicate between systems (Kohen, 2010). Since the beginnings of mind-body connection theories and practices, the field of mind-body medicine has grown tremendously. This review will overview CAM practices in terms of mind-body techniques, there prevalence and outcomes, as well as current calls for more integration of these techniques.

Overview of Mind-Body Medicine. The field of mind-body medicine is expansive; their techniques are described as powerful and non-invasive therapies (Mcclafferty, 2011). Mind-body medicine is described by the National Institute of Health's National Center for Complementary and Alternative Medicine (NCCAM) as one of the five major domains of CAM (Culbert et al., 2010). Mind-body medicine focuses on

the principle that affecting any one of an individual's body, mind, emotions, or

spirituality may affect the other aspects of the individual's life (Kemper, 2010). For the

purpose of this study, research of breath work, progressive-muscle relaxation,

biofeedback, relaxation, mental imagery, and other techniques/practices will be examined

and considered as the primary treatment modalities.

   Breath work. Focused breathing is the methodology of breath work, aiming at

relaxing an individual's mind, body, and spirit (Kohen, 2010). The goal of focusing-

oriented psychotherapy is to identify bodily sensations linked to troublesome experiences

and helps clients acknowledge this link (Santen, 1999). Some breath work can be

incorporated into techniques of concentration and mindfulness (Kemper, 2010).

Restoration of senses of harmony and coherence to obtain more clarity and insight

through focused breathing is a very old, even considered ancient technique (Kemper,

2010, p. 264).

   Progressive muscle relaxation (PMR). The use of progressive-muscle relaxation

(PMR) is easy for children to learn and master (Mcclafferty, 2011). PMR involves

tensing and relaxing to allow the child's muscles to become more relaxed prior to the

tension (Kemper, 2010). There is a systematic focus on the tensing and relaxing of

different muscle groups (Mcclafferty, 2011). PMR allows the individual to dramatically

experience physical relaxation after tension, and to re-create the sensation with each

muscle group (Kohen, 2010). The series of repeated phases promote physical, as well as

mental relaxation (Kemper, 2010). According to Kemper (2010), a child is asked to tense

a specific muscle for 8 to ten seconds, and then focus on the feeling of the muscle

relaxing. Becoming more aware of their bodies can help youth learn the value of focusing

and re-focusing, and that it can contribute to relaxation of the mind (Kohen, 2010). PMR is often used with other mind-body therapies in an individualized fashion, depending on the patient's needs (Mcclafferty, 2011).

Biofeedback. Biofeedback, as previously mentioned, began being practiced in the 1960s and then with children in the 1970s (Kohen, 2010). Biofeedback provides an individual feedback about their physiological processes using electronic or electromechanical equipment (Culbet, 1999). Biofeedback techniques help individuals gauge their mind and body arousal triggers (topics, thoughts, situations, etc.), and are considered an "invaluable tool" for clinicians (Bevans, Gardner, Pajer, Riley, & Forrest, 2012, p. 3). There are various forms in which feedback can be provided to the individual including auditory, visual, kinesthetic, multimedia, and video games (Culbert, 1999). There are now computer programs that allow children (after training) to connect devices to their fingers or earlobes and receive this feedback within any setting that has the technology (Kemper, 2010). A few other biofeedback techniques that can be easily applied in clinical practice are "Biodots", "Dermatherm", or other "Stress Cards" (Kohen, 2010, p. 288). When an individual's body sends themselves signals of their relaxed/less stressed mental states it can be helpful to acknowledge these shifts because understanding them can help promote mental clarity (Kemper, 2010). Ongoing practice of biofeedback techniques makes it easier to reach the state desired, even if the individual is not connected to the biofeedback device (Kemper, 2010). It is important for understanding these interventions to further expand on five specific biofeedback modalities: peripheral temperature, electromyography, and heart rate.

Peripheral temperature. This technique measures finger temperature and is a good indicator of autonomic and sympathetic nervous systems (ANS/SNS) balance (Culbert, 1999). Typically, lower finger temperature indicates stress, anxiety, or anger states (SNS arousal). The goal is to reduce SNS arousal, and for children the technique has a 92-degree finger temperature is desirable measurement. Examples of devices are "Biodots", "Dermatherms", and small alcohol thermometers, which are all considered inexpensive options (Culbert, 1999).

Electromyography. The purpose of this biofeedback technique is considered relaxation training, through measuring and providing feedback of an individual's muscle activity. This technique can help the child further understand mind-body links that can contribute to increased confidence and enjoyment. The technique's device is typically introduced being placed on a child's forearm due to the placement's ability to be quickly controlled and/or mastered by youth. The desirable value for the technique's measurement is about three microvolts (this is considered a relaxed muscle state). However, these values vary depending on the placement of the sensors and their sensitivity (Culbert, 1999).

Heart rate. Heart rate is a commonly known physiological measurement that is assessed during an individual's routine doctor visit. This technique shows individual's increases and decreases in their heart rate, which is commonly related to emotional arousal states (arousal increase) and relaxation (arousal decrease). The measurement is typically reported as beats per minute. The normal variations in heart rate are considered Respiratory Sinus Arrhythmia (RSA), and it has been found RSA is lost in some

individuals who suffer from chronic stress-related conditions. This technique can help

facilitate movement back towards normal RSA (Culbert, 1999).

    Relaxation and mental imagery (RMI). Relaxation techniques are beneficial

because they can be used after brief training and are considered simple psychological

treatment (Jorm, Morgan & Hetrick, 2009). One relaxation technique that can be utilized

is meditation. The many kinds of meditation can be summed up as "paying attention on

purpose, or intentional attention" (Kemper, 2010, p. 260). According to Kemper (2010)

there are two major types of meditation (concentration and mindfulness). Concentration

meditation's key is intentional, attention and attitude to a thought, phrase, emotion, etc.

(Kemper, 2010). It has been reported that focused concentration/awareness is the goal of

meditation, and it can be accomplished by "quieting the mind, not concentrating on the

immediate experience" (Kohen, 2010, p. 291). In the second type of meditation described

by Kemper (2010) there are three different ways one can practice mindfulness meditation

these include body scan, seated meditation, and movement. Overall, each clinician

chooses the way in which they practice and implement meditation techniques with each

individual patient.

    Guided imagery evokes all six senses (sight, sound, taste, touch, smell, and

movement) and is stated to be a "powerful mind-body technique" (Culbert & Olness, p.

5). Guided imagery is non-invasive and has strength due to its applicability amongst

various aged patients and treatment settings. Additionally, it is reported to be a powerful

psychotherapy technique with children and adolescents (Johnson, 1999). Current clinical

guided imagery's perspective is reported to be cognitively based and to function as a skill

to help children cope with stress and conflict (Johnson, 1999). Deep relaxation, focused

attention, and altered states of consciousness are utilized through guided imagery

techniques (Johnson, 1999). The patients' therapeutic goals are achieved by helping the

child form mental images through the professional's guidance of suggested images

(Johnson, 1999). It has been suggested the more an image is familiar to a child the easier

the image may be for them to manipulate (Johnson, 1999). "Safe place, wise guide, and

caring circle" are all helpful guided imagery techniques for improving mental health

(Kemper, 2010, p. 267). Another source suggested images with themes of the future, time

projection, getting through a difficult time/event, substituting a preferred scene when

provoked, and goal rehearsal (Johnson, 1999).

    Other notable techniques. Three other therapeutic techniques that are important

to overview are yoga, aromatherapy, and animal-assisted therapies. Yoga is described to

be sets of different postures, meditations, and breathing exercises with a primary focus of

physical fitness and healing (Sibinga & Kemper, 2010). Yoga is considered a gentle form

of exercise that has shown improvements for patients (Kemper, 2010). And, as previously

stated, yoga is of ancient Indian roots. Aromatherapy is the practice by professionals of

intentionally using plant essential oils to treat/improve health or disease (Culbert &

Olness, 2010). This can be practiced through methods of inhalation, topical, and bath

applications, and practitioners should be cautious of any possible allergic sensitivies

(Culbert & Olness, 2010). Companion animals can be effective in conjunction with a

therapist because of their "interactive, affectionate, nonjudgmental, and social nature"

(Mallon, 1999). One of the benefits of animal-assisted therapy is the animal (dog or cat

typically) can become the child's play object and it may capture the child's attention or

possible fears, making it easier for the patient to relax in the session (Mallon, 1999).

These three techniques are typically utilized in conjunction with other therapies, but can further patients individual mental health goals when applied appropriately by professionals.

      Prevalence and Outcomes of CAM Practices. The prevalence, uses, and outcomes of these four CAM modality themes (breath work, PMR, biofeedback, and RMI) are important to examine. In recent years the use of CAM therapies have increased tremendously, and their use in hospitals have increased. In 1998 7.9% of U.S. hospitals offered CAM services, compared to 19.8% in 2006, according to the American Hospital Association's Annual Survey of Hospitals (Johnson, Ward, Knutson, & Sendelbach, 2012). In a study of health care workers, CAM usage versus the general adult population CAM usage, it was found 76% of health care workers (HCW) and 63% of the general population (GP) have used at least one CAM therapy (Johnson et al., 2012). It is suggested that higher usage amongst HCW may be due to higher exposure and greater access to these therapies (Johnson et al., 2012). Research has reported 26.6% of children have stated to have used at least one CAM service and of these children 43.6% of them have identified to have at least one "emotional, mental, behavioral (EMB)" condition ("National Profile", 2012). Statistics show an increased use of mind-body and biologically-based therapies amongst the EMB population than other children (a13, p. 2).

      Overall CAM therapy techniques have been shown to reduce fear, stress, and pain, as well as helping gain confidence, self-control, and resiliency (Mcclafferty, 2011). They have also shown possible applicability to certain patterns of the complex issue of bullying amongst youth (Mcclafferty, 2011). There is also evidence that CAM techniques have been effective in the treatment of individuals with autism spectrum disorder

(Newmark, 2010). Each technique is utilized for differing reasons and to address different issues.

Each of the overviewed techniques has their own varying applications, and can improve many of the various conditions/symptoms seen in partial hospitalization programs. Breath control has been shown to be supportive in aiding individuals with anxiety, panic attacks, and stress management difficulties (Culbert, 1999). Progressive-muscle relaxation (PMR) places emphasis on narrowed focused attention, which is related to other self-regulation methods (Kohen, 2010). Biofeedback has been shown to facilitate improvements in mood, anxiety symptoms, and certain sleeping difficulties, as well as improvements in overall physical and mental health (Kemper, 2010). In terms of relaxation, meditative interventions have been shown to decrease symptoms of stuttering, sleeping disorders, affective disorders, and eating disorders (Breuner, 2010). In a study of relaxation techniques (progressive muscle relaxation, relaxation imagery, and autogenic training), five trials showed reduction of self-reported depressive symptoms with participants diagnosed with depressions or having high levels of its symptoms (Jorm et al., 2009). Overall, yoga has been shown effective to work with child and adolescents' conditions of various pain, emotional, mental, and behavioral concerns (Culbert & Olness, 2010), Kemper (2010) highlighted benefits specifically for individuals with depression. Aromatherapy has shown to be effective in the reduction of stress and anxiety for patients (Culbert & Olness, 2010). Lastly, animal-assisted therapy has been shown helpful in issues of sharing and separation, or influential in the child's self-image formulation (Mallon, 1999). These CAM-based therapies have all shown some improvement in areas for mental or physical health for patients, and should be considered

potential methods for improving the lives of the patients seen by professionals treating such issues.

Summary

It can be concluded from the research that since the beginnings of partial hospitalization programs the duration of stay patients remain in the program has decreased drastically. Programs are reporting to operate at least half the amount of time seen historically, however the research shows minimal modifications to the treatment interventions or curriculums to accommodate these drastic changes. Meanwhile, CAM practices have been practiced among cultures antiquity but within the last century they have become the clinical focus for many practitioners. One major focus of this process evaluation is to examine if a partial hospital program (currently providing mostly conventional treatment interventions) can successfully integrate alternative medicine techniques into its partial hospitalization program. Alternative medicines have been shown to be of increasing demand from the general population of consumers. The Mind-Body Care Curriculum being studied aims to utilize the mind-body therapies overviewed in the literature review. The Mind-Body Care Curriculum hopes to provide patients therapeutic skills that can be taught quickly to accommodate the pressures of shortening lengths of stay. This leads to the purpose of this process evaluation and what it is seeking to assess, the research questions were: How was the Mind-Body Care Curriculum created? What was needed throughout the curriculum's planning process? And, what improvements can be made for better implementation?

Conceptual Framework

This study has been orchestrated through four main conceptual frameworks: process theory, strategic planning approach, systems theory, and personal framework. These four concepts are further illustrated below and considered the primary conceptual frameworks of the Mind-Body Care Curriculum's process evaluation.

Process Theory

Process theory is designed to assess what a program is and what are the expectations of the program. In short, it is stated as "a conceptual plan" (Issel, 2004, p. 178). It is one of the two main components of program theory and theorizes about the program's resources and actions (Issel, 2004). Rossi et al. was cited in a reference book to consider three components which are typically evaluated in process theory: inputs/capacity ("organizational plan"), activities/interventions ("service utilization plan"), and outcomes (by-products of the inputs and activities and interventions) (Issel, 2004, p. 179).

The organizational plan should outline the resources needed for a successful program implementation and sustainability of the program (Issel, 2004), guiding the evaluation plan portion of services delivered in the program (Issel, 2004). Process theory's service utilization plan elaborates on the program's target audience and the delivery of programmatic interventions and services to the targeted audience (Issel, 2004). The logistics of the program being provided are included in the service utilization plan, such as reflections of cultural sensitivities, social marketing, accessibility/availability, and screening procedures (Issel, 2004). The outcomes of the

organizational and service utilization plans cause a continuum of program

shifts/alterations to produce better effectiveness and efficiency of the program (Issel,

2004). Process theory suggests that making shifts/alterations to the program during the

planning stage may be easier then prior to implementation. All of these theoretical factors

influenced the methods of this research study.

Strategic Planning Approach

The strategic planning approach concentrates on a program's organization and the

ability of an organization to accomplish its program's mission in a responsible manner

(Issel, 2004). This approach often affects program choices, and is especially applicable to

"the infrastructure level of the public health pyramid" (Issel, 2004, p. 96). This approach

is a systematic approach to decision-making that can help show which option is the

"best" (Issel, 2004). There are a few reported disadvantages to this approach, which are

human irrationality and bias to differing interpretations of situations, and the "best"

option does not guarantee it will be the best plan for the program (Issel, 2004). In

conclusion, a time and resource intensive framework should be anticipated, if done

properly (Issel, 2004).

Systems Theory

Systems perspectives approach generally provides a more holistic understanding

of the transactions between individuals and their surroundings and show enhancement in

using "multi-method" techniques and/or roles in assessments and interventions (Siporin,

1978). This relates to this study because the researcher examines the different systems

interacting together to create the Mind-Body Care Curriculum. The committee members

are each trained in different professional areas, therefore it can be assumed they provide a

variety of influential knowledge and opinions that affect the development of program

curriculums. The examination of these "systems" roles and techniques are important for

the process evaluator to acknowledge and provide insight into for this study. Shulman et

al. (2010) elaborates that many different systems function within individual's lives.

Examples of these are intrapersonal, environmental, and family systems, which can all

provide a unique lens into structure. In this study's purpose it was proposed for this study

to have micro, mezzo, and macro level implications, these are all levels of ecological

systems and were important to monitor.

Personal Framework

        This researcher's framework is important to overview for two reasons. The first

reason is this researcher's employment in the partial hospitalization program being

studied. The second reason is due to this study's researcher being an active member in the

Mind-Body Care Curriculum planning committee. These influences guided and impacted

this study's conceptual framework. This process evaluation will be the first publication of

the Mind-Body Care Curriculum, and this researcher plans to produce an outcomes

evaluation after six months of program implementation.

        It is also important to state that this researcher and the partial hospitalization

program's organization will be using the process and outcomes research to create and

empirically substantiate the Mind-Body Care Curriculum. The purpose of the Mind-Body

Care Curriculum's final publication is a structured, integrated curriculum, in which other

partial hospital programs can acquire and implement in their specific setting. Therefore,

the process evaluation's framework needs to align with the overall objectives for the

CAM-Based Curriculum that will be researched. This study's researcher had to

conceptualize how this process evaluation could contribute to the organization's overall

goal. The company's overall goal was to produce a curriculum that provided integrative

medicine techniques that could be purchased by other organizations currently providing

or looking to create a partial hospitalization program and provide gaining for techniques.

Program Description

According the PrairieCare website (2016), their partial hospitalization program is

on average three to five weeks in length, for youth ages five to 18 years old. The program

provides each patient a multidisciplinary team, with each including a psychiatrist,

therapist, registered nurse, and social worker (PrairieCare, 2015). The partial

hospitalization program operates Monday-Friday, 8:45am till 3:45pm, and provides

individual, group, and family therapy treatment intervention. Daily, patients receive

group therapies including combinations of process, psychoeducation, nursing, social

skills, therapeutic movement, and art therapy groups. As well as two hours of education

provided through their respective district teachers/paraprofessionals. In addition to the

daily group and education services, weekly, patients receive one individual therapy

session and one family therapy session. The focus is on "thorough assessment and

symptom stabilization while working on healthy living skills" (PrairieCare, 2015).

In the partial hospitalization program in this study, there are currently four

overarching weekly themes that guide some therapeutic groups. These four themes are

self-esteem, emotional/behavioral regulation, communication, and relationships. The

patients set weekly goals at the start of the week, and daily goals during each morning's

check-in upon arrival. This particular partial program requires numerous professionals on

a day-to-day basis to operate including: a unit secretary, three psychiatric technicians,

two teachers and one paraprofessional, two social workers, two registered nurses, three

therapists, one art therapist, and two psychiatrists. Additional professionals that provide

as needed services are an occupational therapist and a psychologist that can perform

psychological testing. All of this presented program information requires large amounts

of collaboration and communication between professionals.

Methods

Research Design

The purpose of this study was to evaluate the planning process of one agency's

Mind-Body Care Curriculum. This study assessed process-related data collected

beginning from the first planning committee meeting until the month directly prior to the

projected implementation of the Mind-Body Care Curriculum. Beginning July 20, 2015

and data collected up through January 20, 2016.

Sample

The population for this study was mental health child and adolescent partial

hospitalization programs. This study's particular sample was employees of a large

Minnesotan mental health organization's partial hospitalization program site, which was

implementing the Mind-Body Care Curriculum. These participants were selected using a

purposive sampling method based on employment in the organization and their

participation in the Mind-Body Care Curriculum's planning committee. The sample of

individuals asked to participate consisted of eight individuals, and two of the eight-

committee members agreed to participate within the study. Also, note, two planning committee members were excluded from the sample due to their participation on this study's research committee. These excluded participant's positions include an integrative medicine psychologist and the site director of the study's location.

Protection of Human Subjects

The protection of human subjects was addressed through keeping participants' information confidential, by allowing only access to the original interviews and identifiable process notes to the researcher. This data has been password protected, and will be destroyed after August 1st, 2016. The participants were told the purpose of the study and be informed of their rights to withdraw from the study if they choose to participate at any time throughout the process. The participants were asked to read and sign the voluntary informed consent form, Appendix A. There were two possible risks identified and discussed with participants. The first this study carries is the potential risk of possibility of confidentiality of the data breach due to the participants being recruited know each other and are participants in the planning committee for the Mind-Body Care Curriculum together. This risk was minimized by the open coding method this researcher used to analysis the data, and any identifying data was removed. The second possible risk to participants is emotional distress, due to any unforeseeable negative emotions that may have occurred throughout the planning committee process. To minimize the risk of emotional distress to participants, the participants were assured that they only need to discuss what they are comfortable with sharing and reminded that they could withdraw at any time. This study was approved by the University of St. Thomas and PrairieCare's IRB.

Data Collection Instrument and Process

The data collection for the presented study was obtained through multiple means. These means included meeting minutes/notes/agendas and interviews. Data collection included agendas, minutes and notes beginning from the first Mind-Body Care Curriculum committee meeting in July of 2015 throughout meetings until January of 2016, which was to be the month prior to the curriculum's February, 2016 implementation date.

The members of the CAM-Based Curriculum's committee were asked to participate in a 45-60 minute interview during January of 2016. The interview consisted of seven open-ended questions (Appendix B), about the process of the Mind-Body Care Curriculum's development and considerations for future program development. Each participant was informed before the interview process commenced that the audio recording would be transcribed by the researcher.

Data Analysis Plan

Data was analyzed using two different methods, these methods correlated with the types of data that were collected. This researcher began by analyzing the Mind-Body Care Curriculum's planning committee meeting's agendas, minutes and notes. This information is displayed within a flow chart in the findings section. The flow chart helped to analyze the committee's process and progress throughout the planning of the curriculum. This researcher did have to limit the amount of data that were collected, due to the nature of this study any personal correspondence or outside committee meeting communications not related to meeting agendas, notes, or minutes were not included in

this data analysis. Lastly, this researcher transcribed the recorded interviews and coded the transcripts. The researcher transcribed and coded the interviews independently. The researcher used the open coding method to develop initial themes and worked to organize codes into applicable themes.

Findings

This study examined 19 documents regarding the committee meetings' agendas, minutes, and important curriculum documents. Two committee members out of eight eligible participants agreed to participate in interviews reflecting on the process of the curriculum's development. These documents and related information were de-identified to protect confidentiality. The timeline in Figure 1 reflects an overview of the patterns found within the 19 documents and the process of the committee's curriculum development meetings.
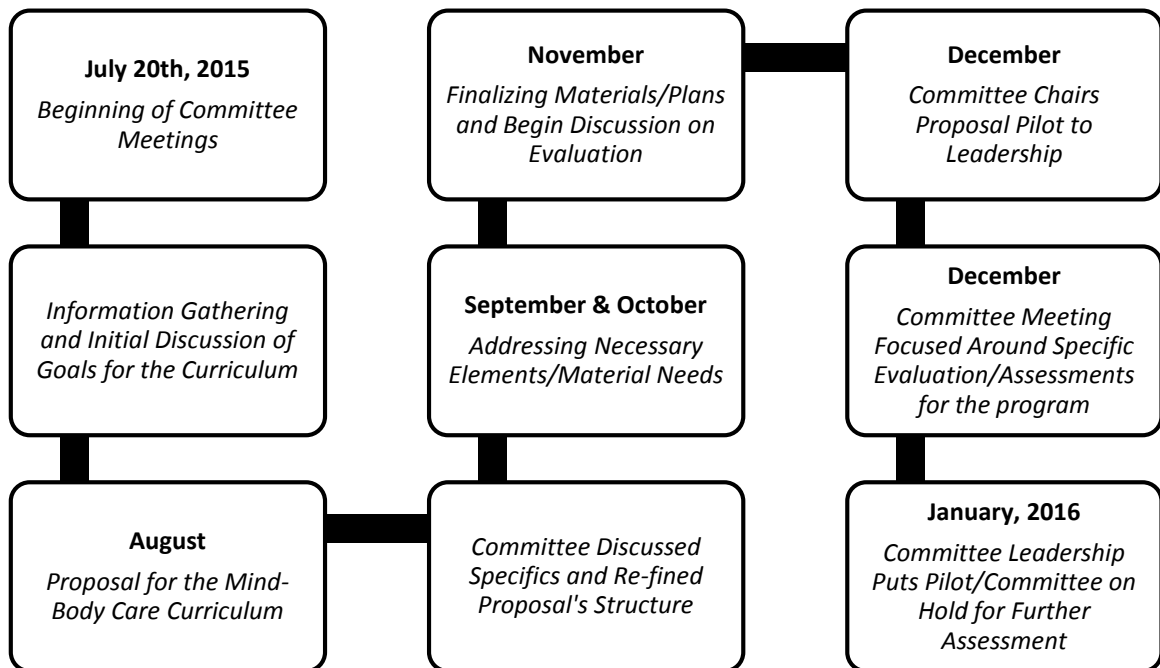
Figure 1. This figure highlights the overall process of the Mind-Body Care Curriculum's committee meetings. This shows data beginning July 20th, 2016 until January 20th, 2016.

After assessing the time line it was determined that the committee met a total of 12 times. The correspondence had the following three common themes: program structure, logistics and operations, and evidence-based. These major themes will be elaborated on below utilizing the data collected, and will reference the timeline and interview responses.

Program Structure

The program structure theme consisted of four major sub-themes, which help understand how the program structure was developed. These four are curriculum development (which consists of information gathering, goal setting, and pilot proposal), behavioral reinforcement system, handouts, and communication.

Curriculum development. The beginning of the curriculum's development focused heavily on information gathering, goal setting, and pilot proposal.

Information Gathering. During the first meeting, there was an agenda point with "Future Topics." Within these points were plans for discussing integrating mind-body into the current weekly partial hospitalization program themes, clarification of current aromatherapy uses and nursing group topics. The agenda also proposal seven mind-body strategies to consider for use in the partial program. After the meeting on 07.20.15, an email summary of the committee's discussions so far was sent out to the members. This 07.31.15 correspondence gave summaries, for example:

> *"We want kids/families coming through our PHP program to absorb mind-body*
>
> *skills that are taught to them in an interesting but repetitive manner. We need*

them to leave here knowing they have a tool set of strategies that can be applied

in a lot of different ways in their life to help them live their best days every day."

Goal Setting. The summaries of the committee's discussions from 07.31.15 were refined and set as the "Goals of proposed PHP Overarching CAM structure" that was sent out in a more formal word document with the proposal on 08.10.15. The three goals for the proposal were:

"1. Kids/families coming through our program

   Absorb mind-body skills that are taught to them in an interesting but

repetitive manner.

   Leave here knowing they have a tool kit of strategies that can be applied

in a lot of different ways in their lives.

2. Concrete, simple but effective skills

   Translate and communicate easily to others involved across settings

      Home, school, clinics (parents, other psychologists, therapists,

      counselors in clinics, primary care, doctors, psychiatrists, school

      counselors)

      Allows carry-through of growth from our setting to other domains

      of the child's life

      Gives focus to skills gained during their time in the program

3. Protocol that is easily mastered by ALL STAFF across all roles within our

program

   Everyone knows the language

   Everyone embraces these skills in their own use

> *At any time, any staff can easily join and connect with our patients*
>
> *and their families*
>
> *Informally and formally as appropriate within their roles*
>
> *These skills represent a core base platform"*

Along with overarching goal development, the committee members also have their own expectations of the pilot: *"I guess the expectation would be modifying the program, and what time patients would have different groups. We haven't currently been able to add these different mind-body skills and how do we incorporate that in our daily routine."*

The goal development at the beginning of the committee's process was an important topic discussed beginning within the document of 07/20/15 and 08/10/15, amounting to about three committee meeting times. There were six initial proposed elements to "build into the daily PHP structure" this was proposed on 07/31/15 and chair asked committee members to give feedback on the following Monday's meeting. Also proposed in the 07/31/15 meeting agenda was the "Skill-Of-The-Day" weekly structure.

Pilot Proposal. The pilot's daily and weekly structure were strongly focused on during the committee meetings in August. The proposed elements to add into the daily routine on 07/31/15 included mindfulness meditation (start of the day, "involving intentions/goals") then behavioral goals checked, and then teach the new "Skill-Of-The-Day", which is "intentionally woven into various pieces of the program throughout the rest of the day." Handouts of the "Skill-Of-The-Day" are given to parents about the skill, and a copy put into the patient's binder. Lastly, end of the day "kids/staff set goal for behavioral reinforcement system in terms of how they will use/practice their new skill at

home that evening." And the day ends with a mindful meditation (focus on "compassion, forgiveness, appreciation"). On 08/10/15 the pilot's proposal document added two more elements to be added to the daily structure, one at the beginning of the day and one at the end for staff only to discuss.

The pilot's weekly structure was set up concentrating on four main mind-body skills. Each of these skills was assigned a day Monday-Thursday, and "each Skill-Of-The-Day is tailored for the week to fit in with the weekly theme (self-awareness, communication, relationships, and emotional/behavioral regulation)." An idea that stayed consistent over 07/31/15 and 08/10/15 committee work was Friday's structure for integration.

> *"Friday Mish-Mash—Circuits--- including a breathwork station, a PMR station, a RMI station, a Biofeedback station, and then a "bonus" station including Aromatherapy and Acupressure (focus upon anxiety calming point only or similar). Friday culminates with awarding rewards in exchange for points earned that week for using their skills within the theme of focus for that week"*

This four "Skill-Of-The-Day" followed by Friday circuits appears to change little in variation after this time in the data. There is one change however noted within the committee's 10/09/15 meeting notes, the members switched Wednesday and Thursday's skill of the day. This made relaxation/guided imagery in the middle of the week and biofeedback the last weekly skill on Thursday. Specific details of discussion for additions and refinement were the committee member's strong of focus of 09/28/15 through 10/19/15.

On 09/28/15 and 10/05/15, the committee members discussed the possibility of offering a parent and patient optional group, 1-2 times per month from 4-5pm (just after discharge). The group would aim to focus upon nutrition coaching and/or the potential of incorporating the nutritionist into the parenting-coaching groups.

Lastly, in the process of curriculum structure and goals was the committee's "Overview Refinement" of the vision of the pilot implementations. The Mind-Body Care Curriculum pilot proposal timeline sent out on 09/28/15 stated five tentative phases for implementation. Phase I would be January, initially "rollout" curriculum, then phase II in April would add in voluntary parent-skills coaching groups (focused on the four core self-regulation skills). Next, phase III would add in formal nutritionist group for all ages, estimated to be in May. Phase IV, in the fall of 2016 review research data of outcomes and process and make any necessary fine tuning needed. Last, phase V would aim to rollout new mind-body care curriculum to other sites.

Behavioral Reinforcement System. The next major theme of the curriculum's development was the behavioral reinforcement system that was modified, and its initial goal was "*to shape use of skills. Will need a way to earn points and earn rewards in exchange for points*" (August 10th Document). A planning committee member remarked "to enhance the partial program, so that the kids are gonna have skills that they're gonna be able to use easily" in regards to the goal behavior reinforcement system. The August 10th document also laid out the outline and an example for goal setting: *"Patient GOAL setting: Specific, behavioral: Goal: Learn (Daily Skill), with focus upon (Weekly Theme). I will use (Daily Skill) during these trigger times for me."*

The more specific discussions of the behavioral development system were discussed during the August 24th, 2015 meeting and on September 14th, 2015. The meeting agenda discussed it *"should be positive only, never punitive (never take away points)"* and six ways patients can earn points. There were several questions and clarifications needed to be reviewed during the August 24th meeting. A few examples of these questions/clarifications: *"who gives points, checks in with patients? Does anyone currently check in with parents? Bonus board- who/what role can be in charge? What type of reward would work for the blue/purple group teens? Need to determine potential number of points possible each day, aim for 75% or 80%?"* During the next meeting on September 14th, 2015 plans were drawn up to work on reformatting the point system chart tracking sheets and the home-tracking sheet with the "*new and improved tracking points for parents.*"

The next refinements to the behavioral reinforcement system were in the October 5th, 2015 meeting. The reinforcement system rewards were proposed as: "*behavioral shaping of kids integrating mind-body skills into their lives,*" prizes for the children and adolescents, "*prize store? Menu,*" and bonus board to recognize efforts during the day ("random reinforcement").

Handouts. The first handout that was discussed was during the July 31st, 2015 correspondence, proposing "*a set of small, portable laminated cards with brief bullet point reminders of the 4 core skills.*" Then, the "take homes" described in the August 10th, 2015 document had the following three points: "*1. Laminated card "Tools To Go" with reminder of 4 core skills, 4 core areas, biodot, 2. Binder of handouts upon discharge arranged by core skill and themes, 3. Coping Skills Box (younger kids and older kids?)*

upon discharge." On September 14th, discussion began of revising the handouts for

parents and having a "*younger kid's version and older kid's/teens version.*"

Correspondence on September 28th, 2015 stated the continuation of working on the four

core mind-body skills handouts.

Then, during the October 05th, 2015 meeting the committee decided to combine

the younger versus older patients' handouts into just one handout, using language that all

ages would understand. The October 5th, 2015 meeting minutes also overviewed the

discussion for sending binders home with parents in regards to the younger "*kids they*

may not hold onto materials as well, could get lost. Sending home binder with parent first

(on admission) to say this is what will be discussed throughout the program." There was

discussion held around would else would go in the binder for information at home for

families. Within the October 05th, 2015's meeting minutes the committee identified the

following handouts as informational sheets for families: "*resources including*

biofeedback apps, nutrition needs like local farmers' markets." The committee also

identified an "outline for the program" that should be reviewed with the family upon

intake when the binder is given to the family. This document would include:

> "*parent information about expectations, skills that will be learned, focus upon*
>
> *other areas important to mental health such as nutrition, exercise, going over*
>
> *skills and strategies that parents can help with at home. Overview of value of*
>
> *learning these skills as an entire family. Making changes at home to bring to a*
>
> *calmer level. Have some answers for parents (i.e., if insurance only covering 4*
>
> *days- in those 4 days the patients will learn the basic values).*"

This informational handout was completed and sent out for overview of the Mind-Body Care Curriculum by the committee on December 7, 2015.

Communication. The communication identified as a key element in the structure. At the beginning of each day, ensuring the following was communicated with the patients: "introduce theme of the week, introduce skill of the day, goal setting." Check in about point system from the previous evening at home and document points." These tasks were listed in the August 10, 2015 document. Then, beginning on September 14th, 2015 the committee began discussing and updating a "menu of themes/mind-body skills for use on the back side of the school staffing sheet," that would be communicated to the schools. Also during the September 14 action points, was to re-name the "school support plan" to "case collaboration summary" that would be sent out to providers who will patients and families after discharge. This discharge support plan was reviewed on September 28, 2015 and October 5, 2015, and then on November 13, 2015 the final update was given, and the template decided upon. This communication would be further supported through the use of handouts, also another commonality within the research.

The program's structure was a major theme throughout the data, and the curriculum development, behavioral reinforcement system, communication, and handouts were all important components within this program's development. The next major theme relates to the logistics and operations of development and the curriculum itself.

Logistics and Operations

The second theme of logistics and operations can be analyzed within the following subcategories: interdisciplinary, trainings, committee meetings, and materials.

These subcategories help better assess the committee's process and what their

organizational plan included.

Interdisciplinary. Interdisciplinary references, ideas, and utilization is found

throughout the data sources. It is discussed within the beginning stage of the process of

development. The committee members made up of multiple disciplines. One participant

reported, "It was helpful to get feedback from other disciplines on what they believe

would be helpful for the patients in learning mind-body control." Participants also

reported "clinical observations" and "information about how the day is running" as their

roles and contributions necessary for the planning of the curriculum. In addition to the

interdisciplinary presence within the planning committee, this collaboration is seen

within the larger overall curriculum goals.

Interdisciplinary staffing was addressed at the first committee meeting's agenda

sent out the morning of the meeting (July 20th, 2015). Item six to be discussed during the

meeting was "staff roles we envision being trained up on techniques and implementing."

Then, Friday's email included the following summary of the committee's discussion

regarding the program's interdisciplinary goals: "Finally, we need a protocol that is easily

mastered by ALL STAFF across roles within our program – from unit secretaries to

school teachers to psych techs to psychiatrists. Everyone knows the language and

embraces these skills in their own use…" This idea is revised and proposed in the August

10th 2015 document stating it as the third proposed goal of the pilot. This study's

participants report the pilot would benefit from the "team willing to work together and

learn these ideas and language" and committee members "be able to try them with

ourselves… being able to actually practice on ourselves before we would teach the

patients what to do." Lastly, the November 30th 2015 email correspondence begins

discussing the planning committee's leaders presenting the pilot to the company's

leadership board. All of the interdisciplinary elements played a role in the planning

committee's process. The trainings that were discussed was the next common category

within the logistics and operations theme.

   Trainings. There were two different types of trainings discussed: committee and

all staff member trainings. The first instance of training discussed was found within

Monday, September 28th 2015's email summarizing action points from the day's

meeting: "Future committee meeting (s) to be dedicated to abbreviated training of

committee on Integrative Medicine/Complementary Modalities." This relates to

participant feedback referring to committee trainings, in which there were

recommendations for training of the committee members more at the start of the process.

The following are two quotes regarding this:

> *"I think that if we all were knowledgeable on the skills prior to trying to plan it,*
>
> *that is what would have been helpful."*
>
> *"I think that may be the leaders coming in to teach the modalities, and what you*
>
> *need to do, may be in like the second meeting and actually teach you what to do,*
>
> *so that when you're talking about these modalities that it's not just like talk week*
>
> *after week."*

   In relation to the pilot's training also includes all staff (versus committee member

training), many elements represented within the data. The initial idea for all staff

trainings began in the initial discussions of July 20, 2015: "training staff, ongoing

consultation" and "staff roles we envision being trained up on techniques and

implementing." The data reflected that next discussion of trainings for all staff was on August 10, 2015, which proposed a possible structure/outline for staff trainings in order to implement the curriculum developed by the committee. This included, "Trainings: All staff, 4 hours, perhaps an evening 4-8pm. Mindful Superusers: Identify core staff that will be responsible for supporting CAM skills in the program."

Then, in the October 05th, 2015 agenda, the point regarding all staff training states "will implement larger scale training for the entire PHP staff perhaps in January. Much work needs to be done in prep for that training to ensure it is thorough and appropriate for all roles." Then, at October 19th, 2015's meeting it was determined by the committee that the staff training day would be December 29th or 30th, 2015 and there would be a "soft entry meeting two weeks before the larger scale training." These trainings were then put on hold due to leadership wanting more time to review the proposal before moving forward.

Meeting Times. Another prominent subject relating to the committee's operations was the meeting times. There were concerns expressed about timeframe, feeling rushed, and meeting cancellations. Participants reported the following in regards to difficulties with meeting times:

"There's a couple things that were pretty tough about the process. First was a meeting time that everybody could dedicate towards the group, so that was probably like the main thing. And then feeling rushed when we did meet because everybody had to get back to their work. It was just really difficult time getting through our planning process and everything that we needed to discuss during those times."

"It is hard to plan and certain things are not always going to be able to happen next without a solid timeframe and books and a lot of little things were adding up. And the bigger things were yet to be determined before a lot of the details."

Lastly, relating to meeting times, the cancellations occurred on November 9th, December 21st, and December 28th of 2015. The participants recommend "make sure you have a dedicated time that everybody can meet and to have a member from each discipline represented in the group."

Materials. The last prominent subject relating to the committee's logistic needs was the materials. Materials needed for the Mind-Body Care curriculum were discussed most in-depth in the data collected from October of 2015. One committee member reported about resources needed: "Mainly resources that we're going to need are materials like the information pamphlets or prizes for the kids to earn or whatever we're going to need for implementing the skills." Within the October 5th and 19th meetings the following materials were discussed: Emwave2, Biodots, Dermatherms, Laptop (with biofeedback programs), an Integration Station, Coping Skills Boxes, and a Retail Store.

During the October 05th, 2015 committee meeting it was decided that "for PHP pilot program, we will need 12 Emwave2's minimum, aim for 15 to have backup in case there are technical difficulties." Also discussed the "need to demonstrate the Emwave2 effectiveness and utility, gather basic data and work with Heartmath company." The Biodots were proposed "may be better to let kids take home because we can get them in larger quantity at cheaper rates, send home resources for parents to get some of their own if desired." In regards to the Dermatherms, it was discussed that they are like band-aids that go on the back of the kid's hand and "help to know when relaxed vs.

stressed/escalated. We could send home with kids to record their temperature." Then, the meeting minutes provided details on the Integration Station proposed that state it would function to allow children to checkout supplies for a short time during programming to utilize mind-body skills.

The committee did decide to reduce spending by agreeing to utilize the PrairieCare backpacks for the patient's "Coping Boxes" versus purchasing additional supplies. The budget was discussed on October 19th, 2015 and it was determined that the pilot "may be costly upfront" to purchase all the materials needed, but most would be a one-time cost (except for the patient's prizes and take home materials that will continue to be ordered as needed). The last idea proposed during the meeting was to provide "retail shelves" that would include biofeedback programs (Emwave2 and Inner Balance) for purchase; therefore, it is a "way parents could pick some up easily."

Evidence-Based

Evidence-based is the last theme gathered from the data collected. There were four evident subjects within this theme that emerged: resources, biofeedback information, data gathering, and assessments. These four subcategories outline the evidenced-based theme that were found throughout the process of the program's development.

Resources. The resources needed for the development began being address during the September 14th's meeting action points. Integrative medicine specialists on the committee agreed to send two different types of resources that would be helpful for committee members: "key review articles on mind-body skills" and "send additional variations of skills handouts with verbiage for younger kids and teen to use as desired." Then, during the action points listed on the September 28th, 2015's correspondence listed

five different resources that were asked to be sent out by specific specialist/representatives: handout with functional medication/nutrition information, nursing articles or chapters from the research, "Superfoods" cards, an article on model used for a similar nursing training, and lastly, send relevant nutrition information.

Biofeedback information. The October 05th, 2015 meeting minutes also revealed information on a discussion with integrative medicine specialists on biofeedback. There was information given specifically on biofeedback and recommendations for integrating into programming proposed:

"We can get the heart rate app for Ipads vs. Emwave2 for heart rate biofeedback as well, teenagers/kids are very interested in these. Technologies engage them more. Emwave2 would be more workable than the iPads, easier to have on hand, and reduces distraction with the kids going online or to different apps with the iPad. Less risk, more clear and clean from a research standpoint. Having the handheld engages kids more, also can send resources for these in case families want to purchase for use at home. Parent can see that iPads can be a useful tool to help with continuing/practicing skills, can send home apps ideas for that as well."

"On the Biofeedback day (Thursdays), kids issued an Emwave, coached and work on mastering the skill. Then, re-issued the Emwave device throughout their PHP day as needed and at certain higher stress times, such as during their school period at PHP, or during breaks with goal of using the Emwave biofeedback right then and there for practice regulating, see what effects these situations have upon their stress level, increased self-awareness of mind-body connection."

The October 5th, 2015 meeting minutes also recorded that discussion of the Friday "Mishmash" or circuits. The goal is to offer computerized games for biofeedback during the circuits time, a committee member reported "*right now there are 3 games that are 3 minutes, one is 5, and 1 minute.*" Additionally, was acknowledgement of the usefulness of tracking the patients' heartmath data:

> *"We may be able to get them for next to free if we agreed with heartmath*
>
> *company to get descriptive or objective data. Kids can write their feedback (feel*
>
> *more relaxed, more irritated) throughout the day with these."*

This relates to the data gathering subcategory, which includes the planning committee's active attunement with evidence-based practice.

Data gathering. The beginning discussions of data gathering were seen in August 10th, 2015's proposal document. Including "*data: pre and post surveys of staff, patients, and parents. Survey monkey vs. paper*" (and a frequency section) and pilot duration estimation of four to six months before rolling out to other sites. The reason for this duration was reported to be "*to allow time to gather data and refine.*" The committee also discussed the need to assess for availability of devices for gathering the data and who will enter/assess the data. During the August 24th, 2015 meeting, the committee discussed incorporating the satisfaction survey data and the pre- and post-test for staff, patients, and parents for program evaluation. The surveys were reviewed by the committee and revised during the Novermber 13th, 2015 meeting.

The September 28th, 2015 correspondence discussed research-focused engagement in "*a) development of initial data gathering specifics b) determining whether we can add a 'treatment as usual' arm to our studies by using one of our other PHP sites*

while collecting data on our pilot program with CM." The correspondence also reported the information would help the committee "*compile a treatment protocol manual for future reference and implementation at other sites. We will also be gathering research data on this process from both a program development process standpoint and from an outcome measure/treatment efficacy standpoint.*" Lastly, the correspondence indicated intention for future committee meetings to be "*dedicated to research pieces.*" During the October 5th, 2015 meeting, minutes showed two different discussions of data gathering. Committee meeting members discussed the possibility of having a "control" arm of study by using other PHP sites. The group discussed possible options for the control location. The research staff overviewed the plan for the program's evaluation:

> *"Plan of working on research and data. Primary initial focus will be on process evaluation. This will also make it easier for other programs to see how we researched and implemented our program. Second phase of research will focus upon outcome data. Will collage clinical data from the onset with implementation, so that this data can be studied later for outcome research. Will need to be deliberate and thoughtful in data collected from patients, parents, and staff."*

Assessment. One of the participants described the "research portion" as a helpful resource during the process of developing the curriculum and "*using a lot of the research, evidence-based practice*" was useful. In the November 13 correspondence, the third meeting agenda item was to review clinical screening options (Child Screening and Assessment Guide and Adolescent Screening and Triage Tool Scoring). These screening options will be considered for use upon admission and discharge. The assessments reviewed were important evidence-based protocol measures.

On December 10th 2015's correspondence, the agenda stated the group will "*re-discuss as needed the BIS vs. other based upon some brief feedback at the leadership meeting.*" BIS stands for the "Brief Impairment Scale." Before the meeting on December 14th 2015 two clinical screening options were sent out as attachments. And the following information was given:

> "*1 is the BIS paper-pencil format that is the measure we have discussed to use on admission and discharge to capture some basic functional data on our PHP patients.*
>
> *2 is the symptoms checklist that outpatient clinics use currently across PrairieCare to capture data regarding mood, anxiety, and other overarching patterns that affect mental health.*
>
> *I'd like to take some time at some point to compare the two and determine which we feel would best capture the level of information we are going to find the most useful for the PHP level of care, and at some point in providing some more outcomes based data to evaluate.*"

The data collected points to multiple different evidence sources, from resources and biofeedback information to data gathering and assessments. It was more prevalent during the last group meetings; however, initial planning shows to have started at the beginning of the planning process as well.

Discussion

This study's discussion is important for the Mind-Body Care Curriculum implementation and other program development purposes. First, the discussion addresses

the purpose of this study in relation to the findings. Then, lessons learned for this study

for developers, members, and organizations as a whole. Next, this discussion gives

implications for social work practice, policy, and research. Lastly, the strengths and

limitations of this study will be overviewed.

Purpose

The first purpose of this study was to evaluate the process in which a conventional

treatment program model was provided structure with a mind-body skills base. Although,

the therapeutic programming groups have not been changed, the curriculum provides

more of a structure and core skills-based system. This evaluation revealed much of the

beginning of the planning process surrounded restructuring unstructured times by adding

mind-body skills into the daily and weekly schedules. Therefore, each day involves

teaching the patients a mind-body therapy technique, a "powerful and non-invasive"

(Mcclafferty, 2011, p. 201) therapy, as discussed during the literature review. The mind-

body skills discussed have been seen throughout the literature. For example, biofeedback

techniques such as "biodots" and "dermatherms" were reported to be easily applied in

clinical practice (Kohen, 2010). Each of the four techniques that will be highlighted in the

Mind-Body Care Curriculum have multiple benefits for children and adolescents with

mental health concerns, as reviewed in the literature.

This next purpose of this study was to provide information to allow for easier

implementation and highlight any changes that could be made during the planning

process. This information will be further discussed within the lessons learned and

implications sections, however much information was obtained regarding this goal of the

study. Lastly, this study aimed to have implications for the micro, mezzo, and macro

levels of the organization. Some of these will be discussed below, however there is evidence that the committee moved through discussing each of the three levels of the systems that were discussed within the conceptual framework.

Lessons Learned

Many lessons can be learned from the evaluation of the process of development for the Mind-Body Care Curriculum. It shows that the committee's process could've been improved by multiple means. During this study's interviews it was evident that training committee member's earlier in the planning process would've benefitted the committee members. Additionally, it was learned that there was truly an impact of committee member attendance on the group's efficiency. Participants recommended finding a solution so that all committee members can be present and committee members have enough time to work through each meeting's agenda. At the start, meeting agendas appeared long, and as the process continued less meeting agenda points were listed per meeting. This reflects the lesson learned even along the way during the planning process, that due to time availability less needed to be on each meeting agenda.

Another lesson learned throughout the process was the need for a note taker. It became difficult for members to be actively engaged in the committee meetings and take note of all the discussions/decisions that were being made. This is important for all future meeting and/or committees to take into consideration, because meeting notes and minutes were valuable throughout this study. The committee only had two meetings were a note taker was able to be present and it is evident from the large amount of data from those meetings that likely this would've been important throughout the entire process.

Last of the lessons learned from this study is the necessity of having upper management support. The committee had an unforeseen halt in planning after upper management wanted to further assess the curriculum's proposal. The compliance with upper management is necessary, but as learned in this study's process, without clear communication with them in the beginning stages there could be interruptions during the planning or implementation processes. These lessons learned very directly relate to the implications of this study.

Implications

Social Work Practice. There are implications for social work practice from this research study's findings. The first being, due to the limited amount of process evaluations of program development available, this study provides insight into the complexity of the process. Social workers are able to observe the different obstacles and considerations that were encountered during the planning process. Another implication that social work practitioners should take note of, is the importance of interdisciplinary cooperation during the planning process. It appears that having input from all different members of the team helped shape how the curriculum would be implemented within the program. Social workers should utilize this interdisciplinary team concept in developing programs. Lastly, this study implies the use of a more holistic healthcare approach and social work practitioners should become more knowledgeable upon these alternative approaches to treatment mental health.

Policy. The implications for policy regarding this study relate to the current trend of a more "holistic" healthcare approach. This process evaluation will be ground work for other programs to begin integrating mind-body therapies and alternative medicine

options. Policyholders should consider the benefits of offering more holistic care

opportunities. In general, the benefits of mind-body care and its techniques should

continue to be monitored. The hope is that the more substantiated research that is

developed, the more seriously policy members will view complementary and alternative

medicines.

Policy and leadership should also learn from this study's implications on the

efficiency and effectiveness of having a notes/minutes taker. This helps organize

committee members ideas and documents the process of development that can be later

used to substantiate a program's proposal. Additionally, policyholders should also

familiarize themselves with process evaluations and understand their importance. The

policies set in place for the Institutional Review Boards of both University of St. Thomas

and PrairieCare also greatly impacted the process of this study. Policyholders would

benefit from familiarizing themselves with the nature of process evaluations in order to

fully understand to study.

Research. This study will be the first of three total program evaluations being

done beginning during development, then implementation, and finally outcomes. Process

evaluations are not often done due to limited time and the need for outcomes data or

results-based studies. The implication this can provide for research is the importance of

evaluating the whole program's development process, this will further substantiate the

program's evidence and provide guidance for how to evaluate progress. This study

should also provide implications for partial hospitalization program research, as shown

within the literature review; the documentation for these programs has been scarce. All

too often, research has clumped day treatment and partial hospitalization programs into

similar categories. Researchers should understand the vast differences between the two programs, and more research should be done on partial hospitalization programs as its own entity.

Strengths

This study has strengths within its' design and data collection processes. The design is a strength because it tends to sample a number of different professionals, which in theory will provide more dynamic feedback due to their various disciplinary approaches. Additionally, this study was strengthened by the purposeful sampling approach chosen making it easy for this researcher to identify the individuals that were attempted to be recruited for this study. Lastly, this study's data collection was strengthened in two ways, one for the note/minutes data and the other is for the interviewing process. This study's researcher was also employed in the partial hospitalization unit and was a participant on the Mind-Body Care Curriculum's planning committee. This researcher was able to use their participation in the development of the Mind-Body Care Curriculum to maintain/collect notes and minutes during the process of development. These strengths helped guide this process evaluation of the Mind-Body Care Curriculum and provided knowledge for a successful evaluation of a partial hospital program's integrative curriculum.

Limitations

One of this study's possible limitations lies inherently within some of the above stated strengths. This limitation being that this researcher's committee involvement and purposeful sampling of committee members may illicit personal bias or false memories of

the process of creation of the Mind-Body Care Curriculum. These considerations are

typical when using human subjects as study participants, and no issues during the data

analysis were revealed pointing to bias or false memories. The second limitation to this

study was the timeline of the procedure. This researcher had to adhere to two separate,

but equally important timelines, including this study's required deadlines and the

committee's curriculum development process. This limitation applied pressure on the

production of the study, but also was informative for each timeline's establishment. This

second limitation did have impacts that are considered another limitation of this study.

Due to the timeline limitation, there was not enough availability or responses from the

individuals asked to participate in an interview. This limited the amount of input that was

gathered directly from the committee members. Lastly, another limitation was the

questions that were asked of the committee members or the time expectation. The two

interviews both did not exceed twenty minutes, and therefore took half the amount of

time this study's researcher had estimated. This many have increased the amount of

participants able to participate if the time commitment had been adjusted.

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Appendix A

Consent Form

Process Evaluation of the Mind-Body Based Curriculum

866354-1

You are invited to participate in a research study about the process of creating the Mind-Body Based Curriculum for the child and adolescent partial hospitalization program. I invite you to participate in this research. You were selected as a possible participant because of your role on the planning committee for the curriculum. You are eligible to participate in this study because *of your participation on the Mind-Based Based Curriculum's planning committee.* The following information is provided in order to help you make an informed decision whether or not you would like to participate. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by *Cady Nielsen, BS, LSW under the supervision of Courtney Wells, and the School of Social Work of the University of St. Thomas and St. Catherine's University.* This study was approved by the Institutional Review Board at the University of St. Thomas.

Background Information

The purpose of this study is to evaluate the process of the curriculum's creation, and examine if the committee met its goals and was overall success rate for goals. This research would like to gain knowledge of the necessary resources needed during the development, a timeline for its' development, and committee members' perceptions of the overall process. I will be examining committee agendas and meeting notes, as well as conducting interviews with committee members willing to provide feedback on the process. By participating in this study, you can provide feedback of how you felt throughout the process and provide insight into any suggestions or changes others should make for the planning process.

Procedures

If you agree to participate in this study, I will ask you to do the following things: Participate in a 45-60 minute interview, which will be audio recorded and can be held in a place of your most convenience (e.g., at your place of work, private room at a local public location, etc.). This will be a one-interview study, and will not require any participant follow-up. However, participants will be welcomed to seek any follow-up on results or conclusions to this study.

Risks and Benefits of Being in the Study

The study has risks. This study carries the potential risk of possibility of confidentiality of the data breach due to the participants being recruited know each other and are participants in the planning committee for the Mind-Body Care Curriculum together. There is no guarantee that the participants won't be able to identify their data, due to their knowledge of committee's process. In order to minimize the risk of a confidentiality breach this researcher will remove any participants' names, identifying, or suggestive information during transcription. Additionally, during the decoding process this researcher will assess themes and codes relevant to the process as a whole and attempt to eliminate any implicating personal participant data. The second possible risk to participants is emotional distress, due to any unforeseeable negative emotions that may have occurred throughout the planning committee process. To minimize the risk of emotional distress to participants, they will be assured that they only need to discuss what they are comfortable with sharing. If any participants are seen beginning to have emotional distress this researcher will stop the interview and converse with the participant to ensure they would like to continue with the interview, as they can choose not to participate at any time.

The direct benefits you will receive for participating are: There are no direct benefits for participating in this study.

Privacy

Your privacy will be protected while you participate in this study. You will be in control of the location, timing, and circumstances of sharing information during the study.

Confidentiality

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you. The types of records I will create include recordings, which will be transcribed and the recording will be destroyed after transcription. The transcripts will be saved on this researcher's personal computer in a pass code protected file. Only this researcher will have access to these transcriptions, and these transcriptions will be stored and deleted one year after transcription. All signed consent forms will be kept for a minimum of three years upon completion of the study. Institutional Review Board officials at the University of St. Thomas reserve the right to inspect all research records to ensure compliance.

Voluntary Nature of the Study

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with this researchers, PrairieCare, or the University of St. Thomas/St. Catherine's University. There are no penalties or consequences if you choose not to participate. If you decide to participate, you are free to withdraw at any time without penalty or loss of any benefits to which you are otherwise entitled. Should you decide to withdraw, data collected about you may indicate to this researcher if any data given thus far may be used within the study. You can withdraw by

indicating your wish to stop at any time throughout the interview. You are also free to skip any questions I may ask.

Contacts and Questions

My name is *Cady Nielsen*. You may ask any questions you have now and any time during or after the research procedures. If you have questions later, you may contact me at *612.710.67.12 or cady.nielsen@stthomas.edu or my faculty advisor Courtney Wells at 651.235.0346.* You may also contact the University of St. Thomas Institutional Review Board at 651-962-6035 or muen0526@stthomas.edu with any questions or concerns.

Statement of Consent

I have had a conversation with the researcher about this study and have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I give permission to be audio recorded during this study.

You will be given a copy of this form to keep for your records.

_____   _____

Signature of Study Participant   **Date**

_____

Print Name of Study Participant

_____   _____

Signature of Researcher   **Date**

Appendix B

Interview Questions

1. Please explain your role/participation in the planning of the CAM-Based Curriculum.
2. In your opinion, what was helpful during the process of planning the CAM-Based Curriculum?
3. In your opinion, was there anything that could have been improved during the process of planning the CAM-Based Curriculum?
4. Can you describe any resources necessary that were addressed during the planning of the CAM-Based Curriculum?
5. What are your expectations of the CAM-Based Curriculum?
6. What would you recommend to other partial hospitalization programs that would like to implement the CAM-Based Curriculum?
7. If you could, what would you change about the planning process of the CAM-Based Curriculum?
8. Do you have any final thoughts or opinions about the CAM-Based Curriculum you'd like to share?