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The Factor Structure of the Barriers to Treatment Participation Scale (BTPS): Implications for Future Barriers Scale Development

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Abstract Untreated mental disorder is a major problem, and barriers to care are not well understood. Four hundred and sixty-two mothers bringing children to community mental health centers reported barriers on the BTPS. Exploratory factor analysis (EFA) was performed on the first split-half sample to identify factor structure. Confirmatory factor analysis (CFA) was performed on the remaining half sample using structural equation modeling. EFA revealed two factors measuring "treatment expectations" and "external demands." CFA revealed good model fit for this two-factor solution. This analysis contributes to ongoing empirical validation of barriers measures in community settings, emphasizing the development of a short, community applicable measure.

Keywords Barriers · Psychometrics · Outpatient therapy · Instrument development · Community mental health

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Introduction

Attracting and retaining adults and children to mental health treatment is a significant public mental health problem. Many treatments are available but oftentimes are not used effectively, or even used at all (Wells et al., 2002). Nearly 20% of children who require specific mental health care services do not have their needs met, and as many of 75% of children who do seek treatment drop out of that treatment prematurely (Armbruster & Fallon, 1994; Greeno et al., 2002; Child and Adolescent Health Measurement Initiative, 2005). The numbers tell a similar story for adults who seek mental health treatment; up to 88% of adults who need mental health care have some or all of their needs unmet (Craske et al., 2005; Howard, Cornille, & Lyons, 1996; Norquist & Regier, 1996). "No-shows" also affect service costs and treatment time slot availability (Kazdin, Holland, & Crowley, 1997a). People from minority groups as well as people from lower socioeconomic backgrounds, especially those who receive services at community clinic settings, may even be less likely to get needed services because of barriers that are often significant (Flisher et al., 1997; Matthews & Peterman, 1998; Kouyoumdjian, Zamboanga, & Hansen, 2003).

The Barriers to Treatment Participation Scale (BTPS) is one of a number of attempts to measure barriers. It was developed in 1991 and validated in 1997 by Kazdin and colleagues in order to address the retention of children and adolescents in outpatient therapy. The items in the BTPS emerged as a result of focus group discussions with therapists, not consumers. Four a priori subscales, suggesting a particular underlying factor structure, were proposed; these include (1) stressors and obstacles that compete with treatment, (2) treatment demands and issues, (3) perceived relevance of treatment, and (4) relationship with the therapist (Kazdin, Holland, Crowley, & Breton, 1997b).

Although a number of systems for categorizing barriers have been proposed, in general, barriers instruments have not been subjected to rigorous psychometric testing. Kazdin's subsequent psychometric testing of the BTPS did not support the a priori four factor solution, but instead suggested that nearly all the items loaded onto only one factor (Kazdin et al., 1997b). A clearer understanding of the factor structure underlying barriers would be useful to further the development of instruments that are reliable and valid. Studies addressing psychometric properties have rarely been conducted in community settings. Furthermore, the length of the BTPS instrument—58 items (including ratings of 44 barriers and 14 "critical events")—limits its usefulness in community settings, where brevity is a virtue (Greeno, Colonna-Pydyn, & Shumway, in press).

We undertook an analysis to improve the reliability, validity, and generalizability of the BTPS. In this analysis, we factor analyzed responses to the BTPS made by mothers bringing their children to community mental health centers for care. The analysis has several goals. First, we sought to learn more about the underlying factor structure of the BTPS that could perhaps illuminate an underlying factor structure for other barriers measures. Second, we sought to propose a shorter, 20–item, version of the BTPS which could be more user-friendly in community settings. Third, we closely examined items to determine if recommendations could be made that could be validated in future studies with adult as well as child populations; instruments appropriate for adults and children could be used for comparisons across settings and populations, which could allow for a more comprehensive and generalizable understanding of barriers to care.

Methods

Study Participants

Five hundred and twenty-six mothers obtaining services for their children at four community mental health centers in Southwestern Pennsylvania participated in the study. Given that not all mothers answered every question, listwise deletion was performed to produce a final subset of 464 participants. Data were obtained from participants in two related research studies. The main purpose of these studies was to examine mental health needs among mothers seeking mental health care for their children; these studies are described elsewhere (Anderson et al., 2006; Swartz et al., 2005). Mothers were eligible if the child presenting for treatment was between the ages of 6 and 17, was nonpsychotic, was not mentally retarded, and did not require hospitalization. Mothers who agreed to be contacted by a member of the research team were referred to the team. Informed consent was attained by a member of the team, and data collection occurred in participants' homes. Both mothers and children completed standardized assessments and were compensated for their time. All study procedures were approved by the University's Institutional Review Board.

Demographic information for the study sample is shown in Table 1. The sample of mothers ranged in age from 22 to 61 years, with a mean age of 36.81 and standard deviation of 7.18 years. The ethnicity of the sample was predominately White (77.7%) as well as African-American (19.9%). Eighty-one percent of participants had at least a high school diploma or equivalent. In the sample, three-quarters (74.6%) of participants' households had an annual income of $30,000 or less, and over half (54.8%) of mothers were employed. Thirty percent (29.9%) of participants were recruited from clinics in urban settings.

Procedure and Instruments

Participants were given a battery of clinical tests and questionnaires in order to assess, among other measures, psychiatric symptoms of the mothers and children, caregiver burden and strain, working alliance with the therapist, barriers to care, and cultural competence of the clinician and agency.

Table 1 Demographic information of study participants

Variable	Sample
Age at interview (N = 461)	
M ± SD	36.81 ± 7.18
Range	22–61
Race (N = *462)*	
White	77.7%
African-American	19.9%
Other	2.4%
Education (N = 460)	
Less than high school	18.7%
High school, G.E.D, or greater	81.3%
Income (N = 460)	
$30,000 or less	74.6%
More than $30,000	25.4%
Employment Status (N = 462)	
Employed	54.8%
Unemployed	45.2%
Recruitment Site (N = *462)*	
Rural	69.9%
Urban	30.1%

The BTPS was a self-administered questionnaire completed at the follow-up timepoint in each study, either three months or six months after the baseline assessment. The main section of this instrument contains 44 items that are rated on a 5-point Likert scale (1 = never a problem, 5 = very often a problem). The second section of the BTPS is the critical events scale, 14 items that include specific, distinct events and are answered in a yes/no format. These items are not included in the total barriers score determined by the first section (Kazdin et al., 1997b), and are not included in our analysis.

Analytic Plan

We chose to perform an exploratory factor analysis (EFA) on the first split-half sample, randomly selected using SPSS 12.0 software for Windows, attempting to identify factor structure using principal axis factoring (SPSS Inc., Chicago, IL, USA). Because we wanted an abbreviated scale that would be used more frequently in community settings, we retained the 10 highest loading items on each factor. After the factor structure was revealed and items chosen, we performed a confirmatory factor analysis (CFA) on the remaining half of the sample in order to confirm the factor structure.

Results

Exploratory Factor Analysis

A variety of underlying factors of barriers have been proposed, yet little empirical testing is currently available. The initial EFA was performed on items 1–44 of the BTPS. The statistical analyses were performed using the SPSS 12.0 software for Windows (SPSS Inc., Chicago, IL, USA). Factors were initially extracted using principal axis factoring and Varimax rotation, in order to yield uncorrelated factors. We believed the factors to be orthogonal; a high score on one factor does not necessarily mean a high score on another factor. Orthogonal rotations are often regarded as yielding more simple structures, and Varimax rotation is the best procedure for it (Kline, 1998). The visual scree test (Gorsuch, 1983; Thompson, 2004) indicated two factors. Additional factors with eigenvalues greater than one were omitted because they added little additional variance. Table 2 shows the 44 items included in the analysis and their loadings. Indicated in bold type are the 10 items from each factor chosen for the abbreviated scale.

We examined the items comprising each factor for common themes in order to suggest underlying constructs. As noted above, these are situations that compete with getting to treatment and remaining on a consistent therapy timeline. The first factor dealt with issues regarding the client's experience of the treatment or the therapist, and is labeled "treatment expectations." After analysis, ten items were retained in this factor, referring to client-held expectations about mental health treatment, such as therapist demeanor or treatment techniques. These items all tap into a combination of the core aspects of treatment engagement and working alliance. High ratings would indicate that clients' treatment expectations are not being met. The second factor contained items related to scheduling conflicts, unexpected illness, and other caregiver burdens, and thus, it was designated "external demands." There were ten items retained in this factor, referring to events and circumstances that compete with getting to and staying in treatment.

Confirmatory Factor Analysis of 2-factor 20-item BTPS

A confirmatory factor analysis of a 20-item BTPS scale was performed on the other half of the sample ($N = 231$) using EQS 6.1 software (Bentler, 2004). The two-factor model confirmed the relationships among the scale items, $\chi^2(168) = 193.37$, $p = .09$, $CFI = .95$, $RMSEA = .03$. These three indices are noted because they provided a statistical correction for data that departs from normality, as our data were highly leptokurtic. The standardized factor loadings for the two-factor model are noted in Table 3. Given that initial work on this scale indicated only a single factor, we tested our modified scale against a one-factor instrument, by fixing the correlation between the two factors to 1.0. Kline (2005) has noted that this an important test in CFA models because if single-factor model is comparable, there is no reason to examine multiple factor models. The results of the chi-square difference test were $\chi^2(1) = 7.86$, $p < .01$, indicating that the two-factor model was statistically better than the single-factor model. The correlation between the two factors was estimated as 0.60.

Factor 1, treatment expectations, exhibited good internal consistency, with an alpha coefficient of 0.90. Factor 2, external demands, exhibited adequate internal consistency, with an alpha coefficient of 0.80. There were no differences in scores on these two factors across demographic groups, except that African American mothers (M = 12.65) did report less treatment expectation barriers than White mothers (M = 14.05), t (196.9) = –2.33, $p = .02$.

Discussion

This study extends our ability to measure barriers with valid and reliable instruments in a number of ways. We used a large, community-based sample. This extends

Table 2 EFA factor loadings for BTPS

Item	Factor	
	1	2
11. Treatment was not what I expected.	**0.74**	–0.14
32. I do not feel the therapist supported me or my efforts.	**0.73**	0.04
24. I did not feel that I had enough to say about what goes on in treatment.	**0.71**	0.00
30. Treatment did not seem to be working.	**0.58**	0.05
12. Information in the session seemed confusing.	**0.57**	0.07
27. The therapist did not seem confident in my ability to carry out programs.	**0.52**	0.18
8. I did not like my therapist.	**0.49**	0.00
13. My child had trouble understanding treatment.	**0.49**	0.24
26. The therapist did not seem confident that treatment would work for my child.	**0.48**	0.11
25. I felt treatment did not focus on my life and problems.	**0.48**	0.28
15. I lost interest in coming to sessions.	0.45	0.27
21. I felt treatment did not seem as important as the sessions continued.	0.39	0.09
19. I felt I had to give too much personal information to the therapist.	0.39	0.19
23. The atmosphere in the clinic makes it uncomfortable for appointments.	0.38	0.19
37. The therapist did not call often enough.	0.31	0.22
39. Finding a place to park at the clinic.	0.30	0.16
28. My child now has new or different problems.	0.28	0.18
22. I felt this treatment was more work than expected.	0.27	0.24
9. I felt that treatment cost too much.	0.27	0.00
10. I was billed for the wrong amount.	0.07	0.02
43. Treatment took time away from spending time with my children.	0.10	**0.60**
5. Treatment lasted too long (too many weeks).	0.30	**0.58**
41. I was too tired after work to come to a session.	0.00	**0.58**
38. Getting a baby-sitter so I could come to sessions.	0.06	**0.58**
44. I had trouble with other children at home which made it hard to come to treatment.	–0.02	**0.54**
4. Scheduling of appointment times for treatment.	0.22	**0.50**
18. Crises at home made it hard for me to get to a session.	0.19	**0.50**
6. Treatment was in conflict with another of my activities (classes, job, friends).	0.11	**0.49**
42. My job got in the way of coming to a session.	–0.03	**0.48**
36. There was always someone sick in my home.	0.15	**0.42**
16. I was sick on the day when treatment was scheduled.	0.12	0.41
14. During the course of treatment I experienced a lot of stress in my life.	0.30	0.40
34. I did not have time for the assigned work.	0.34	0.37
35. My child was never home to do the assigned homework.	0.03	0.38
20. Treatment added another stressor to my life.	0.37	0.38
2. Transportation (getting a ride, driving, taking a bus) to the clinic for a session.	0.07	0.38
3. My child was in other activities (sports, music lessons) that made it hard to come to a session.	0.11	0.38
33. The assigned work for me to do as part of treatment was much too difficult.	0.18	0.35
40. I had a disagreement with my husband, boyfriend, or partner about whether we should come to treatment at all.	0.21	0.33
31. There was bad weather and this made coming to treatment a problem.	0.14	0.32
1. My child refused to come to the sessions.	0.19	0.29
17. My child was sick on the day when treatment was scheduled.	0.11	0.22
29. My child's behavior seems to have improved, therefore, treatment no longer seems necessary.	–0.04	0.19
7. Treatment did not seem necessary.	0.14	0.16

Extraction method: Principal axis factoring. Rotation method: Varimax with Kaiser normalization

Table 3 Standardized coefficients from a CFA of a two-factor BTPS ($N = 231$)

Item	Factor	
	1	2
11. Treatment was not what I expected.	**0.82**	
32. I do not feel the therapist supported me or my efforts.	**0.73**	
24. I did not feel that I had enough to say about what goes on in treatment.	**0.64**	
30. Treatment did not seem to be working.	**0.63**	
12. Information in the session seemed confusing.	**0.80**	
27. The therapist did not seem confident in my ability to carry out programs.	**0.69**	
8. I did not like the therapist.	**0.76**	
13. My child had trouble understanding treatment.	**0.60**	
26. The therapist did not seem confident that treatment would work for my child.	**0.74**	
25. I felt treatment did not focus on my life and problems.	**0.64**	
43. Treatment took time away from spending time with my children.		**0.67**
5. Treatment lasted to long (too many weeks).		**0.53**
41. I was too tired after work to come to a session.		**0.64**
38. Getting a baby-sitter so I could come to the sessions.		**0.39**
44. I had trouble with other children at home which made it hard to come to treatment.		**0.46**
4. Scheduling of appointment times for treatment.		**0.53**
18. Crises at home made it hard for me to get to a session.		**0.58**
6. Treatment was in conflict with another of my activities (classes, job, friends).		**0.60**
42. My job got in the way of coming to a session.		**0.57**
36. There was always someone sick in my home.		**0.45**

Kazdin's original findings, which were based on therapist, rather than consumer, opinions. Furthermore, community-based samples are not common, yet they add considerably to our understanding. The application of strong psychometric techniques to advance instruments for use in community settings is uncommon and badly needed.

Client expectations and perceptions are an important predictor of treatment initiation and follow-through, and instrument development is one way in which client perceptions may be captured. A key aspect of this development is the involvement of consumers of community clinics, as the majority of instruments are developed and tested in university-based, academic settings.

One of the goals of this study was to develop a brief instrument that has good psychometric properties, a clear underlying factor structure, and the ability to measure different types of barriers. An individual's score on the external demands scale may indicate that he or she has a chaotic life or difficulty with finding time for treatment appointments. Many people having high scores signals that the clinic should consider, for example, offering expanded hours or changing its policy regarding missed appointments. Furthermore, a high score on treatment expectations may suggest that a client's perceptions of the treatment process do not match the actual process, either because the expectations are unrealistic or because the clinician did not adequately outline the process. We were somewhat surprised that African American mothers reported less treatment expectation barriers. Given that most of the treatment providers were White, we expected that African American mothers would have more perceived barriers, perhaps due to an issue of lower cultural competence on the part of treatment providers. However, these results suggest that the providers may in fact be successful at reducing these barriers. As mental health researchers and clinicians consider barriers to care, we hope that more research will be conducted in this area.

Another goal of this work was to meaningfully shorten the BTPS by removing items that do not correlate highly with the principal factors. By using data from a community setting, we are giving a voice to our participants and using their experiences in our instrument development process. Having a shorter, less cognitively complex instrument is preferable in community settings, as community mental health centers have many time demands. Furthermore, data are likely to be more reliable when respondents are faced with a straightforward instrument.

Barrier constructs overlap with the constructs of working alliance, consumer satisfaction, and cultural competence. Others are working to develop instruments to measure these concepts, but a lack of a clear definition of barriers is a challenge to this work. Future developments may address how these constructs relate to each other.

This study represents what could be another part of the foundation for ongoing work in this area. Kazdin hoped to

understand and address treatment barriers with the BTPS. A related instrument, the Parent Expectancies for Therapy Scale (PETS), was developed by Kazdin and Holland (1991) in order to address the role of parents' beliefs in relation to participation in their children's treatment. This therapist-administered, 25-item scale was validated in a university setting in 2001. As in the BTPS, scale items resulted from focus group discussions with therapists who focused on their clients who had dropped out of treatment. The study found that treatment attendance and treatment termination were predicted by parents' expectations of their children's therapy (Nock & Kazdin, 2001).

It should be noted that other instruments have appeared since the beginning of data collection for the analysis presented here. One of them, the Reasons for Ending Treatment Questionnaire (RETQ), developed by Garcia and Weisz in 2002, builds upon this foundation of similar instruments but was administered in a community setting. The RETQ determined that therapeutic relationship problems was the largest factor that discriminated between children who completed therapy and those that dropped out (Garcia & Weisz, 2002). It is interesting to note the importance of the parental role in treatment adherence and perception of barriers. As well, other studies have shown that family support of treatment is a predictor of treatment engagement (Armbruster & Fallon, 1994; Compton, 2005; Nock & Kazdin, 2001; Mitrani, Prado, Feaster, Robinson-Batista, & Szapocznik, 2003). Thus, we may infer that the role of a parent seeking treatment for a child is not unlike another adult seeking treatment for his or her own self. A person seeking treatment must perceive that he or she is supported during the treatment experience, not just from family but also from the clinician and mental health agency.

The shortened version of the BTPS is an improved instrument, but it is not meant to be definitive. The variance explained in the shorter BTPS is not ideal; other items may increase the variance, and more modifications are necessary. As well, data from other populations is essential in order to develop a scale that is relevant across many treatment-seeking groups. For instance, our study participants were mothers, so our scales' items are more applicable for caregivers. Furthermore, the mothers in our sample were mostly White and African American, largely due to the demographics of the communities served by the clinics. We hope that this limitation can be addressed by researchers and treatment providers serving more diverse areas. A coordinated effort is needed to use the brief BTPS more often and in larger populations so that we can continue to refine barrier measurement. In order to improve services for people seeking mental health services, we must increase our efforts to measure and to understand what barriers they may be facing. Coordinated efforts to design good tools that can be used across settings is needed.

References

Anderson, C. M., Robins, C. S., Greeno, C. G., Cahalane, H., Copeland, V. C., & Andrews, R. M. (2006). Why low-income mothers do not engage with the formal mental health care system: Perceived barriers to care. *Qualitative Health Journal, 16*, 926–943.

Armbruster, P., & Fallon, T. (1994). Clinical, sociodemographic, and systems risk factors for attrition in a children's mental health clinic. *American Journal of Orthopsychiatry, 64*, 577–585.

Armbruster, P., & Kazdin, A. E. (1994). Attrition in child psychotherapy. *Advances in Clinical Child Psychology, 16*, 81–108.

Bentler, P. M. (2004). *EQS 6 structural equations program manual*. Encino, CA: Multivariate Software.

Child and Adolescent Health Measurement Initiative (2005). *National survey of children with special health care needs*. Data Resource Center on Child and Adolescent Health website. Retrieved 01/25/06 from www.cshcndata.org.

Compton, M. T. (2005). Barriers to initial outpatient treatment engagement following first hospitalization for a first episode of nonaffective psychosis: A descriptive case series. *Journal of Psychiatric Practice, 11*, 62–69.

Craske, M. G., Edlund, M. J., Sullivan, G., Roy-Byrne, P., Sherbourne, C., Bystritsky, A., & Stein, M. B. (2005). Perceived unmet need for mental health treatment and barriers to care among patients with panic disorder. *Psychiatric Services, 56*, 988–994.

Flisher, A. J., Kramer, R. A., Grosser, R. C., Alegria, M., Bird, H. R., Bourdon, K. H., Goodman, S. H., Greenwald, S., Horwitz, S. M., Moore, R. E., Narrow, W. E., & Hoven, C. W. (1997). Correlates of unmet needs for mental health services by children and adolescents. *Psychological Medicine, 27*, 1145–1154.

Garcia, J. A., & Weisz, J. R. (2002). When youth mental health care stops: Therapeutic relationship problems and other reasons for ending youth outpatient treatment. *Journal of Consulting and Clinical Psychology, 70*, 439–443.

Gorsuch, R. L. (1983). *Factor Analysis* (2nd ed.). Hillsdale, NJ: Erlbaum.

Greeno, C. G., Anderson, C. M., Stork, E., Kelleher, K. J., Shear, M. K., & Mike, G. (2002). Return to treatment after assessment in a community children's mental health clinic. *Psychiatric Services, 53*, 624–626.

Greeno, C., Colonna-Pydyn, C., & Shumway, M. (in press). The need to adapt standardized outcomes measures for community mental health. *Journal of Health and Social Policy*.

Howard, K. I., Cornille, T. A., & Lyons, J. S. (1996). Patterns of mental health service utilization. *Archives of General Psychiatry, 53*, 696–703.

Katon, W. J., & Ludman, E. J. (2003). Improving services for women with depression in primary care settings. *Psychology of Women Quarterly, 27*, 114–120.

Kazdin, A. E., Holland, L., & Crowley, M. (1997a). Family experience of barriers to treatment and premature termination from child therapy. *Journal of Consulting and Clinical Psychology, 65*, 453–463.

Kazdin, A. E., Holland, L., Crowley, M., & Breton, S. (1997b). Barriers to treatment participation scale: Evaluation and validation in the context of child outpatient treatment. *Journal of Child Psychology and Psychiatry, 38*, 1051–1062.

Kendall, P. C., & Sugarman, A. (1997). Attrition in the treatment of childhood anxiety disorders. *Journal of Consulting and Clinical Psychology, 65*, 883–888.

Kline, P. (1998). *The new psychometrics*. New York, NY: Routledge.
Kline, R. B. (2005). *Principles and practice of structural equation modeling* (2nd ed.). New York, NY: Guilford Press.
Kouyoumdjian, H., Zamboanga, B. L., & Hansen, D. J. (2003). Barriers to community mental health services for Latinos: Treatment considerations. *Clinical Psychology: Science and Practice, 10*, 394–422.
Matthews, A. K., & Peterman, A. H. (1998). Improving provision of effective treatment for racial and cultural minorities. *Psychotherapy, 35*, 291–305.
Mitrani, V. B., Prado, G., Feaster, D. J., Robinson-Batista, C., & Szapocznik, J. (2003). Relational factors and family treatment engagement among low-income, HIV-positive African American mothers. *Family Process, 42*, 31–45.
Nock, M. K., & Kazdin, A. E. (2001). Parent expectancies for child therapy: Assessment and relation to participation in treatment. *Journal of Child and Family Studies, 10*, 155–180.
Norquist, G. S., & Regier, D. A. (1996). The epidemiology of psychiatric disorders and the de facto mental health care system. *Annual Review of Medicine, 47*, 473–479.
Owens, P. L., Hoagwood, K., Horwitz, S. M., Leaf, P. J., Poduska, J. M., Kellam, S. G., & Ialongo, N. S. (2002). Barriers to children's mental health services. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*, 731–738.
Sanders Thompson, V. L., Bazile, A., & Akbar, M. (2004). African Americans' perceptions of psychotherapy and psychotherapists. *Professional Psychology: Research and Practice, 35*, 19–26.
Swartz, H. A., Shear, M. K., Wren, F. J., Greeno, C. G., Sales, E., Sullivan, B. K., & Ludewig, D. P. (2005). Depression and anxiety among mothers who bring their children to a pediatric mental health clinic. *Psychiatric Services, 56*, 1077–1083.
Thompson, B. (2004). *Exploratory and confirmatory factor analysis: Understanding concepts and applications*. Washington, DC: American Psychological Association.
Wells, K. B., Miranda, J., Bauer, M. S., Bruce, M. L., Durham, M., Escobar, J., Ford, D., Gonzalez, J., Hoagwood, K., Horwitz, S. M., Lawson, W., Lewis, L., McGuire, T., Pincus, H., Scheffler, R., Smith, W. A., & Unützer, J. (2002). Overcoming barriers to reducing the burden of affective disorders. *Biological Psychiatry, 52*, 655–675.