**Goal: Family and Youth Engagement**
**This will be assigned to the Healthy Minds Fairfax Intern**

## CHILDREN'S BEHAVIORAL HEALTH SYSTEM OF CARE BLUEPRING TRANSITION AGE YOUTH WORKGROUP

The Transition Age Youth Blueprint work group is requesting grant funding for a Part Time Temporary Position that will serve as a Transition Age Youth Navigator. This position would be attached to the Healthy Minds Fairfax program under supervision of Peter Steinberg, Program Manager. The purpose of this position is to assist the TAY Blueprint work group in developing a Drop-in Center program for Transition Age Youth in Fairfax County. The purpose of the temporary position would be to research existing services for Transition Age Youth in the Fairfax County community and to identify stakeholders to participate in planning for the development of Transition Age Youth Drop-In Centers.

Project Description:

Transition Age Youth are defined as youth ages 16-24 years of age. The goal of this work group is to determine how best to engage youth in the Fairfax County community who may require mental health/substance abuse and other life skills supports services that may not be served currently due to the gap in service from CSB Youth Services to CSB Adult Services. Many of these youth may not meet the criteria for Seriously Mentally Ill and therefore have unmet mental health needs that lead to instability in housing, unemployment, and difficulty accessing educational and vocational training that would allow them to becoming functioning adults.

The TAY Blueprint workgroup has determined, based on benchmarking and research, that the best way to draw youth 16-24 into the needed mental health supports is to provide them a community based location that addresses their holistic needs for job skills, health care and financial aid assistance, peer support, and mentoring, as well as access to basic resources such as computers and referrals to existing community resources. After researching how jurisdictions in the United States and Canada have approached this population, the TAY Workgroup determined that a drop-in center that mirrors our existing Teen Centers through the

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Neighborhood and Community Services program would be the most beneficial way to create a one-stop space for community supports for these youth. In speaking with a staff person from the Teen Center in Reston, VA, the TAY Workgroup learned that transition age youth in our community are already making use of these centers to find the needed support.

As the TAY Blue print workgroup began to seek out and engage community providers and resources, it became clear that there were a number of resources already in existence that were unknown to many of the group members. Before concrete planning for the drop-in center could be proposed, it was necessary to identify and create a team of community shareholders to work with the TAY Workgroup to enhance rather than duplicate existing services.

Proposal:

The Transition Age Youth Navigator would serve as an adjunct member of the TAY Workgroup and would research and identify existing services. In addition, this position would assist in creating a report from the survey of Transition Age Youth within Fairfax County to determine youth buy in to the Drop-in model and suggested services or supports that may draw these youth.

It is the goal of the TAY workgroup to gain funding for this position for a period no less than 6 months and no more than 12 months to support development of Drop-in centers, initially in the Reston/Herndon and South County regions, which CSB data supports as hot spots for this population. The position would then be either terminated or folded into to the staffing of the Drop-in centers long term.

Outcome measures:

1. Creating data report from Transition Age Youth Survey to support development of services within regional Drop-In Centers.
2. Directory of existing resources and services for TAY
3. Development of TAY community shareholders/resource team

**Goal: Family and Youth Engagement**
**This will be assigned to the Healthy Minds Fairfax Intern**

4. Development of proposal for Drop-In Centers in Herndon/Reston and South County in collaboration with the TAY workgroup.

Budget/Costs:

E Class S23 Position at the midpoint salary of $30 per hour at the maximum of 1,560 hours per year.

6 month= 780 hours x $30/hr=$23,400 plus 13.45% non-merit benefit eligible = $ 26,547.03

12 month= 1560 hours x $30/hr= $46,800 plus 13.45% non-merit benefit eligible = $ 53,094.06

Timeline:

Position start date by May 13, 2019.

Report out of Youth Survey by July 5, 2019

Present a list of Community Stakeholders for TAY services to the TAY Workgroup by September 1, 2019 and develop schedule with TAY Workgroup for meetings with these Community Stakeholders.

Fairfax County TAY Directory of Services completed (living document that will be updated ongoing) by September 30, 2019

Completion of proposal for TAY Drop-in Support Centers by October 31, 2019

Report out to Children's Behavioral Health Collaborative by November 13, 2019 by the Transition Age Youth Workgroup members.

**HEALTHY MINDS FAIRFAX PROPOSAL 4**

**Goal: Quality**

# MEMORANDUM

**To:** CBHC Management Team

**From:** SOC Training Committee

**Date:** March 8, 2019

**Issue:** FY2020 Children's Behavioral Health Funding Request to Expand the Knowledge and Skills of Systems of Care Workforce and Families

**a. Description of the project and how it will accomplish a Blueprint strategy or action step.**

The Systems of Care Training Committee recognizes the benefit of effective training for all stakeholders to build and sustain a robust Systems of Care. Outlined below is a training request composed of two components. Each component contributes to the success of specific Goals and Strategies outlined in the Blueprint.

1. **Training for Providers and Families - Youth & Family Lens**
Training that provides insight into the Youth and Parent/Family perspective. Training on this topic is expected to increase collaboration between client-youth & families and providers, thereby increasing engagement and improving long-term outcomes. These training opportunities will be offered to agency staff, medical and behavioral health providers throughout the community, and parents/caregivers.

A strong System of Care uses the valuable perspectives offered by youth and families to inform what works well and offer constructive insight into additional strategies that can be used across the spectrum of services and supports offered by a community. This type of education is vital to successful collaboration between the client-youth & families and providers. Successful collaboration leads to increased engagement and improved long-term outcomes. The training may cover such topics as:

a. Developing a deeper understanding of the perspectives of clients/patients and family members;
b. Strategies for effective collaboration with clients/patients and family members;
c. Understanding community mental health resources available to clients/patients, family members, providers and the community.

Anecdotally, local providers are expressing interest in learning more on this topic to support improved patient interactions and outcomes. Further, youth and families have frequently expressed that this type of training would be likely to improve treatment engagement and outcomes. A one-time pilot presentation by a family-led organization, entitled, **Overcoming Barriers to Collaboration in Mental Health and Medical Health** was well received by a local hospital. It was attended by more than 40 physicians, nurses, social workers, other providers and two parents/caregivers. The response was overwhelmingly positive and included evaluation responses such as "Please, more of this!!!"

2. **Conference & Trainings for Workforce and Parent Leaders**
Attendance at conferences and professional trainings that will build new skills and bring fresh perspectives to agency staff and parent leaders. Where possible and appropriate, multi-agency teams made up of key stakeholders from agency and community partners (e.g. FAPT members, parents/caregivers) will have the

opportunity to attend conferences and trainings focused on increasing family engagement, trauma-informed care, evidence-based interventions, and innovations/improvements in residential care, for example. The trainings/conferences will be selected based on how well they further the work of the Blueprint.

The conferences and trainings allow for broad collaboration among System of Care stakeholders, emphasize family voice, and are aligned with the System of Care Blueprint goals, including but not limited to the following:

- Goal 1: Deepen the Community Systems of Care Approach
- Goal 3: Family and Youth Involvement
- Goal 7: Care Coordination and Integration
- Goal 10: Evidence-Based and Informed Practices
- Goal 11: Trauma Informed Care
- Goal 12: Behavioral Health Intervention
- Goal 14: DD/Autism Services
- Goal 15: Transition Age Youth

**b. Description of why current available services in the county cannot meet the need.**

Currently, there are no known programs being delivered, consistently and broadly, that address the proposed training program topic. The trainings/conferences proposed for staff and parent leaders to attend will offer fresh perspectives and new skills provided by other leaders in the field.

**c. Have other funding sources been explored?**

There are currently no known funding sources for launching training on the proposed training topic. For the trainings and conferences proposed for workforce development, no other funding sources are available.

**d. How will the program be sustained after the funding?**

**Training Program for Providers and Families - Youth & Family Lens**
During the pilot, various funding sources will be explored for sustaining the program.

**Conference & Trainings for Workforce**
These would be one-time expenses. While the Training Committee budget has a current balance of $8,357, the workgroup expects to utilize those funds in FY19/FY20 to develop training(s) that would address Blueprint Goal 8. Equity/Disparities. CSA program dollars will be used to pay for any CSA program staff that may attend any of the above referenced conferences.

**e. What are the outcome measures including how will the data be collected and reported back to the Children's Behavioral Health Collaborative?**

Outcome measures for the proposed trainings for providers and families.

1. Examples of what may be collected and reported:

a. Numbers of training events and number of participants trained in total and by category.
   - Category examples:
     - **Provider** -Physician, pediatrician, psychiatrist, nurse, social worker, etc. Behavioral health provider or other medical provider
     - **Youth and family** - Parent/caregiver, Youth, Other family member or friend
     - **Other** - Law enforcement/criminal justice

2. Results of participant surveys

Sample questions and rating items might include: Did the training meet the stated objectives? What will you do differently as a result of this training? Other meaningful outcome measures would be developed.

It is expected that at least 90% of participants will state they feel more confident in treatment collaboration.

Outcome measures for the Conference & Trainings for Workforce

It is believed that providing individuals actively involved in our system of care work the opportunity to attend national, high quality trainings helps with retention and participation on workgroups, infuses the ongoing work with new and innovative ideas, and keeps the work energized and focused.

16 people will attend high-quality and effective conferences and trainings focused on innovative ways to develop and improve programs for children, youth, and young adults with mental health and substance use disorders. Each conference attendee will be expected to share what they've learned with Blueprint workgroup(s). Before each conference, the conference participant will be expected to discuss with their team, workgroup or supervisor, as appropriate, the expected learning goals of the conference and also do a debrief to the appropriate person(s) after the conference.

100% of participants will indicate that these conferences/trainings developed their competencies, knowledge, skills, or abilities to achieve current and/or future goals

**f. A project budget identifying how county funds will be used and whether a one-time or ongoing expenditure is being proposed.**

| One-Time Budget Requests for Training | Est. Budget |
|---|---|
| Training Program for Providers and Families -Youth & Family Lens | $10,000 |
| Conference & Trainings for Workforce | $15,000 |
| **Total Request** | **$25,000** |

**g. A timeline for when the project will be completed if county funds are approved.**

**Training for Providers and Families - Youth & Family Lens**

July 1 – October 1: Training and certification of training team; development of surveys and other outcome measurement tools and reports

October 1 – June 30: Delivery of at least 8 trainings to Providers which are, ideally, also open to the community.

**Conference & Trainings for Workforce**

Various dates July 1, 2019-June 30, 2020

**Goal: Quality**

**Healthy Minds Fairfax Grant Proposal**

**Title: Evaluation of the REACH program to increase clinicians' comfort with assessing, identifying, and treating pediatric behavioral health concerns**

Julia Painter, PhD, MPH[1], Benjamin Schwartz, MD[1], Diane Dubinsky, MD[2]
[1]Division of Epidemiology and Population Health, Fairfax County Health Department (FCHD)
[2]Pediatric Locum Tenens and Medical Consulting Services

March 7, 2019

## 1. Description of the project

**1.a. Background.** Following the 2014 investigation of pediatric suicides in Fairfax, a county priority has been to improve the delivery of behavioral health services to children. In 2017, Fairfax County began training pediatric primary care providers using the REsource for Advancing Children's Health (REACH) curriculum, a program designed to increase clinicians' comfort with assessing, identifying, and treating pediatric behavioral health concerns.

The Healthy Minds Fairfax - Children's Behavioral Health Integration Team is interested in learning whether the REACH program is having an impact on pediatric primary care providers' practices regarding 1) use of behavioral health screening tools, and 2) management of behavioral health conditions. Given the limited number of pediatric behavioral health specialists in Fairfax County, increasing treatment at primary care practices can reduce the time to implement effective therapy and reduce barriers for families and children.

Thus, the Healthy Minds Fairfax - Children's Behavioral Health Integration Team requested that the FCHD Department of Epidemiology and Population Health conduct an evaluation of the REACH program. We are seeking funding to evaluate the impact of the REACH training on knowledge, attitudes, and practice behaviors of providers regarding diagnosis and treatment of behavioral health conditions.

**1.b. Goals.** The goals of the evaluation are to:

1) Evaluate the impact of REACH training on knowledge, attitudes, and practice behaviors regarding diagnosis and treatment of behavioral health conditions among physicians.
2) Assess the extent of REACH training diffusion from physicians who completed the training to other physicians in the same practice who did not attend the training.
3) Assess facilitators and barriers to implementation of the REACH curriculum (i.e., diagnosis and treatment of behavioral health conditions in-house) among physicians who completed the training.

**1.c. Study Design.** There will be 2 methods of data collection: 1) surveys of clinicians assessing their knowledge, attitudes, and practice behaviors, and 2) a review of electronic health record (EHR) codes.

1) **Provider Surveys.** For the provider surveys, we will survey 3 clinicians per practice: 1 clinician who attended the REACH training, and 2 practice-matched controls. We will aim to survey all clinicians who attended the REACH training and practice in Fairfax County (n=65). Combined with the controls, the total target sample size is (n=195). Realistically, we can expect approximately 50% of targeted physicians to participate in the survey, which would lead to a sample size of about 100.

**Goal: Quality**

2) **EHR codes.** We will also abstract diagnosis and treatment codes from EHRs for patients of practices with physicians who attended the REACH training, to serve as a validation measure for clinician self-report through the survey. We could compare medical diagnoses and in-house treatment for children diagnosed with conditions addressed in REACH (ADHD, anxiety, depression, etc.) for the 6 months before and after the REACH training, as well as after the 6month post-training REACH follow up calls. In addition to analyzing overall behavioral health diagnoses and management, we will stratify results by physician to determine whether practices have changed more for the REACH-trained provider than her/his peers within the same practice environment.

**1.d. Significance.** Fairfax County has allocated substantial funding to provide REACH training to clinicians. The value of this investment depends on whether this training is leading to actual changes in diagnosis and management of children with behavioral health conditions. This evaluation would be the first in Fairfax County and, to our knowledge, nationally, to evaluate the impact of the REACH program on physician knowledge, attitudes, and practice behaviors. While the REACH program does an evaluation immediately after the course to assess participants' impressions about the course, no longer term evaluation is done. Furthermore, a search of the literature (published and unpublished) provides a dearth of evidence assessing the impact or success of the REACH training. The results of our evaluation would be used to provide needed feedback on outcomes to the Healthy Minds Fairfax - Children's Behavioral Health Integration Team, and would guide funding decisions regarding the REACH program. Additionally, if other barriers are identified that affect the ability of clinicians to put their training into practice, additional attention can be devoted to addressing these barriers.

**1.d. How the project will project accomplish a Blueprint strategy or action step.** This project will provide critical data to help accomplish two Blueprint Strategies and corresponding Action Steps under the goal of *Care Coordination and Integration*:

1) *Strategy: Provide behavioral health consultation to primary care providers and patients; Action step: Provide behavioral health training to primary care providers.*
   The project will provide data regarding the impact of providing behavioral health training to primary care providers.
2) *Strategy: Increase the appropriate implementation of behavioral health screenings and referrals in primary care settings; Action step: Train primary care providers on using appropriate screening tools and on referring patients to care*
   The project will provide data regarding the impact of training primary care providers to utilize appropriate screening tool, manage patients' behavioral health conditions in-house, and when appropriate, refer patients out to care.

**2. Why current available services in the county cannot meet the need.** Currently, there is a high demand for behavioral health services among pediatric and adolescent patients in Fairfax County; however, there are not enough behavioral health care specialists in the County to meet those needs. Thus, one of the goals of the Healthy Minds Fairfax - Children's Behavioral Health Integration Team has been to improve capabilities of pediatricians and other primary care providers to provide behavioral health services for their patients. The centerpiece of this capacity building effort has been providing REACH training. To date, around 65 Fairfax County providers have been trained through the REACH program (as well as a similar number of providers in other Northern Virginia health districts). For each cohort of REACH trainees, the cost to the county is approximately $60,000. However, the extent to

which the REACH training is impacting provider knowledge, confidence, and practices regarding screening and managing behavioral health conditions is unclear.

In addition, REACH training may improve provider knowledge and increase capabilities, but other barriers might remain, which could impact physicians' ability to provide treatment. For example, despite REACH training, physicians might have a limited amount of time available, or might face obstacles to behavioral health screening and treatment due to the organization of their practice. We will assess not only physicians' individual knowledge, attitudes, and practices, but also changes to their practices at the organizational level that might facilitate behavioral health services.

**3. Have other funding sources been explored?** We have not explored other funding sources to date; however, we are unaware of any grant program that would be appropriate to support this evaluation. This evaluation has been requested by the Healthy Minds Fairfax - Children's Behavioral Health Integration Team to identify whether progress is being made, and to determine whether further expenditures on REACH are worthwhile.

**4. How will the program be sustained after the funding?** We are not proposing to implement a program that would need to be sustained. Rather, we are proposing a one-time expenditure to support an evaluation of an existing program. The evaluation will inform decisions about whether further REACH training should be continued within the County.

**5. Outcome Measures** There will be 2 sources of outcome measures in our evaluation: 1) surveys of clinicians assessing knowledge, attitudes, and practice behaviors, and 2) a review of electronic health record (EHR) codes. While our overarching outcome measure is increased diagnosis and management of pediatric behavioral health conditions within primary care practices by REACH-trained (and potentially other) providers, we also will assess "intermediate" outcomes – changes in provider knowledge and attitudes, and changes in practice management that may facilitate in-house care.

**Provider Surveys.** For the provider surveys, outcomes will comprise answers to questions about providers' knowledge, attitudes, and practice behaviors (KAP). REACH participants will answer about their KAP both before and after the REACH training, using themselves as a baseline. Controls will only answer questions about diagnosis and treatment once, to assess current KAP. If funded, we would solicit input from the Healthy Minds Fairfax - Children's Behavioral Health Integration Team to ensure that the survey adequately captures key outcomes of interest.

**Knowledge.** We will include 5 – 10 actual knowledge questions (about conditions, treatment, drugs, etc.), and a few self-rated knowledge questions (Sample question: How would you rate your knowledge of treatment for children with an anxiety disorder? Likert scale answer choices: a. Strong; b. Moderate; c. Weak).

**Attitudes.** We will include 5 – 10 questions to assess physicians' interest and confidence in diagnosing and treating patients with behavioral health conditions (Sample question: I feel confident in treating patients with drug therapy for anxiety disorder. Likert scale answer choices: a. Strongly agree; b. Agree; c. Neutral; d. Disagree; e. Strongly disagree). We will also ask questions about facilitators and barriers to diagnosing and treating patients with behavioral health conditions within their practice (Sample question: How much of an impact does lack of time with patients impact your ability to diagnose behavioral health conditions? Likert scale answer choices: a. Large impact; b. Some impact; c. Little impact; d. No impact). Finally, we will ask questions related to practice norms (Sample question: Among other physicians in my practice, what proportion manage patients diagnosed with anxiety disorder in-house? Answer choices: a. 10% or less; b. 11–40%; c. 41–60%; d. 61–89%; e. 90% or more.)

**Goal: Quality**

**Practices.** With respect to the **survey**, we will ask 5 – 10 questions regarding practices. (Sample question: For what proportion of your patients ≥10 years old do you perform behavioral health screening using standard screening tools? Answer choices: a. 10% or less; b. 11–40%; c. 41–60%; d. 61–89%; e. 90% or more.) We will also abstract **diagnosis and treatment codes from EHRs** for patients of practices with physicians who attended the REACH training, to serve as a validation measure for clinician self-report.

**6. How the data will be collected and reported back to the Children's Behavioral Health Collaborative.** We will hire a contractor to collect the physician survey and EHR data for us. Per County regulations, we will solicit bids from three County-approved contractors. Approved contractors include: Making Good Work, LLC; Compass Evaluation and Research Inc.; Health Management Associates (HMA); and Weldon Cooper Center for Public Service at the University of Virginia. Based on previous experience, we estimate it will cost $60,000 to complete the project. If the selected bid is less than this amount, then we will return the unallocated funds to the County.

We will work closely with the contractors to develop the methodology and survey tools. We will ensure that they are collecting the information in a secure, appropriate, and timely manner. Once the data have been collected, we will analyze them using quantitative methods (Excel and SPSS). We will present the data, along with our analysis and interpretation of the findings, to the Children's Behavioral Health Collaborative via one or more presentations and in a final report.

**7. Timeline.**

| Activities | Summer 2019 | Fall 2019 | Winter 2019-2020 | Spring 2020 |
|---|---|---|---|---|
| Receive funding | x | | | |
| Put out an RFP for contractors | x | | | |
| Hire a contractor | x | x | | |
| Develop the evaluation plan (materials and methods) | | x | | |
| Identify and recruit REACH-trained physicians and controls to participate in the evaluation | | x | x | |
| Collect survey and EHR data from physicians | | x | x | |
| Analyze data | | | | x |
| Disseminate findings in presentations and reports to stakeholders | | | | x |

* If there is funding available for FY 19, then the work could be started earlier.

**Goal: Quality**

## Healthy Minds Fairfax Funding Proposal

## Supporting Evidence-Based Practices: DBT in Schools

Fairfax County Public Schools (FCPS) Department of Intervention and Prevention Services is submitting a request for funding in the amount of $8,420 for an 8-week training course offered in the fall 2019 and spring 2020 provided by Sarah Fischer, Ph.D., Associate Professor at George Mason University. The training course will be provided to school psychologists and school social workers who will utilize Dialectical Behavior Therapy (DBT) in schools. This course is designed for school social workers and school psychologists supporting mental health needs of students in schools. A substantial percentage of youth enrolled in public school settings experience difficulty with emotional regulation, which leads to problems with disruptive behavior, impulse control, avoidance behaviors, and conflict with teachers and peers. Dialectical Behavior Therapy is an empirically-supported treatment that was originally developed for high-risk suicidal individuals with complex disorders who had difficulty regulating their emotions effectively. Several applications of this treatment paradigm have since been designed for youth exhibiting difficulties with emotional regulation. The goals of this course are to provide an overview of the conceptual model of DBT, and to teach specific skills and principles which can be taught and applied via school-based counseling, consultation, and intervention. Long-term outcomes will include improved mental wellness and educational success.

- ***A description of the project and how the project will accomplish a Blueprint strategy or action step?***

The project aims to train FCPS school psychologists and school social workers on evidence-based practices and strategies to provide a meaningful set of skills for emotion management, relationship building, and decision making that adolescents can acquire and apply to navigating the emotionally difficult situations and stressors that accompany adolescence.

The proposed training program will be available to 60 psychologists and social workers within FCPS divided between two cohorts. The course will be taught by Dr. Sarah Fischer, a licensed clinical psychologist. She is a psychotherapist at Potomac Behavioral Solutions and an Associate Professor of Psychology at George Mason University. Dr. Fischer has had extensive training in DBT and has supervised DBT programs for adults and adolescents. She has also published case studies on adaptations of this program. Dr. Fischer received her Ph.D. in clinical psychology from the University of Kentucky in 2006 and completed her internship and postdoctoral fellowship at the University of Chicago in 2006 and 2007. Her research uses a variety of methodologies (laboratory experiments, functional Magnetic Resonance Imaging, ecological momentary assessment) to study impulse control under varying mood conditions. She supervises the training of student therapists in cognitive behavioral therapy and Dialectical Behavior Therapy at George Mason University, and is a member of the DBT team at Potomac Behavioral Solutions.

This project will primarily work toward Blueprint Goals 10 and 12

**Goal 10: Evidence-Based and -Informed Practices,** *Increase the availability and capacity for evidence-based practices/interventions along the continuum of prevention through treatment*

> **Strategy C** -- Train county, school staff and providers on EBPs, including how and when to use them.

**Goal 12: Behavioral Health Intervention,** *Address the needs of children with emerging behavioral health issues who have not been able to access appropriate, timely, and matching treatment services in the community.*

> **Strategy D** – Expand access to timely and available behavioral health services for school age children and youth with emerging behavioral health issues who have not been able to access such services.

- ***A description of why current available services in the county cannot meet theneed.***

Research indicates that one in five school-age students exhibit signs and symptoms of a diagnosable mental health condition. Only 20% of these students actually receive any mental health services, and the majority of them receive those services in a school setting. Research increasingly suggests that schools function as the de facto mental health service provider for children and adolescents.

The mental health challenges that students experience adversely affect school engagement and performance. Many students are not able to access community providers, particularly those who specialize in DBT treatment. This access is limited due to financial resources, medical insurance coverage, transportation, and long waitlists by mental health professionals offering this specialized treatment. Having DBT-trained school psychologists and school social workers in the school building benefits students needing specialized intervention and reduces the barriers to this quality evidence-based practice.

- ***Have other funding sources been explored?***

The past two cohorts have been paid with Medicaid funds. These Medicaid funds are not guaranteed each year.

- ***How will the program be sustained afterfunding?***

Following completion of the DBT course, school psychologists and school social workers will receive ongoing consultation with Dr. Sarah Fischer as they implement DBT strategies working with students. Additional funding may be requested in the future to offer training to another cohort of school psychologists and social workers. Only 15% of FCPS school psychologists and school social workers have received this training thus far, and continued expansion is needed to meet the needs of the students being served.

- ***What is the evidence that the proposed intervention will achieve the desired outcomes with the target population?***

As a comprehensive treatment for pervasive emotional difficulties, DBT has gained empirical support for its effectiveness from research with adults and adolescents. Several randomized clinical trials have demonstrated the efficacy of DBT for reducing self-harm and suicide attempts in adolescents. Given that evidence on effective treatment for adolescents who engage in suicidal and self-harm behaviors is limited, it is especially noteworthy that DBT is a well-established, empirically-supported treatment for decreasing repeated suicide attempts and self-harm in youth.

DBT has also been shown to reduce office referrals and disciplinary actions in schools, thereby saving valuable school resources. Because DBT teaches effective skills for emotion management, problem solving, interpersonal effectiveness, and decision making, students who acquire these skills are less likely to be suspended or require specialized placements due to emotional and behavioral challenges. This serves the dual purpose of saving school districts money and keeping students in school (attendance).

More recently, the skills component of DBT as a stand-alone treatment has been recently studied through the use of the DBT Skills Training for Emotional Problem Solving for Adolescents (DBT STEPS-A) curriculum with school-based adolescents, and the findings have been encouraging. One of the first schools to implement the DBT STEPS-A curriculum was a group of selected inner-city middle and high schools in Philadelphia. After the first year, ninth graders who received the intervention showed a significant reduction in their overall emotional distress compared to peer controls.

- ***What are the outcome measures including how will the data be collected and reported back to the Children's Behavioral Health Collaborative?***

Data will be collected from school psychologists and school social workers implementing DBT skills in working with students. Data will focus on students' proficiency in applying the foundational DBT skills to alleviate emotional distress, and will be linked to school-based outcome measures (e.g., discipline referrals, attendance, grades).

- ***A project budget identifying how county funds will be used and whether a one-time or ongoing expenditure is being proposed.***

A total of $8,420 is requested for two cohorts to participate in an 8-week DBT training by Sarah Fischer, Ph.D. This total amount will fund the training of 30 school psychologists and school social workers in each cohort. The breakdown of the total funding cost is below:

| | |
|---|---|
| Training | $4,400 |
| Curriculum | $2,520 |
| Consultation | $1,500 |
| **Total** | **$8,420** |

***A timeline for when the project will be completed if county funds are approved.***

The training will occur during the 2019-20 school year and be completed by June 30, 2020.