School-Based DBT: Merging Mental Health and Behavioral Supports for High School Students at Tiers II & III: Dialectical Behavioral Therapy in the Public Schools

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Dialectical Behavioral Therapy in the Public Schools

James B. Hanson, M.Ed.
GAPBS Conference
Wednesday, December 2, 2015
Atlanta, GA
What is DBT?

Comprehensive cognitive–behavioral treatment developed to treat problems caused by pervasive emotion dysregulation:

a) Chronic suicidal behaviors
b) Non-suicidal self-injury

Balances teaching acceptance-based and change-based skills
Dialectical Behavior Therapy in Public Schools

BPD Re-conceptualized

- Emotional Regulation (labile, anger)
- Interpersonal Regulation (chaotic, abandoned)
- Self Regulation (identity, emptiness)
- Behavioral Regulation (suicide, cutting, impulsive)
- Cognitive Regulation (black and white thinking)
Why apply DBT skills to schools

DBT skills focus on coping strategies and decision-making abilities (esp. emotionally difficult situations)

Where could adolescents use these skills?
1. Alcohol and drug use
2. Relationships with peer, family, and romantic
3. Self-harming behavior
4. Suicidal behavior
5. Bullying victimization and perpetration
6. Antisocial behavior
7. Academic pressures
Outcomes for DBT

For Adults
reduction in suicidal behavior, self harming behavior, PTSD, depression, substance dependence, impulsivity, & BPD

For adolescents
Reduction in suicidal thoughts and attempts, self-harming behavior & depression

(Miller et al., 2010; Neacsiu et al., 2010)
Dialectical Behavior Therapy in Public Schools

Outcomes for School Based (SB)-DBT

**Ardsley High School, NY (7 years)**
- improved school attendance
- 50% reduction in disciplinary referrals

**Lincoln High School, OR (8 years)**
- BASC-2 significant reductions in anxiety, depression, social stress, anger control
- increased GPA

(Miller et al., 2014)
What is a Dialectic?

Balance of polar opposites
1. Thesis, Antithesis, Synthesis
2. Actions, emotions, cognitions

Acceptance & Change
Everyone has something to offer.
I am doing the best I can and I can do better.
I am tough and I am gentle.
I may not have caused all of my problems, and I’m responsible for working on them.
Dialectical Behavior Therapy in Public Schools

Biosocial Theory of Behavior

- Biological, Genes, Emotional Vulnerabilities
- Invalidating Environment (e.g., chronic stress, chaos, perfectionism, inconsistency)
- Can occur inside or outside the family setting
Creating a Life Worth Living

Increasing Behavioral Skills

Decreasing Quality-of-Life Interfering Behavior

Decreasing Therapy-Interfering Behavior

Decreasing Life-Threatening Behaviors

Adaptive Functioning
Dialectical Behavior Therapy in Public Schools

Potential Outcomes

a) Less self-medicating
b) Less use of alcohol and drugs
c) Less risky sexual behavior and students feeling pressured to have sex
d) Less self-harming behavior
e) Less suicidal behavior
f) Less bullying
g) Less conduct problems and thus less suspensions and expulsions
h) Less school dropout, better academic success measure through GPA, homework, etc.
DBT Skills and Therapy

Continuum of Services

STEPS-A Curriculum

TIER I

Health Teacher
Trained Teacher
School Psychologist

TIER II & III

DBT Therapy in Schools

School Psychologist
School Counselor
Social Worker

Mazza, 2015
Dialectical Behavior Therapy in Public Schools

STEPS-A = Skills Group/Large Class
SB-DBT = All Five Components/Small Class

“Phone Calls”
Individual Therapy
Consultation Team for Therapists
Parent Group
*Skills Group
Mindfulness
Distress Tolerances
Emotion Regulation
Interpersonal Relationships
Dialectical Behavior Therapy in Public Schools

STEPS-A is a Universal program; selective if used with an at-risk population

SB-DBT is an Indicated program; selective if used with students identified at risk and gauging RTI

Using MTSS model

Tier I
Universal Population
80-85%

Tier II
Selected Population
10-15%

Tier III
Indicated
5-10%

Mazza, 2015
If DBT in Schools doesn’t work, then outpatient DBT for adolescents (Miller, Rathus, & Linehan, 2008) would be the next logical tier.
DBT: Starting upstream

Program Evaluation and Research

Outpatient DBT

School-based DBT + STEPS-A

Residential Treatment + DBT

Hospitalization + DBT

IOP/PHP + DBT

Miller & Mazza, 2014
Dialectical Behavior Therapy in Public Schools

Curriculum Structure – Recommended Sequence

- Mindfulness
- Distress Tolerance
- Emotion Regulation
- Interpersonal Effectiveness
- Mindfulness
Dialectical Behavior Therapy in Public Schools

Curriculum Structure

STEPS-A CURRICULUM

Mindfulness
1. Wise Mind
2. Observe
3. Describe
4. Participate
5. Non-judgmental
6. One-mindfully
7. Effectively

Distress Tolerance
1. ACCEPTS
2. Pros & Cons
3. IMPROVE
4. Radical Acceptance
5. Turning the Mind

Emotion Regulation
1. Observe/Identifying
    Emotions
2. Describing Emotions
3. Opposite Action
4. ABC
5. PLEASE

Interpersonal Effectiveness
1. Ranking Priorities
2. DEAR MAN
3. GIVE
4. FAST
5. Evaluating Options

Mazza, 2015
Walking the Middle Path (SB-DBT)

Walking the Middle Path

1. Dialectics
2. Thinking Mistakes
3. What’s Typical?
4. Validation
5. Behavior Change

1. Two seeming opposite position can both be true, Dialectical Dilemmas
2. “Stinking Thinking” Mindful, Name, Claim, Tame
3. What’s typical and what’s cause for concern?
4. Validating self and other; Validation doesn’t mean agreement
5. Ways to Increase, Positive Reinforcement; Ways to Decrease; Extinction and Punishment

Mazza, 2015
Every student has the chance to receive immediate consultation during the week if trying to use skills and they aren’t working. Accommodation in IEP or 504 to come to the counseling center to see their DBT coach. Communicated to teachers if not on IEP/504. See the student before target behavior occurs. Do not see the student for 24 or 48 hours after target behavior occurs. Shaping appropriate help-seeking.
Effectiveness research shows clearly that parent evenings are crucial. Emphasis on validation, behaviorism, and communication. Students whose parents come are the students who make the best gains. Beyond the nuclear family.
Dialectical Behavior Therapy in Public Schools

SB-DBT Team Meetings

- Purpose: “To allow therapists to discuss their difficulties providing treatment in a nonjudgmental and supportive environment that helps improve their motivation and capabilities” (Miller, et. al., 2007).

- “Group therapy for therapists”

- Integral part of DBT program
Dialectical Behavior Therapy in Public Schools

SB-DBT Team Members

- School Psychologist
- School Nurse
- School Social Work Intern
- School Psychology Practicum Student and School Psychology Intern
- School Counselor
- School Counseling Intern
Dialectical Behavior Therapy in Public Schools

SB-DBT Team Training


- **Leader Training for School Psychologist**:
  - 6 Days, Portland DBT
  - 6 Days per year, Behavioral Tech
DBT in Action in the Schools
School Psychologists: Qualified Health Professionals Providing Child and Adolescent Mental and Behavioral Health Services

Tier 3 (direct and indirect services to address identified mental and behavioral health problems):

- Direct therapeutic services to all students in need, including individual and group counseling, even in the absence of a clinical diagnosis or identified educational disability
- Cognitive–behavioral therapy, behavior therapy, and dialectical behavior therapy
The National Association of School Psychologists Practice Model Domain 4 indicates, “School psychologists have knowledge of...evidence-based strategies to promote social–emotional functioning and mental health.”

NASP “Principles for Professional Ethics” (2010) Standard II.3.9 states that preference for intervention selection is given to interventions described in the peer-reviewed professional research literature and found to be efficacious.”
DBT in Schools (Comprehensive &/or STEPS-A)

- Ulster County HS Health Class Curriculum (1999)
  - Far Rockaway HS
- Hanson (2007-present)
  - Lincoln HS, Oregon
- Perepletchikova et al, (2010)
  - New Haven Elementary School/Yale University
  - PS 8 Bronx, NY/Albert Einstein College of Medicine
- Ardsley School District, NY- Elementary, MS, and HS (2008-present)
  - Presented data at conferences (Catucci et al.; Mason et al)
- Pleasantville, NY School District- MS and HS (2009-present)
- Mamaroneck, NY School District (2010-present)

Miller & Mazza, 2014
DBT in Schools (Comprehensive &/or STEPS-A)

- BOCES Rockland County (2012 – Present)
- New Rochelle School District (2012 – Present)
- University of Washington, MS & HS Education
- Golden Hill Elementary, Florida, NY (2013 – Present)
- Irvington Elementary, Middle, and High Schools, NY (2013-present)
- Hasting on Hudson Elementary, Middle, and High Schools, NY (2013-present)
- Briarcliff Elementary, Middle, and High Schools, NY (2013-present)
- Manteca MS & MS, CA (2014-present)
- Oakland, MS & CA (2014-present)
- Project GRAD, LA (2014-present)
- Aloha HS, Beaverton SD, OR (2015-present)

Miller & Mazza, 2014
Lincoln High School
1600 SW Salmon St, Portland, OR 97205
RTI & PBIS Accountability

- Coordinated School Health Model
- PBIS and SEL Based on Oregon State Health Standards
- School Improvement Plan
ASCD/CDC Model

WHOLE SCHOOL, WHOLE COMMUNITY, WHOLE CHILD

COORDINATING POLICY, PROCESS, & PRACTICE

HEALTHY

SAFE

CHALLENGED

SUPPORTED

ENGAGED

IMPROVING LEARNING AND IMPROVING HEALTH

COMMUNITY

COMMUNITY

COMMUNITY

COMMUNITY
Counseling Center Brochure

Social/Emotional Services
- Suicide Prevention: syork@pps.net
- Anti-Bullying: jmihanson@pps.net
- School Nursing: johnsonm@pps.net
- Health Curriculum: tgochhammer@pps.net
- Collaborative Problem Solving: ksilver@pps.net
- Cardinal Mentors: clickinersey@pps.net
- Peer Mediation: smanris1@pps.net
- Project Options: beniaiad@reed.edu
- Student Diversity Clubs: jmogee9@pps.net
- Dialectical Behavioral Skills: jmihanson@pps.net
- Social Thinking Curriculum: jcinamberg@pps.net
- Mental Health Counseling: See Counselors

Academic Services
- Writing Center/Math Tutor: ffox@pps.net
- All Tier 1 Services: VP or school counselors
- Staff Mentor: cammea@pps.net
- Peer Advocate: dchingan@pps.net
- English Lang. Learners/SiOP: jlaboyon@pps.net
- Spanish Lang. Family Support: sfalco@pps.net
- Credit Recovery/Night School: scounselor
- Virtual Scholars: amqueen@pps.net
- Academic Support Classes: cammea@pps.net
- 504 Plans: cammea@pps.net
- Special Education: cdingan@pps.net
- Options Conference: school counselors

School Counselors
- A-D: jmogee9@pps.net, D-I: smanris1@pps.net
- J-M: choi@way@pps.net, M-R: :

Whole School, Whole Community, Whole Child
Health and education affect individuals, society, and the economy and, as such, must work together wherever possible. Schools are a perfect setting for this collaboration. At Lincoln we embrace the WSCC Model

Whole SCHOOL WHOLE COMMUNITY WHOLE CHILD

Lincoln High School
LHS Student Supports Information

Tier One Interventions are programs that all students may access. About 80% of students at Lincoln perform well with these “universal” supports.

Tier Two Interventions are programs that about 20% of students might need in order to succeed academically and socially/emotionally at Lincoln. Students access Tier Two interventions through referrals to the Student Support Team and parent permission.

Tier Three Interventions are programs that about 5% of Lincoln students require in order to make adequate academic progress. Students access Tier Three interventions through the Student Support Team and Special Education referral and evaluation.

Lincoln’s academic programs are reviewed for effectiveness for all students, for students by race, and for students by disability status. Information on Lincoln’s academic support programs and effectiveness can be found at: http://cdelingan.blogspot.com/p/2014-15-lincoln-high-school-academic.html

Lincoln’s social/emotional learning programs are assessed for effectiveness yearly. Information on the effectiveness of these programs may be accessed in the School Improvement Plan-Optional (Health & Mental Health/Positive Behavior and Supports) under “SIP” (by year) at www.pps.k12.or.us/schools/lincollin/1674.htm.
Conceptual Analysis

Current Policy
NASP
EBP

Preventative Activities within a Public Health Model of Service Delivery

Traditional Test and Place Activities within a Medical Model

Policy (Pre-2004)
SpEd Funding Perpetuated through Re-Evaluation
Student Information Team

Lincoln High School: 2015-2016 School Year
Struggling Student Concerns
No Immediate Safety Threat

Social or Emotional Issues
(e.g., depression, anxiety, drugs, outbursts, etc.)
Data Sources: Child Find, Nurse Screening, Discipline Records, and Teacher, Student, & Parent Referral
- Counselor
- Nurse
- Social Worker

Attendance
(e.g., skipping, often ill, etc.)
Data Sources: Dashboard Attendance Records, Teacher & Parent Referral
- Counselor

Academic
(e.g., not making progress to graduate)
Data Sources: Grades, Tier Status, Teacher & Parent Referral
- Academic Support Team
  - Academic Counselor, Administrative Vice Principal, Attendance Officer

Student Support Team (SST)
Vice Principals, Counselors, Academic Counselor, (Teachers), Nurse, School Psychologist, School Resource Officer, Attendance Officer

Staffing:
- Student, Parent(s), Counselor, Administrative Vice Principal, Parent, Student

Optimizing Conferences
(District/Private)

Credit Recovery Plan
(Night/Summer School, On-Line Courses, etc.)

Tier Two RTI
(Tutoring, Reading, FLEX, Peer Advocate, Support Class, VS, etc.)

Tier Two SEL
(Project Options, FBA, Attendance Contract, Peer Mediation, Mentoring, etc.)

Building Screening Committee (BSC):
- Student, Parent(s), Teacher(s), Counselor, Nurse, Spec. Ed. Teacher, School Psychologist

Special Ed Team

504 Team
- Student, Parent, Teachers, Counselor, Curriculum Vice Principal, School Psychologist, Nurse (as needed)

Mental Health Referral:
- Parent, Counselor, Nurse, Social Work Intern, School Psychologist

Referral to:
- Social Work Intern, EHS Safe Schools, Community Counselor, Therapist, Primary Care, Psychiatrist, etc.

Create Safety Plan
- Student, Parent, Counselor, Nurse, School Psychologist

** Students who have self-harmed or are suicidal should be referred immediately to The School Psychologist or the School Nurse. **

Revised 10/1/14
School Improvement Plan

2014
Oregon Student Wellness Survey

<table>
<thead>
<tr>
<th>PSENTATION STEPS FOR</th>
<th>PERSON RESPONSIBLE</th>
<th>TIMELINE</th>
<th>EVIDENCE OF IMPLEMENTATION</th>
<th>ASSESS PROGRESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increasing Center will continue to</td>
<td>Hanson-Psychologist</td>
<td>December to June</td>
<td>Certificates of completion for staff training</td>
<td>Students in DBT will see significant decreases in anxiety and/or depression (&gt;.8) that will result in increases in Grade Point Averages of &gt;.5 or better.</td>
</tr>
<tr>
<td>iatrical Behavioral Skills</td>
<td>Begansky-Student</td>
<td></td>
<td>Data summary for student outcomes and program effectiveness</td>
<td></td>
</tr>
<tr>
<td>DBT as a Tier Two and</td>
<td>Johnson-Nurse</td>
<td></td>
<td></td>
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<tr>
<td>gree intervention. Two more</td>
<td>Clingan, Morris-School Counselors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>school counselors will be fully</td>
<td>Cramer-PDDBTI Therapist</td>
<td></td>
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<tr>
<td>trained this year on DBT.</td>
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</table>

Intervention: This year the Lincoln School-Based Dialectical Behavioral Therapy program expanded to serve 20 students. DBT in an evidence-based practice listed in the National Registry of Evidence Based Programs and Practices. It has been shown to significantly improve students’ emotional, social, and behavioral self-regulation. DBT reduces anxiety, depression, and anger. This year students participated in a sixteen-week skills training, weekly individual coaching session on skills, and a pre-emergency coaching session on skills (when he or she needs immediate help/coaching to use skills and then return to class without incident). Classes are limited to a total of 7 or fewer students. Parents attend a monthly training session. With Health Action Network and PTSD support, two interns and two school counselors received full training in providing DBT. This year’s DBT team included the school psychologist (program coordinator, student and parent class facilitator, individual coach), school nurse (co-facilitator), school psychology intern (co-facilitator, individual coach), two school counselors (individual coaches), school counseling intern (parent class co-facilitator), and a Portland DBT Institute (individual coach). Lincoln established a Memo of Understanding with Portland DBT Institute to include one of their therapists on site at Lincoln. The PDDBTI therapist provided individual coaching to 7 students who participated in the Lincoln DBT classes. He provided program consultation (fidelity checks) at the weekly meeting for Lincoln’s DBT Team. Because Portland DBT Institute provided a therapist, the Lincoln School-Based DBT program was able to support students with more pronounced social/emotional needs. Students participating in Lincoln’s DBT program were invited through a variety of sources. 9 students received special education services, 10 students were identified through “Child Find” suicide prevention meetings (2 students had both SPED and Child Find invitations). 3 students were on 504 Plans or had Academic Priority status. In addition to improving program capacity and depth, the Lincoln SB-DBT Program team made improvements including initiating a family and student orientation checklist, developing a DBT factsheet for other schools interested in establishing a DBT program, and distributing a “DBT Skills At A Glance” two-page handout for Lincoln staff, parents, and students. In June 2015 Marsha Linchuck, Ph.D., the originator of DBT, provided two research assistants to Lincoln to help Mr. Hanson and Dr. Ed Krupinski, PPS Special Education Assistant Director, collect and summarize seven years of positive student outcomes and program evaluation and to write an implementation research article for publication. Results: Of the 20 students, 18 completed the full program for a retention rate of 90%. Three DBT classes were provided. Attendance at classes averaged 93%. Two classes received the standardized DBT Teen curriculum. One class piloted a version of DBT for teens adapted to meet the needs of students with autism spectrum disorder, ADHD, and specific learning disabilities (special atypical). The curriculum for the class for special atypical students re-ordered the DBT skills from most concrete to most abstract. Average effect sizes were moderate-to-large for reductions in anxiety (>.6) and large for reductions in both depression (>.5) and overall internalizing problems (>.5). Results of previous special atypical students suggest the adaptation of DBT for special atypical students increased its effectiveness. This year’s students achieved gains compared to gains with typical students. However, there was no matched control group of special atypical students using the standard curriculum. Therefore, the actual effectiveness of this adaptation remains to be seen but shows promise. Results from the special atypical class were similar for the standard SB-DBT classes. Overall, across all three classes, average effect sizes for reductions in anxiety were moderate-to-large (>.6), reductions in depression were large (.92) and reductions in overall internalizing problems were large (.92). This is the seventh year of school-based DBT at Lincoln. In those seven years, our Special Education Team’s referrals of students for more restrictive placements for social emotional challenges have ceased. Lincoln has been able to successfully transition back 7 students from more restrictive placements, 5 of which have participated in Lincoln’s DBT program, and 1 whose parents attended Parent DBT training. This has resulted in a much more favorable learning environment for students and families and a substantial cost savings for the school district (in delivering social and emotional services in neighborhood schools rather than special schools).
SB-DBT Goals
via Oregon DOE Health Standards

• Explain how to build and maintain healthy relationships
• Classify personal stressors at home, in school, peers
• Describe how social environments affect well-being
• Identify resources at home, school, and in the community for managing family and relationship problems
• Practice strategies for managing and reducing stress, anger and conflict
• Demonstrate the ability to take the perspective of others in a conflict situation
• Identify influences that contribute to positive and negative self-image
• Demonstrate pro-social communication skills
• Demonstrate the steps in problem solving, anger management and impulse control
2009-2016 Student Groups

- 2009 Girl’s Group, Closed, Semester
- 2010 Mixed Group, Closed, Semester
- 2010 Mixed Group, Open, Year-Long
- 2011 Mixed Group, Closed, Year-Long
- 2012 Mixed Group, Closed, Semester
- 2013 Two Mixed Groups, Closed, Semester
- 2014 Three Mixed Groups, Closed, Semester
- 2015 Three Mixed Groups, Closed, Semester
- 2016 Two Mixed Groups, Open, Year-Long
Measures

- BASC-2 Pre and Post (Student, Parent, Teacher Versions)
- Attendance
- Grade Point Average
- Written Reflection
- Progress Monitoring: Daily Diary Cards
Data

- School Records
- Pre- and Post-Testing Standardized Checklists
- Formative and Summative Assessment
- Student Work and Progress Monitoring

Data from Attendance Credit Earned G.P.A.

Measuring Attitudes, Beliefs, Behaviors

Performance of Oregon State Health Standards Skills

Written Reflections and Portfolio Work Samples
Students’ voices:

- “This group rocked. I learned a lot and you were pretty tough on me. You know that, right?”

- “All those chain analyses. They laid it all right out, like, ‘Girl, this is your life.’ It helped me quit smoking and I’m not cutting on myself anymore.”

- “Now I like myself. After group ended, a relationship failed. I did ‘accepting myself rehab’ and it worked.”
“The Mindfulness skill allowed me to heighten my awareness of my limits. I’m more aware of when I’m overworked, or over emotional and I know what triggers the overload.”

“My experience here with DBT has been truly life changing. I’ve developed skills that will help me the rest of my life.”
Example of BASC-2 SRP

SRP Progress T-Score Profile

<table>
<thead>
<tr>
<th>T Score</th>
<th>Attitude to School</th>
<th>Attitude to Teachers</th>
<th>Sensation Seeking</th>
<th>School Problems</th>
<th>Atypicality</th>
<th>Loss of Control</th>
<th>Social Stress</th>
<th>Anxiety</th>
<th>Depression</th>
<th>Sense of Inadequacy</th>
<th>Sensitization</th>
<th>Externalizing Problems</th>
<th>Attention Problems</th>
<th>Hyperactivity</th>
<th>Indulgence/Hyperactivity</th>
<th>Emotional Symptoms Index</th>
<th>Relations with Parents</th>
<th>Interpersonal Relations</th>
<th>Self-Esteem</th>
<th>Self-Reliance</th>
<th>Personal Adjustment</th>
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<tr>
<td>T Score</td>
<td>32</td>
<td>34</td>
<td>49</td>
<td>40</td>
<td>42</td>
<td>41</td>
<td>40</td>
<td>42</td>
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<td>36</td>
<td>63</td>
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<td>38</td>
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<td>38</td>
<td>62</td>
<td>55</td>
<td>57</td>
<td>58</td>
<td>61</td>
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<tr>
<td>Percentile</td>
<td>1</td>
<td>2</td>
<td>46</td>
<td>6</td>
<td>4</td>
<td>14</td>
<td>18</td>
<td>23</td>
<td>1</td>
<td>1</td>
<td>88</td>
<td>10</td>
<td>22</td>
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<td>52</td>
<td>63</td>
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<td>88</td>
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<td>Percentile</td>
<td>99</td>
<td>97</td>
<td>20</td>
<td>94</td>
<td>84</td>
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<td>96</td>
<td>47</td>
<td>92</td>
<td>81</td>
<td></td>
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</table>
## 7-Year Summary

<table>
<thead>
<tr>
<th>Year</th>
<th>Students Enrolled</th>
<th>School lunch qualifiers</th>
<th>Ideators</th>
<th>Attempters</th>
<th>Attendance M(SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>4</td>
<td>50%</td>
<td>75%</td>
<td>50%</td>
<td>--</td>
</tr>
<tr>
<td>2010</td>
<td>5</td>
<td>20%</td>
<td>80%</td>
<td>60%</td>
<td>--</td>
</tr>
<tr>
<td>2011</td>
<td>9</td>
<td>55.6%</td>
<td>55.6%</td>
<td>22.2%</td>
<td>94.44 (8.59)</td>
</tr>
<tr>
<td>2012</td>
<td>5</td>
<td>80%</td>
<td>60%</td>
<td>60%</td>
<td>87.14 (12.78)</td>
</tr>
<tr>
<td>2013</td>
<td>7</td>
<td>71.4%</td>
<td>85.7%</td>
<td>85.7%</td>
<td>--</td>
</tr>
<tr>
<td>2014</td>
<td>9</td>
<td>22.2%</td>
<td>66.7%</td>
<td>44.4%</td>
<td>98.15 (2.78)</td>
</tr>
<tr>
<td>2015</td>
<td>17</td>
<td>5.9%</td>
<td>64.7%</td>
<td>58.8%</td>
<td>93.33 (8.17)</td>
</tr>
<tr>
<td>Totals</td>
<td>56</td>
<td>35.7%</td>
<td>67.9%</td>
<td>53.6%</td>
<td>93.89 (8.43)</td>
</tr>
</tbody>
</table>
## 7-YEAR SUMMARY

<table>
<thead>
<tr>
<th>BASC Subscale</th>
<th>Mean Pre (SD)</th>
<th>Mean Post (SD)</th>
<th>95% CI</th>
<th>t-score</th>
<th>Cohen’s d</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>59.57 (12.17)</td>
<td>53.90 (13.62)</td>
<td>2.13-9.21</td>
<td>3.22*</td>
<td>.91</td>
</tr>
<tr>
<td>Depression</td>
<td>62.27 (14.65)</td>
<td>51.45 (10.29)</td>
<td>6.75-14.90</td>
<td>5.34**</td>
<td>1.51</td>
</tr>
<tr>
<td>Internalizing</td>
<td>60.51 (11.95)</td>
<td>52.65 (11.86)</td>
<td>4.14-11.59</td>
<td>4.24**</td>
<td>1.20</td>
</tr>
<tr>
<td>Anger Control</td>
<td>57.70 (10.74)</td>
<td>51.63 (10.22)</td>
<td>2.50-9.63</td>
<td>3.42*</td>
<td>1.02</td>
</tr>
</tbody>
</table>

* <.005  ** < .001; Bonferroni correction = .0125
## Table x. Associated costs of DBT implementation

<table>
<thead>
<tr>
<th>Item</th>
<th>Cost ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adoption</td>
<td></td>
</tr>
<tr>
<td>Team leader training</td>
<td>600</td>
</tr>
<tr>
<td>Support staff training</td>
<td>1,125</td>
</tr>
<tr>
<td>Consultation</td>
<td>1,575</td>
</tr>
<tr>
<td>Materials</td>
<td>750</td>
</tr>
<tr>
<td>Training tapes</td>
<td>376</td>
</tr>
<tr>
<td><strong>Start-up Total</strong></td>
<td><strong>4,951</strong></td>
</tr>
<tr>
<td>Sustainment (annual)</td>
<td></td>
</tr>
<tr>
<td>Consultation</td>
<td>1,000</td>
</tr>
<tr>
<td>Training new staff and interns</td>
<td>500</td>
</tr>
</tbody>
</table>
It’s Not a Walk on the Beach

- And It Ain’t Bad

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