

WESTPORT BOARD OF EDUCATION

***AGENDA**

(Agenda Subject to Modification in Accordance with Law)

PUBLIC CALL TO ORDER: 6:00 p.m., Staples High School, Principal's Conference Room

ANTICIPATED EXECUTIVE SESSION: Strategies for Negotiations

RESUME PUBLIC SESSION

PLEDGE OF ALLEGIANCE: 7:30 p.m., Staples High School, Cafeteria B (Room 301)

ANNOUNCEMENTS FROM BOARD AND ADMINISTRATION

PUBLIC QUESTIONS/COMMENTS ON NON-AGENDA ITEMS (15 MINUTES)

MINUTES: March 9, 2015

DISCUSSION:

Review with Lockton Companies, LLC Health and Medical Insurance Projected Insurance-Related Revenues and Expenses for 2014-15 and 2015-16; Projected Year-End Balance in Health Reserve Account for 2014-15 and 2015-16	(Encl.)	Mr. Longo
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PRESENTATION:

1. Dialectical Behavior Therapy	(Encl.)	Mr. Rizzo Dr. Babich Dr. Dadd
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DISCUSSION/ACTION:

1. Adoption: Student and Faculty Calendar: 2016-17 School Year	(Encl.)	Dr. Landon
2. Capital Expenditure Request: BMS Gymnasium Floor	(Encl.)	Dr. Landon Mr. Longo
3. Approval of School Transportation Contract Provisions: 2015-2020	(Encl.)	Mr. Longo Ms. Evangelista

INFORMATION:

1. Report: School Bus Arrival and Departure Times	(Encl.)	Ms. Evangelista
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ADJOURNMENT

*A 2/3 vote is required to go to executive session, to add a topic to the agenda of a regular meeting, or to start a new topic after 10:30 p.m. The meeting can also be viewed on cable TV on channel 78; AT&T channel 99 and by video stream @www.westport.k12.ct.us

PUBLIC PARTICIPATION WELCOME USING THE FOLLOWING GUIDELINES:

- Comment on non-agenda topics will occur during the first 15 minutes *except* when staff or guest presentations are scheduled.
- Board will not engage in dialogue on non-agenda items.
- Public may speak as agenda topics come up for discussion or information.
- Speakers on non-agenda items are limited to 2 minutes each, except by prior arrangement with chair.
- Speakers on agenda items are limited to 3 minutes each, except by prior arrangement with chair.
- Speakers must give name and use microphone.
- Responses to questions may be deferred if answers not immediately available.
- Public comment is normally not invited for topics listed for action after having been publicly discussed at one or more meetings.

WESTPORT PUBLIC SCHOOLS

ELLIOTT LANDON
Superintendent of Schools

110 MYRTLE AVENUE
WESTPORT, CONNECTICUT 06880
TELEPHONE: (203) 341-1010
FAX: (203) 341-1029

To: Members of the Board of Education
From: Elliott Landon
Subject: Review with Lockton Companies, LLC
Date: March 16, 2015

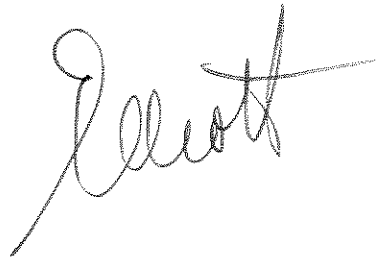
Among the many items included for discussion and approval by the Board of Education during the current school year, is the following:

Review with Lockton Companies, LLC Health and Medical Insurance Consultant
Projected Insurance-Related Revenues and Expenses for 2014-15 and 2015-16 and
Projected Year-End Balance in Health Reserve Account for 2014-15 and 2015-16.

This review is scheduled for our public meeting of March 16.

In advance of that meeting, Elio has submitted for your perusal:

1. Westport Board of Education 2015 Projection
2. 7/1/2014-6/30/2015 Claim Projection (Project Current Experience to End of Year)
3. 7/1/2015-6/30/2016 Claim Projections
4. Lockton Prescription Drug Pricing Terms (7/1/2014-7/1/2017)
5. Lockton 2015 Stop Loss Evaluation
6. Lockton Individual Stop Loss (ISL) Analysis
7. Bridge-to-Lockton Net Board of Education Cost Projections
8. Medical Health Insurance Fund FY 14-15 & FY 15-16 Projections with Claims
Cash Draw Data as of February 28, 2015



**Westport Board of Education
2015 Projection**

Fiscal Year	2012		2013		2014		1/13/15 Projections		3/12/15 Projections	
	Actual		Actual		Projected	Updated Lockton Projection *	Projected *	Updated Lockton Projection *	Projected *	Projected *
Paid Claims										
Medical/Rx	\$15,095,423		\$12,996,043		\$12,919,800	\$12,396,088	\$13,776,445	\$12,351,541	\$14,027,050	
Dental	1,048,297		977,520		936,600	1,052,170	1,055,782	1,048,094	1,082,451	
Change from 2014 Projected	\$16,143,720		\$13,973,563		\$13,856,400	\$13,448,258 -2.9%	\$14,832,227 7.0%	\$13,399,635 -3.3%	\$15,109,502 9.0%	
Enrollment										
Medical	874		835			801	801	804	801	
Dental	1,008		988			961	961	960	959	
Plan Expenses										
Medical/Rx Admin Fees	\$377,758		\$401,695		\$444,600	\$467,143	\$478,822	\$401,043	\$422,832	
Network Access Fee	166,793		164,724		164,600	160,617	164,632	160,015	163,981	
Dental Admin Fees	52,682		53,418		46,300	53,401	54,964	53,512	54,850	
Stop-Loss Premiums	526,497		605,998		682,700	666,112	772,613	663,617	772,613	
PCORI Fee						1,634	1,666	1,628	1,666	
ACA Reinsurance Fee					111,700	128,205	89,540	128,205	89,540	
FSA Administration	5,776		2,931		2,000	2,931	2,931	2,931	2,931	
Consulting Fee	36,862		57,374		25,000	45,000	45,000	45,000	45,000	
Medical Waivers	44,500		38,000		39,000	38,000	38,000	38,000	38,000	
BOE HSA Contribution	\$1,210,867		\$1,324,140		\$1,515,900	\$1,563,042	\$1,648,168	\$1,493,951	\$1,591,412	
Total Health Plan Cost	\$17,354,587		\$15,297,703		\$16,656,300	\$16,170,300 -2.9%	\$17,639,395 5.9%	\$16,052,585 -3.6%	\$17,859,914 7.2%	
Change from 2014 Projected										
Participant Contributions										
Actives					\$2,222,200	\$2,416,297	\$2,672,011	\$2,416,297	\$2,672,011	
COBRA					11,500	18,446	18,100	18,446	18,100	
Retirees					461,800	365,701	365,701	365,701	365,701	
Life & LTD Premium					\$2,695,500	\$2,800,443	\$3,055,813	\$2,800,443	\$3,055,813	
Net BOE Cost					\$281,900	\$245,796	\$250,712	\$245,796	\$250,712	
Change from Prior Year					\$14,242,700	\$13,615,653 -4.4%	\$14,834,294 4.2%	\$13,497,938 -5.2%	\$15,054,813 5.7%	

* Difference off 2014 projected Dental projections for 2014 do not appear to include retirees

Westport BOE
7/1/2014 - 6/30/2015 Claim Projection
Project Current Experience to End of Current Fiscal Year, 6/30/2015

	OAP		HDHP		Dental	
	Claims	Emps.	Claims	Emps.	Claims	Emps.
Jan-13	1,425,126	872	0	0	100,409	1,008
Feb-13	1,309,440	874	0	0	91,234	1,005
Mar-13	1,286,344	870	0	0	82,320	997
Apr-13	1,309,817	867	0	0	114,541	1,000
May-13	1,240,257	869	0	0	74,476	995
Jun-13	1,145,976	869	0	0	76,400	996
Jul-13	1,074,012	868	0	0	111,686	996
Aug-13	1,382,014	866	0	0	102,545	996
Sep-13	1,001,686	376	55,429	456	73,154	1,009
Oct-13	650,719	373	197,930	456	77,733	1,019
Nov-13	577,636	372	197,389	456	75,455	994
Dec-13	597,020	373	263,998	457	71,619	982
Jan-14	608,659	367	510,110	456	62,167	979
Feb-14	494,952	367	346,493	454	82,333	973
Mar-14	655,829	366	455,423	452	91,158	972
Apr-14	614,029	365	628,783	453	92,043	970
May-14	537,307	366	796,000	453	75,854	968
Jun-14	527,594	367	823,048	453	61,773	966
Jul-14	391,172	365	325,536	452	114,510	965
Aug-14	1,059,102	364	823,484	452	105,531	965
Sep-14	567,420	125	408,480	678	93,994	954
Oct-14	248,397	122	497,016	679	75,114	961
Nov-14	163,290	120	495,624	684	69,277	957
Dec-14	316,040	119	621,671	682	78,990	959
Jan-15	157,677	120	960,634	678	81,523	959
Feb-15	229,152	120	674,550	681	79,885	959
Latest 12	\$5,467,009	3,166	\$7,510,249	6,570	\$1,019,652	11,569
PEPM Paid Claims	\$1,727		\$1,143		\$88	
Trend Factor	1.0591		1.0526		1.0331	
Proj. Paid PEPM 3/2015 - 6/2015	\$1,829		\$1,203		\$91	
Benefit Plan Adjustments	0.8280					
Total Paid Projection HDHP PEPM	\$1,500	Blended	\$1,303			
Total Paid Projection 7/14-6/15	\$4,010,122		\$8,341,419		\$1,048,094	

Experience Period:	3/1/2014	-	2/28/2015	3/30/2014
Projected period:	3/1/2015	-	6/30/2015	4/30/2015
	Trend period:			8.0

	OAP	HDHP	Dental
Trend %	9.00%	8.00%	5.00%

EXPENSES	Projected Employees	Renewal 7/1/2014 Monthly Fees	Projected Annual Cost
Medical/Rx Admin Fees	798	\$41.88	\$401,043
Network Access Fee	798	\$16.71	\$160,015
Dental Admin Fees	959	\$4.65	\$53,512
Stop-Loss Premiums	798	\$69.30	\$663,617
PCORI Fee	798	\$0.17	\$1,628
ACA Reinsurance Fee			\$128,205 TRF due for 2014
FSA Administration			\$2,931
Consulting Fee			\$45,000
Medical Waivers			\$38,000
Total Expenses			\$1,493,951
Total Expected Claims Liability			\$ 13,399,635
Total Expected Claims Liability with Expenses			\$ 14,893,585
BOE Contributions to HSA			1,159,000
Employee Contributions			2,416,297
COBRA Premiums			18,446
Retiree Premiums			365,701
Total BOE Health Cost			13,252,142
Life Premium			227,004
LTD Premium			18,792
Total BOE Cost			13,497,938

No claim margin built in expected cost

Westport BOE
7/1/2015 - 6/30/2016 Claim Projection

	OAP		HDHP		Dental	
	Claims	Emps.	Claims	Emps.	Claims	Emps.
Jan-13	1,425,126	872	0	0	100,409	1,008
Feb-13	1,309,440	874	0	0	91,234	1,005
Mar-13	1,286,344	870	0	0	82,320	997
Apr-13	1,309,817	867	0	0	114,541	1,000
May-13	1,240,257	869	0	0	74,476	995
Jun-13	1,145,976	869	0	0	76,400	996
Jul-13	1,074,012	868	0	0	111,686	996
Aug-13	1,382,014	866	0	0	102,545	996
Sep-13	1,001,686	376	55,429	456	73,154	1,009
Oct-13	650,719	373	197,930	456	77,733	1,019
Nov-13	577,636	372	197,389	456	75,455	994
Dec-13	597,020	373	263,998	457	71,619	982
Jan-14	608,659	367	510,110	456	62,167	979
Feb-14	494,952	367	346,493	454	82,333	973
Mar-14	655,829	366	455,423	452	91,158	972
Apr-14	614,029	365	628,783	453	92,043	970
May-14	537,307	366	796,000	453	75,854	968
Jun-14	527,594	367	823,048	453	61,773	966
Jul-14	391,172	365	325,536	452	114,510	965
Aug-14	1,059,102	364	823,484	452	105,531	965
Sep-14	567,420	125	408,480	678	93,994	954
Oct-14	248,397	122	497,016	679	75,114	961
Nov-14	163,290	120	495,624	684	69,277	957
Dec-14	316,040	119	621,671	682	78,990	959
Jan-15	157,677	120	960,634	678	81,523	959
Feb-15	229,152	120	674,550	681	79,885	959
Latest 12	\$5,467,009	3,166	\$7,510,249	6,570	\$1,019,652	11,569
PEPM Paid Claims	\$1,727		\$1,143		\$88	
Trend Factor	1.1218		1.1081		1.0672	
Proj. Paid PEPM 7/2015 - 6/2016	\$1,937		\$1,267		\$94	
Benefit Plan Adjustments	0.8200					
Total Paid Projection HDHP PEPM	\$1,588		Blended \$1,375			
Total Paid Projection 7/15-6/16	\$2,789,352		\$11,237,698		\$1,082,451	

Experience Period:	3/1/2014	-	2/28/2015	8/30/2014
Projected period:	7/1/2015	-	6/30/2016	12/30/2015
	Trend period:			16.0

	OAP	HDHP	Dental
Trend %	9.00%	8.00%	5.00%

EXPENSES	Projected Employees	Renewal 7/1/2015 Monthly Fees	Projected Annual Cost
Medical/Rx Admin Fees	801	\$43.99	\$422,832
Network Access Fee	801	\$17.06	\$163,981
Dental Admin Fees	959	\$4.77	\$54,850
Stop-Loss Premiums	801	\$80.38	\$772,613
PCORI Fee	801	\$0.17	\$1,666
ACA Reinsurance Fee			\$89,540 TRF due for 2015
FSA Administration			\$2,931
Consulting Fee			\$45,000
Medical Waivers			\$38,000
Total Expenses			\$1,591,412
Total Expected Claims Liability			\$ 15,109,502
Total Expected Claims Liability with Expenses			\$ 16,700,914
BOE Contributions to HSA			1,159,000
Employee Contributions			2,672,011
COBRA Premiums			18,100
Retiree Premiums			365,701
Total Health Cost			14,804,101
Life Premium			231,544
LTD Premium			19,168
Total BOE Cost			15,054,813

No claim margin built in expected cost

Westport BOE
Prescription Drug Pricing Terms



7/1/2014 **7/1/2015** **7/1/2016** **7/1/2017**

Guaranteed Discount

Retail				
Brand	AWP - 16.10%	AWP - 16.25%	AWP - 16.50%	AWP - 16.75%
Generic	AWP - 68.00%	AWP - 70.50%	AWP - 70.50%	AWP - 70.50%
Mail Order				
Brand	AWP - 20.00%	AWP - 24.00%	AWP - 24.25%	AWP - 24.50%
Generic	AWP - 69.00%	AWP - 73.00%	AWP - 73.00%	AWP - 73.00%
Specialty				
Retail	AWP - 10.50%	AWP - 10.50%	AWP - 10.50%	AWP - 10.50%
Mail Order	AWP - 11.80%	AWP - 11.80%	AWP - 11.80%	AWP - 11.80%

Dispensing Fee - Retail

Brand	\$1.40	\$1.20	\$1.15	\$1.10
Generic	\$1.40	\$1.20	\$1.15	\$1.10
Specialty	\$1.40	\$1.20	\$1.15	\$1.10

Dispensing Fee - MOD

Brand	\$0.00	\$0.00	\$0.00	\$0.00
Generic	\$0.00	\$0.00	\$0.00	\$0.00
Specialty	\$0.00	\$0.00	\$0.00	\$0.00

Rebates

Brand Retail	\$0.00	\$20.00	\$20.00	\$20.00
Brand MOD	\$0.00	\$60.00	\$60.00	\$60.00

Rebates paid

	Annually	Annually	Annually	Annually
	<u># of Scripts</u>	<u>Avg Cost/Script</u>		
Retail - Brand	4,358	\$170.78		
Retail - Generic	13,624	24.41		
Mail Order - Brand	465	1,308.47		
Mail Order - Generic	1,461	55.73		
Total	19,908			

Projected Savings

Dispensing fees	\$3,596
Rebates	\$115,060
Claim discounts	\$81,822
Total	\$200,478

Westport BOE

2015 Stop Loss Evaluation



Individual Stop Loss

Current Premium	\$666,112
Renewal premium	\$772,613
Premium Increase	\$106,501
Initial Increase	16.0%

Consideration: changing ISL level

	<u>\$250k</u>	<u>\$275k</u>
ISL Rate	\$71.10	\$63.12
Annual Stop Loss Premium	\$683,413	\$606,709
Savings over Renewal	\$89,199	\$165,903

Stop Loss History

	7/11-6/12	7/12-6/13	7/13-6/14	7/14-12/14	Cumulative
Premiums Paid	\$477,617 *	\$491,558	\$566,982	333,056	\$1,868,313
ISL Claims	2	6	2	0	0
Claims in excess of ISL	331,658	867,847	36,211	0	1,235,716
Avg Covered Employees/Retirees	888	874	835	810	
Loss Ratio - Claims to Premium	69.4%	176.6%	6.4%	0.0%	66.1%

* Estimated

Individual Stop Loss (ISL) Analysis

Methodology

Lockton used a Monte Carlo simulation model to project 10,000 scenarios of paid claims both in aggregate as well as claims above the specific. The average of those 10,000 simulations and the min/max and percentiles are shown. This methodology allows a plan sponsor to see the variance around the expected value in analyzing the quotes. The simulation starts with a claim probability distribution that represents annual claims for over 1 million members.

Group Name: Westport BOE

Time period of projection: 7/1/2015 - 6/30/2016

Number of Employees: 801

Number of members (estimated): 2035

Analysis of Specific Reimbursements

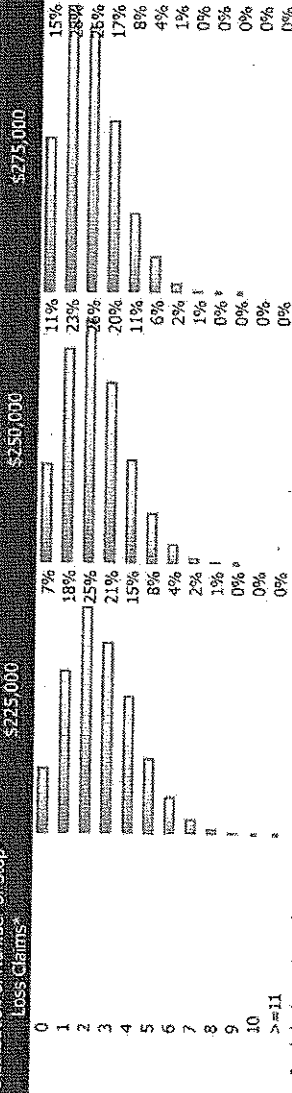
This part of the analysis focusses on the number of claims exceeding the stop loss deductible. This shows how many claims we expect to be reimbursed by the stop loss carrier.

Number of Claims Exceeding Specific Deductible*	\$225,000	\$350,000	\$275,000
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*excludes known large claimants

Average	2.7	2.3	1.9
Minimum in 10,000 simulations	0.0	0.0	0.0
25th Percentile	2.0	1.0	1.0
75th Percentile	4.0	3.0	3.0
Maximum in 10,000 simulations	12.0	12.0	11.0

Distribution of Number of Stop Loss Claims*



*excludes known large claimants

This part of the analysis focusses on the total amount of claims exceeding the stop loss deductible. This shows how many dollars we expect to be reimbursed by the stop loss carrier.

Total Dollar Amount of Claims Exceeding Specific Deductible*

Total Dollar Amount of Claims Exceeding Specific Deductible*	\$225,000	\$350,000	\$275,000
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*excludes amounts associated with known large claimants

^reflects modeled reimbursements

Average	\$525,395	\$462,817	\$410,572
Minimum in 10,000 simulations	\$0	\$0	\$0
25th Percentile	\$122,000	\$89,000	\$53,500
75th Percentile	\$720,125	\$637,000	\$567,125
Maximum in 10,000 simulations	\$7,649,000	\$7,512,500	\$7,424,500

Individual Stop Loss (ISL) Analysis

Methodology

Lockton used a Monte Carlo simulation model to project 10,000 scenarios of paid claims both in aggregate as well as claims above the specific. The average of those 10,000 simulations and the min/max and percentiles are shown. This methodology allows a plan sponsor to see the variance around the expected value in analyzing the quotes. This simulation starts with a claim probability distribution that represents annual claims for over 1 million members.

Group Name: Westport BOE
 Time period of projection: 7/1/2015 - 6/30/2016
 Number of Employees: 801
 Number of members (estimated): 2035

Comparison of Quotes

This part of the analysis shows the plan's expected costs under the various options considered. This also shows the percentage of simulations where the particular option "wins", produced the lowest total cost to the plan sponsor (retained claims plus ISL/ASL premiums). Note that any contract option under consideration should be consistent with the plan sponsor's risk tolerance. The simulation does not take into account risk tolerance or the insurance purchasing philosophy of any plan sponsor. These factors should obviously be weighed when selecting the retention level. A tendency to "win" from a financial perspective is only one consideration in choosing an appropriate stop loss contract.

	CURRENT	ALTI	ALTI
Without Stop Loss	\$225,000	\$250,000	\$275,000
Total Expected Claims (Paid by Plan after specific and aggregate)	\$14,292,325	\$13,829,508	\$13,881,753
Specific Premium	\$0	\$683,413	\$606,709
Aggregate Premium	\$0	\$0	\$0
Total Expected Cost. (Expected Claims + Stop Loss Premium)	\$14,292,325	\$14,512,921	\$14,488,463
% of simulations this option "wins" when all contract options considered	22%	0%	78%
Premium savings from Current	\$0	-\$89,199	-\$165,903
Average Additional Claim Liability from Current	\$0	\$62,578	\$114,823
Total Expected Plan Savings (negative is cost) from Current	\$0	-\$26,622	-\$51,080

The following is in all in relation to the current ISL level.

% of simulations this option ties or wins compared one-on-one to the \$225,000 Option

If it won, on average how much did it win by?

If it lost, on average how much did it lose by?

	CURRENT	ALTI	ALTI
Distribution of (Savings) or Additional Costs	\$225,000	\$250,000	\$275,000
Minimum (Most Savings)	\$	(\$9,199)	(\$165,903)
25th Percentile	\$	(\$4,184)	(\$115,903)
75th Percentile	\$	29,826	(\$11,903)
95th Percentile	\$	44,301	84,097
Maximum in 10000 simulations	\$	210,801	424,597

*Includes amounts associated with known large claimants.

**BRIDGE-TO-LOCKTON
NET BOE COST PROJECTIONS**

FY 2014-2015

	<u>3/12/15 Projection</u>
Lockton's Net BOE COST	\$ 13,497,938
Adjustments:	
Life & LTD Premium	\$ (245,796)
Other Fund Contributions	\$ (85,000)
Retirees (TRB) Contributions	\$ (160,000)
Ee Life Insurance Contributions	\$ (25,000)
Retirees over 65 Contributions	\$ (421,847)
Medical Waivers	\$ (38,000)
Retirees over 65 Premium	\$ 688,985
	<u>\$ (286,658)</u>
NET BOE COST (Adjusted)	\$ 13,211,280
ACCT 210 APPROPRIATION	\$ 14,501,700
OPERATING SURPLUS(DEFICIT)	<u><u>\$ 1,290,420</u></u>

**Medical Health Insurance Fund
FY 14-15 & FY 15-16 Projections
with Claims Cash Draw Data as of February 28, 2015**

	FY15 Projections			FY16 Projections	
	Aug-14	Jan-15	Mar-15	Jan-15	Mar-15
Cash receipts					
General Fund Budget from line 210	\$ 14,501,700	\$ 14,501,700	14,501,700	15,226,785	14,049,493
Other Fund Contributions	85,000	85,000	85,000	85,000	85,000
Employee Contributions (Active)	2,433,811	2,416,297	2,416,297	2,672,011	2,672,011
Flex Spending Accounts	-	-	-	-	-
Cobra Participants	25,008	18,446	18,446	18,100	18,100
Retirees under 65	365,701	365,701	365,701	365,701	365,701
State Teachers Retirement (TRB)	146,824	160,000	160,000	160,000	160,000
Life Insurance Premiums	25,000	25,000	25,000	25,000	25,000
Retirees over 65	421,847	421,847	421,847	442,939	442,939
Other Contributions (FMLA, Retiree Life, etc.)	-	-	-	-	-
Total cash receipts	18,005,891	17,993,991	17,993,991	18,995,536	17,818,244
Cash disbursements					
Medical	10,751,572	10,558,130	10,581,030	11,658,199	11,914,994
Prescription	1,988,348	1,837,958	1,770,511	2,118,246	2,112,056
Dental	1,007,255	1,052,170	1,048,094	1,055,782	1,082,451
Flex Spending Accounts	-	-	-	-	-
Contribution to HSA	1,329,000	1,159,000	1,159,000	1,159,000	1,159,000
Medical Administrative	478,224	467,143	401,043	478,822	422,832
Network Access Fee	164,426	160,617	160,015	164,632	163,981
Individual Stop-Loss	681,912	666,112	663,617	766,028	772,613
Dental Administrative	53,903	53,401	53,512	54,964	54,850
FSA Administrative	2,931	2,931	2,931	2,931	2,931
Consulting Fee	45,000	45,000	45,000	45,000	45,000
ACA Related Fees	112,258	128,205	128,205	89,540	89,540
PCORI Fee	-	1,634	1,628	1,666	1,666
Retirees over 65	675,000	688,985	688,985	723,435	723,435
Total cash disbursements	17,289,829	16,821,286	16,703,571	18,318,245	18,945,349
Change in cash balance	716,062	1,172,705	1,290,420	677,292	(727,105)
BOE approval to reduce Acct 210 request	-	-	-	(677,292)	-
Insurance Fund Draw Down	-	-	-	-	500,000
Change in cash balance (Net)	716,062	1,172,705	1,290,420	(0)	(227,105)
Beginning cash balance	930,839	930,839	930,839	-	-
Ending cash balance(deficit)-projection	1,646,901	2,103,544	2,221,259	-	-
Less: Incurred but not reported claims (carrying FY14)	(908,233)	(980,000)	(980,000)	-	-
Net Position(Deficit) end of year-projection	738,668	1,123,544	1,241,259		
		1,603,544	1,721,259	12.8% (with a \$500k FY16 draw down)	
		(980,000)	(980,000)	-7.3%	
		623,544	741,259	5.5%	

	Claims Cash Draw Against Insurance Fund Account				Total	Avg. Monthly Claims (Med/Rx/Dental)	Variance
	Medical/Rx	Dental	Flex	Other			
Jul 2014	\$ 940,672	\$ 94,171	\$ 6,419	\$ -	\$ 1,041,262	\$ 1,034,843	
Aug 2014	\$ 1,551,384	\$ 93,150	\$ 396	\$ -	\$ 1,644,930	\$ 1,339,689	\$ 304,846
Sept 2014	\$ 1,237,176	\$ 110,586	\$ 6,691	\$ 119	\$ 1,354,572	\$ 1,342,380	\$ 2,691
Oct 2014	\$ 680,049	\$ 68,680	\$ 7,696	\$ 1,156	\$ 757,581	\$ 1,193,967	\$ [148,413]
Nov 2014	\$ 698,892	\$ 71,691	\$ 7,137	\$ -	\$ 777,720	\$ 1,109,290	\$ [84,677]
Dec 2014	\$ 884,181	\$ 89,533	\$ 9,540	\$ -	\$ 983,254	\$ 1,086,694	\$ [22,596]
Jan 2015	\$ 1,145,696	\$ 73,529	\$ 11,182	\$ -	\$ 1,230,407	\$ 1,105,627	\$ 18,933
Feb 2015	\$ 934,601	\$ 63,053	\$ 6,074	\$ -	\$ 983,728	\$ 1,089,630	\$ [15,997]
Mar 2015					\$ -		
Apr 2015					\$ -		
May 2015					\$ -		
Jun 2015					\$ -		
	\$ 8,052,650	\$ 664,393	\$ 55,136	\$ 1,275	\$ 8,773,454		
YTD/Estimate	65.2%	63.4%	n/a	n/a			
Theoretical YTD Spend Rate	66.7%	66.7%	n/a	n/a			
variance %	-1.5%	-3.3%					
variance \$	\$ (185,828)	\$ (34,686)					
FY15 Projection (March-15):	\$ 12,351,541	1,048,094					
YTD Expense:	\$ (8,052,650)	\$ (664,393)					
Balance available to June 30:	\$ 4,298,891	\$ 383,701					
Average remaining monthly allowance:	\$ 1,074,723	\$ 95,925	=	\$ 1,170,648			

DEPARTMENT OF PUPIL SERVICES
WESTPORT PUBLIC SCHOOLS
72 North Avenue
Westport, Connecticut 06880-2721

MICHAEL RIZZO
DIRECTOR OF PUPIL SERVICES

(203) 341-1253
FAX (203) 341-1295

TO: Dr. Elliott Landon
FROM: Mike Rizzo, Dr. Valerie Babich, Alycia Dadd
SUBJECT: Dialectical Behavioral Therapy
DATE: March 16, 2015

Westport Public Schools has long been committed to meeting the social and emotional needs of our students. Our school psychologists, social workers, and guidance counselors employ a range of methodologies within the school setting for the purpose of helping students access their education. Over the past year, under the leadership of Dr. Babich, we have engaged our K-12 psychologists, guidance counselors, and social workers in professional development in the methodology of Dialectical Behavior Therapy (DBT) and how to implement this within a school setting. This empirically supported treatment methodology is at the leading edge of school-based mental health interventions for students and will allow our pupil services staff to continue to meet the needs of our students.

DBT is an intervention used with students experiencing emotional dysregulation (e.g. anxiety, school refusal), impulsivity (e.g. substance abuse, suicidal threats or actions, eating disorders), interpersonal problems, and parent-student dilemmas (e.g. rigid thinking and poor problem solving). These are issues that affect our students and which interfere with their ability to access their education. By providing our pupil services staff training in DBT, we are directly empowering them to work with our students and address these issues in the school setting.

During the 2014-15 school year our psychologists, guidance counselors, and social workers have had 3 full days of training in which they learned the principles of DBT. Planning for the 2015-16 school year is currently underway to identify opportunities to teach DBT skills to Staples High School students. Our work next year will include bi-weekly consultation and supervision with Cognitive & Behavioral Consultants of Westchester and Manhattan, LLP, founded by Dr. Alec Miller, a leader in the field of DBT training and implementation, to provide ongoing training, help our staff implement DBT, and meet the needs of our students with fidelity.

Our presentation tonight will provide an overview of DBT and how it can be successfully used in a school setting.

Dialectical Behavior Therapy in a School Setting

Valerie Babich, Psy.D.
Alycia Dadd, Ed.M.

Development of DBT

- Initially developed by Dr. Marsha Linehan for individuals with Borderline Personality Disorder (1993)
- Emerged from unsuccessful attempts using Cognitive Behavioral Therapy to help suicidal and self-injurious clients

Development of DBT

- Modified for clinical use with adolescents by Dr. Alec Miller and Dr. Jill Rathus, along with Dr. Linehan (1995)
- Now being adapted for the school setting

What is DBT?

- A synthesis of
- Behaviorism
 - Mindfulness
 - Dialectics

What is DBT?

- An effective treatment for people who have difficulty coping with their emotions and behaviors
- Addresses the relationship between the individual and his/her environment
- Aims to replace problem behaviors with skillful behaviors

What is DBT?

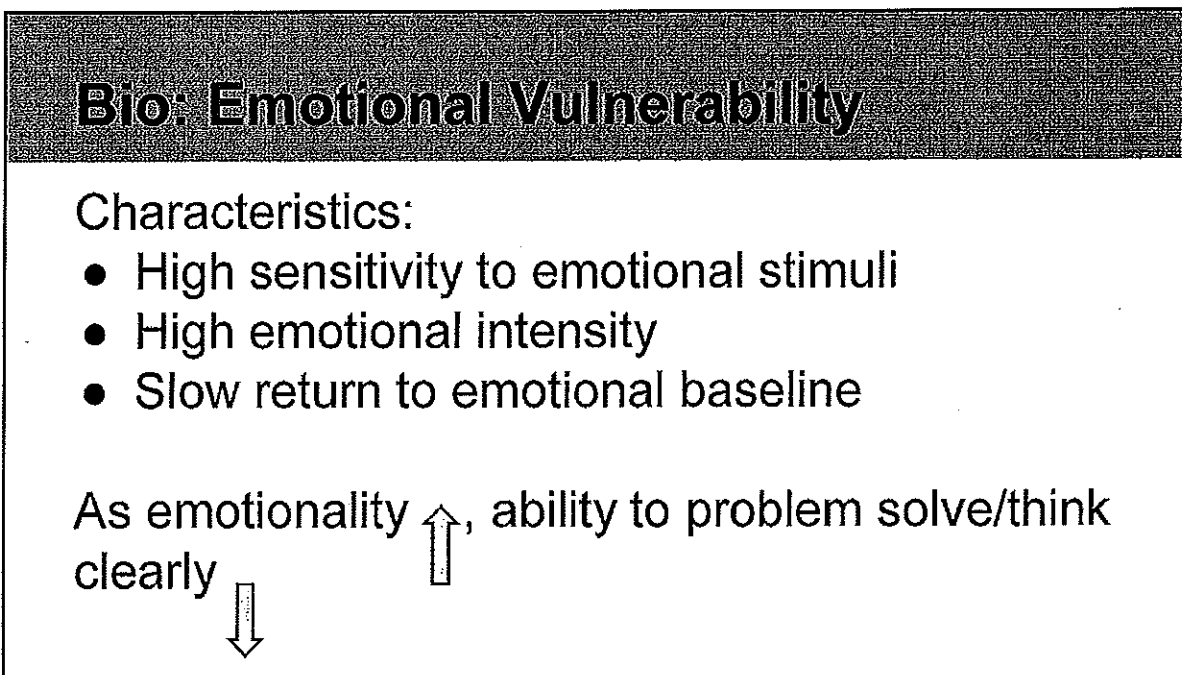
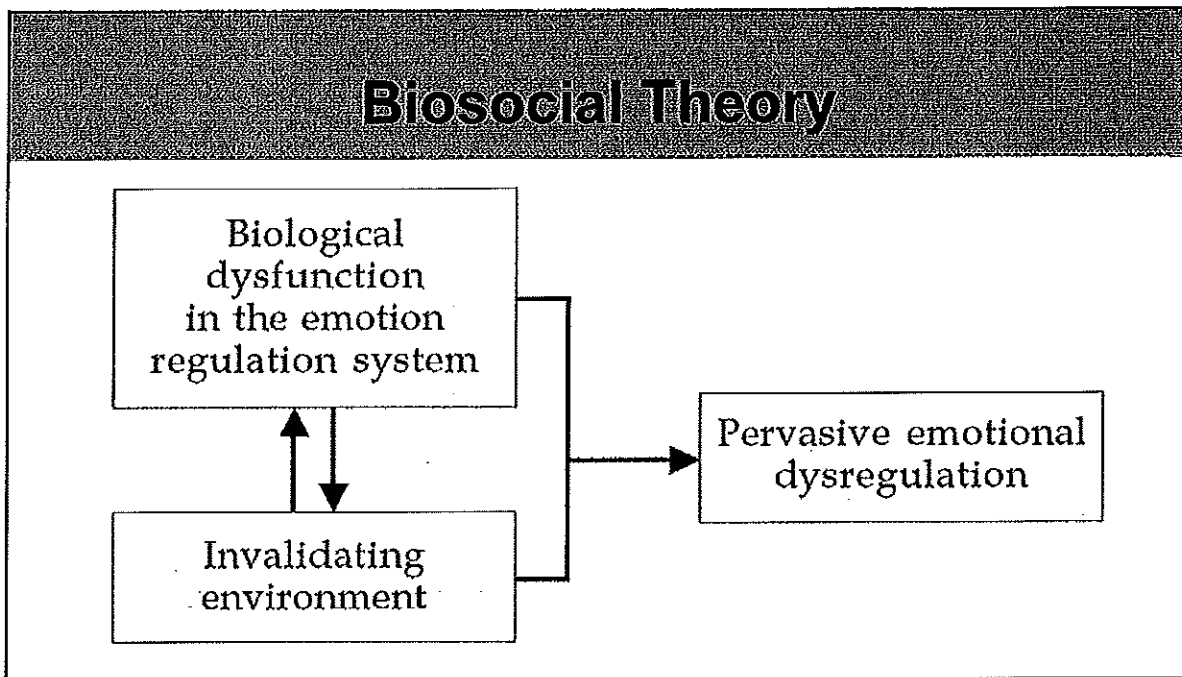
DBT helps people create
“a life worth living”

DBT Philosophy

- Balance between promoting **change** and **acceptance**.
- There is always more than one way to think about a situation.
- A life worth living has both positive and negative aspects and all of these are necessary and valuable.
- Recognizing that people are doing the best they can *and* they can do better; these two beliefs are not mutually exclusive

Examples of Teen Dialectics

- There is no absolute truth; 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, but I'm responsible for working on them
- A life worth living has happiness, sadness, anger, and call, and all of these things are valuable and necessary



Social: Invalidating Environment

Characteristics:

- Pervasively negates, punishes, corrects, ignores, or dismisses behavior independent of actual validity
- punishes emotional displays and reinforces emotional escalation
- oversimplifies/minimizes problems and solutions

Invalidation occurs frequently and over a course of time, not an isolated incident.

Problem Areas for Adolescents

Reorganization of Problem Areas (BPD):

- Emotional Dysregulation
 - emotional lability, problems with anger
- Interpersonal Dysregulation
 - Problematic relationships, fears of abandonment
- Self Dysregulation
 - Difficulties around sense of self, sense of emptiness
- Behavioral Dysregulation
 - self-harming behaviors, impulsive behaviors,
- Cognitive Dysregulation
 - Dissociative responses, paranoid ideation, black-and-white thinking

Matching Problems with Skills

Problems

- I. Confusion about yourself
- II. Impulsivity
- III. Emotional instability
- IV. Interpersonal Problems
- V. Teenager and Family dilemmas

Skills

- I. Mindfulness
- II. Distress Tolerance
- III. Emotion Regulation
- IV. Interpersonal Effectiveness
- V. Walking the Middle Path

DBT Core Components

- Weekly skills with two co-facilitators
- Weekly individual sessions/coaching
- Parent training
- Weekly DBT providers team meeting/consultation team

Why DBT in schools?

- An effective treatment for adolescents
- DBT is skills-based and a manualized approach
- Enhancing coping skills of students can improve academics, educational functioning and overall functioning in life
- Coaching is brief, provided as needed, and by a variety of trained staff

References

- Cognitive-Behavioral Treatment of Borderline Personality Disorder, Marsha Linehan, The Guilford Press (1993).
- DBT Skills Training Manual, Marsha M. Linehan, The Guilford Press. (2015).
- Dialectical Behavior Therapy with Suicidal Adolescents, Alec L. Miller, Jill H. Rathus, Marsha M. Linehan, The Guilford Press; (2006).
- DBT Skills Manual for Adolescents, Jill H. Rathus and Alec L. Miller, The Guildford Press; (2015)

Dialectical Behavior Therapy with Multi-Problem Adolescents in a School Setting

By Dawn Catucci

We all have had those students who are our frequent flyers; you know the ones who are in constant crisis at school, at home, and with friends? They may be acting impulsively, failing classes, depressed, arguing, fighting and maybe even self-harming. Counseling seems to always be focused on putting out the latest fire, leaving little time developing new skills to prevent the next meltdown. The saddest part is that these students are suffering, and as school psychologists, we are often the first to offer counseling and support. Because these students may be resistant to seeking and accepting help, the school setting provides a way to reach kids who might not seek help otherwise. These are the students that come up each week at our team meetings. Because these students present with multitude of difficulties and they are very resistant to treatment, teachers, administrators, guidance counselors, and school psychologists become frustrated in our multiple attempts to help.

A few years ago, my colleagues and I were mulling over this very question. We had attended some workshops on Dialectical Behavior Therapy (DBT). DBT was developed by Marsha Linehan, and is a complex form of cognitive behavioral therapy that teaches pro-social skills. It was originally developed for and used with adults who were diagnosed with Borderline Personality Disorder and were chronically suicidal. More recently DBT has been used with individuals who are diagnosed with various mental and emotional disorders (Dimeff & Linehan, 2001). After becoming familiar with Alec Miller's work, we learned that DBT was being used with multi-problem adolescents. As soon as I opened his textbook *Dialectical Behavior Therapy with Suicidal Adolescents* (Miller, Rathus, & Linehan, 2007), I knew that these were the skills that our students were lacking and that if this treatment could be done in our school, these kids might actually begin to, dare I say it... get better (or in DBT language, act more skillfully).

DBT is inherently dialectic. Simple, pro-social skills are taught and practiced to help teens with: coping strategies and skills to help them to gain control of their emotions (distress tolerance and emotion regulation skills); teach them to be less black and white or rigid in their thinking (walking the middle path); helping them to communicate better with others (interpersonal effectiveness) and most importantly at the core of DBT, teaching them to quiet their mind and to focus on one thing at a time (mindfulness skills), (Miller, Rathus, & Linehan, 2008). While these skills seem simple as shown in the treatment manual, learning how to implement DBT is highly complex, hence the first dialectic.

Next we "DEAR MANNED" (a DBT acronym for an interpersonal effectiveness skill of asking for what you want without hurting the relationship) our administrators to fund our training to gain their support in implementing this treatment in a school setting.

We were one of the first schools to implement a comprehensive DBT program. In talking with our administration, we pointed out that DBT is a research-based cognitive behavioral approach and in alliance with the Response to Intervention (RTI) initiative. At the high school level, the majority of our referrals to the Committee on Special Education are for emotional and behavioral reasons. Also, these students can take up an exorbitant amount of staff resources as they are often in crisis. Not only are these students seen in the guidance offices, they are also in the Assistant Principal's office for disciplinary reasons. These students are also failing and at times interrupting classes, missing school and even hospitalized. In some cases, these are the students who would be sent out of district to other more restrictive environments because everything we tried has been to no avail. Needless to say, we have fantastic and supportive administrators who agreed to let us move forward with this treatment model for our most at risk students. We contacted Alec Miller, who trained our entire team and consulted with us as to how we might implement this treatment program in our school. We came up with a plan to get one of Alec Miller's colleagues from Cognitive Behavioral Consultants of Westchester to train and supervise us with this treatment model. Sarah Steinberg has been our advanced trainer now for the past three years. She is highly skilled and has been an amazing resource for us. Initially, she met with us twice per month for an hour to teach us how to utilize this treatment manual. Several months later we ran our first groups. Sarah's supervision continued for the next two years. This past year we had supervision several times throughout the year and next year, it will continue with intermittent supervision. We are now going into our fourth year of using DBT in our high school and we are seeing amazing results. Sarah is now training our middle school team in DBT. Other local school districts in Westchester County have since been trained and are utilizing DBT in their schools.

The number of students that have been in our DBT is generally very small, around a dozen or so per year that complete the program. However small the number, the effects have been remarkable. We have found that the students who have been through DBT have had a decrease in the number of disciplinary referrals (at least a 50% drop in our first pilot year of DBT). These at risk students have been maintained in their home school district and are acting more skillfully as they navigate through their teenage years. As clinicians, we can attest to far less crisis with these students and that they are more skillful in their approach to the world around them. For the clinicians, DBT has changed how we work with every student, even those not in DBT. We are more skillful in our approach to the students, spending more time on therapeutic commitment strategies and being mindful within each session.

Now for the next dialectic, while DBT as utilized within our school setting has been amazing, it is an enormous undertaking in

terms of training and applying DBT within this setting. The commitment of the clinicians that is extensive. As school psychologists, we are pulled in many directions; adding DBT to our already demanding jobs has been very difficult at times. In implementing DBT we have a weekly DBT team meeting, weekly DBT groups, individual counseling for every student in the DBT group, monthly parent training, and supervision with our DBT advanced trainer. On the other hand, the DBT skills are perfect for a school setting in terms of "teaching" these skills and having a very structured group. We have had to make some accommodations for how DBT is utilized in a school setting that is different from standard DBT, while attempting to maintain the integrity of DBT. We have found that DBT has been a worth while commitment and that it has helped many kids over the past four years that were struggling and suffering in terms of how they were living their life. These skills have given them a way to cope, tolerate and communicate better with those around them, helping them to "create a life worth living".

If you are interested in learning more about Dialectical Behavior Therapy here are some suggestions:

1. behavioraltech.org offers training opportunities, books, videos and training modules.
2. Read Dialectical Behavior Therapy with Suicidal Adolescents (Miller, Rathus & Linehan, 2007)
3. Check out the Skills Training Manual for Treating Borderline Personality Disorder (Linehan, 1993) - note that these skills are for adults.

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Dimeff, L., & Linehan, M.M. (2001). Dialectical Behavior Therapy in a nutshell. *The California Psychologist*, 34,10-13.

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Miller, A. L., Rathus J. H., Linehan, M.M. (Unpublished 2008) *Dialectical Behavior Therapy Multi-Family Training Group*.

Miller, A. L., Rathus J. H., Linehan, M.M. (2007) *Dialectical Behavior Therapy with Suicidal Adolescents*. New York: Guilford Press. Ψ

Dawn Cataracts is a School Psychologist for the Ardsley School District in Westchester County, NY and she is the NYA SE Chapter 1 Alternate Representative. The DBT team at Ardsley High School includes Dawn Cataracts, M.S., Ed. P.D., Victoria Luski, M.A., Douglas Johnson, J.C.S.W. and Michelle Bellino, M.S., NCSP.

Educating the Whole Child...

(continued from p. 11)

are most welcome in giving us the best hope for the future of all children. I extend a special word of thanks to Dr. Mark Barth in the NYSED for his years of leadership in mentoring the Metro SEL group, and for his endurance in seeing this project to its final phase. Please visit the following web sites, only a small taste of what is contained in the Guidelines, and WELCOME to the adventure of SEDL.

Resources:

www.casel.org (Collaborative for Social Emotional Learning)

www.isbe.state.il.us/ils/social_emotional/standards.htm (State of Illinois SEL Standards)

www.search-institute.org/developmental-assets (Search Institute Developmental Assets)

www.esmational.org (Educators for Social Responsibility)

<http://smhp.psych.ucla.edu/> (UCLA Center for Mental Health in the Schools)

www.sel.eboard.com (Long Island Social Emotional Learning Forum) Ψ

The Brown University Child and Adolescent Behavior Letter



BROWN



Bradley Hospital
A Lifespan Partner

Published in cooperation with Bradley Hospital

December 2014

Vol. 30, No. 12 • ISSN 1058-1073

Online ISSN 1556-7575

Highlights...

In this month's top lead, Dr. Natalie Zervas explores the effects of DBT on treating NSSI, suicidality, and other impulsive behaviors in adolescents.



Keep Your Eye On... See page 2

- Suicide risk screening tool for emergency departments
- Daily marijuana use on the upswing among teens

What's New in Research... See pages 3-5

- "Sense of coherence" a protective factor for health effects of bullying victimization
- Screen time-ADHD behavior link, but more research is needed on causality and mechanism

Editor's Commentary

- To tweet or not to tweet ... is that even the question?

— By Gregory K. Fritz, M.D.

See page 8



Free Parent Handout...
**Holiday Stress: A
Guide for Parents**

Monthly reports on the problems of children and adolescents growing up

C A B L

DBT with Adolescents

Demystifying DBT with adolescents

By Natalie Zervas, Ph.D.

One of the benefits of working in the mental health field today is that the availability of evidence-based treatments has greatly increased in recent years. This increase can be a double-edged sword, however. With this greater variety of effective treatments comes the need for increased training on the part of providers and increased understanding of the treatments by consumers. This understanding can be particularly difficult to achieve in the treatment of less studied mental health problems faced by our children and adolescents. Non-suicidal self-injury (NSSI) and suicidality are examples of such problems. Seen with growing frequency by schools, families, pediatricians, and mental health care providers, detailed information about effective treatments for these presenting

problems has not been adequately disseminated to either the professional community treating these youth or the families who love and care for them.

Dialectical Behavior Therapy (DBT) is a treatment with growing empirical support that has been found to be effective in treating NSSI and suicidality, as well other problematic impulsive behaviors in adults, with promising research support in adolescents as well (Groves et al., 2012; Mehlum et al., 2014). Unfortunately, solid understanding of its treatment rationale and structure remains lacking among mental health professionals. Without the understanding of what comprises effective DBT, providers and families are ill served as they seek appropriate services. To address the current See *DBT with Adolescents*, page 5...

Late Talking

What does it mean when a child talks late?

By Stephen Camarata, Ph.D., CCC-SLP

Up to 10% of all children have not yet begun using meaningful words by the time they reach their second birthday. Naturally, when a child begins speaking late, this can be the source of great anxiety for parents. The situation has become even more important in recent years with the implementation of early-screening identification for autism and autism spectrum disorder (ASD) as recommended by the American Academy of Pediatrics. This is especially true because one of the most salient early markers for autism is late onset of talking. However, late onset of speech is not a specific marker for ASD, as the late talking may be a symptom of not only autism,

but also intellectual disabilities (formally known as mental retardation), hearing loss, speech/pronunciation difficulties, language disorders, or social communication disorder as well. In addition, for the overwhelming majority of late-talking children, the delayed onset is simply a passing developmental stage with no long-term adverse consequences for communication, achievement, or intellectual development.

The challenge for physicians and other clinicians is providing accurate information to parents with regard to what the late talking can mean. It is especially important to complete a comprehensive differential See *Late Talking*, page 6...

dent effect-size estimates for attention problems, one for hyperactivity, and seven for impulsivity.

There was no meta-analysis for the sole hyperactivity study, but that study did find a positive correlation between media use and hyperactivity.

The meta-analysis found a moderate correlation with attention problems and media use, and a small but significant positive correlation between impulsivity and media use.

Most of the studies included did use composite measures of ADHD-related behaviors, and the meta-analysis of these studies showed a positive relationship between all three measures of media use and ADHD-related behaviors.

Although the researchers had expected to find an age effect, they didn't. They were not able, however, to directly compare effect sizes for different age groups because most of the empirical studies reported for a sample that comprised a large age range.

Gaps in the literature

Future research is needed to fill this gap in the literature, the authors said. The meta-analysis was limited: several analyses could not be conducted at all due to the low number of available effect sizes for the three separate ADHD-related behaviors. This also shows that more research is needed on this topic. "This is important because the study of the relationship between television and

ADHD-related behaviors has been characterized by an ephemeral research interest," they write. "Researchers contributed with at most one or two studies, after which they disappeared from the field again."

The researchers found a positive relationship between media use and ADHD-related behaviors but noted that future studies are needed to address questions of causality, individual susceptibility, and the mechanisms of the media use-ADHD relationship.



Nikkelen SW, Valkenburg PM, Huizinga M, Bushman BJ. Media use and ADHD-related behaviors in children and adolescents: A meta-analysis. *Dev Psychol* 2014 Sep; 50(9):2228-2241. doi: 10.1037/a0037318. Epub 2014 Jul 7. E-mail: s.w.c.nikkelen@uva.nl.

DBT with Adolescents

From page 1

need among youth and families, this article provides a practical overview of the fundamentals and treatment components of effective DBT for adolescents (DBT-A).

DBT background

Dialectical Behavior Therapy (DBT) is an empirically-supported treatment developed by Marsha Linehan, Ph.D., ABPP, over 20 years ago (Linehan, 1993a, 1993b). It grew out of a need for an effective treatment to help a difficult to treat population for whom standard cognitive behavioral therapy (CBT) and supportive therapies were not beneficial. DBT is a modification of standard CBT that balances the *change* focus of CBT (i.e., the need to stop engaging in NSSI) with the *acceptance* strategies of other types of therapy (i.e., validating that NSSI works for you temporarily). The balance between these acceptance and change strategies in DBT forms the fundamental "dialectic" that resulted in the treatment's name. In brief, dialectic is the existence or action of opposing ideas or concepts.

Originally developed to treat chronically suicidal adults also suffering from borderline personality disorder (BPD), DBT has since been found to be especially effective for individuals with suicidality, NSSI, and other dysfunctional behaviors (e.g., eating disorders, substance abuse), with the core problem being extreme emotion dysregulation. With these individuals, research has shown DBT to be effective in reducing sui-

cidal behavior, psychiatric hospitalization, treatment dropout, substance abuse, anger, and interpersonal difficulties (Linehan, et al., 1999). After identifying a need for an effective treatment for suicidal and self-injurious adolescents, Alec Miller, Psy.D. and Jill Rathus, Ph.D., along with Marsha Linehan, successfully adapted the treatment for use with adolescents (Miller, Rathus, & Linehan, 2007). Notably, DBT has been successfully implemented across a variety of ethnic and socio-economic backgrounds (Rathus & Miller, 2002), with research on the efficacy of DBT-A being ongoing.

DBT Treatment Overview

Below are some key points for providers and families to know about DBT as they consider the appropriateness of the treatment. Please note that the information provided below is based on an outpatient DBT-A program. Other types of DBT-A treatment are available (e.g., inpatient, residential, etc.) and may have different structures of treatment. For a thorough overview of DBT-A please refer to Miller, Rathus, and Linehan (2007).

What problems does DBT-A treat? DBT-A addresses five major problem areas through a variety of treatment modes and specific skills (addressed below). These five areas include:

1. Confusion about Self (identity confusion, unawareness of emotions, dissociation, emptiness)
2. Emotion Dysregulation (emotional lability, angry outbursts)
3. Impulsivity (NSSI, substance abuse, aggression, suicidal threats/actions)

4. Interpersonal Problems (unstable relationships, interpersonal conflict, social isolation, loss)
5. Parent-Teen Dilemmas (poor problem solving, rigid thinking, poor communication)

DBT-A addresses problems in a structured way. When an adolescent is in individual DBT-A, their life-threatening behaviors are addressed first, often utilizing behavior chain analysis as a way to better understand the problematic behavior (e.g., NSSI, suicidal ideation). From there, behaviors that negatively impact therapy (e.g., lateness, missed sessions, limited engagement in sessions) are addressed, followed by behaviors that negatively impact the adolescent's quality of life (e.g., depressed mood, conflict with peers, anxiety).

DBT-A is a multi-modal treatment. When DBT-A is provided in a comprehensive, evidence-based way, it includes three main modes of treatment:

1. Individual (and Family) Therapy
 - Sessions occur 1-2 times per week for 45-50 minutes with the adolescent's individual therapist.
 - This modality exists to help adolescents build motivation to work toward change and apply the skills they learn during group sessions to their daily experiences.
2. Multi-Family Skills Group
 - Sessions occur weekly for ~2 hours. They include parents and other adolescents/parents and are run by two leaders.

Continued on next page...

Continued from previous page...

- This modality exists to teach adolescents and parents new skills to help them move closer to achieving their treatment and life goals.

3. Phone Consultation

- This modality exists to promote skills generalization by helping adolescents implement skills in real-life situations and in real-time. Adolescents are encouraged to call their individual therapist for skills coaching when they are "in crisis" (e.g., urges arise to engage in maladaptive behaviors) prior to engaging in a problematic behavior (e.g., NSSI). Similarly, parents are encouraged to call their assigned skills group leader when they are in need of coaching to use skills learned in group (e.g., during a conflict with adolescent).

DBT-A is a team treatment. An additional component of DBT-A exists to help ensure therapists are providing the best possible care for adolescents and families. This is called *Consultation Team* and is a weekly meeting attended by all DBT therapists on a team during which guidance and support is provided to all therapists by all therapists.

DBT-A utilizes a "Diary Card." An essential component of individual DBT-A is an adolescent's completion of a diary card. This tool is a way for adolescents to self-monitor their behavioral urges and actions, as well as their emotions week to week. The diary card is then shared during individual sessions, providing a "snap shot" of the week. Notably, it is something meant to be shared between an adolescent and their provider only, and not shared with parents (within the general limits of confidentiality and safety).

DBT is a principle based treatment, rather than a manualized treatment. This means that it follows general principles throughout its course with flexibility to address relevant topics within its structure.

It is important to note that, should an adolescent enter into DBT-A, the best resource of information regarding the specific structure of their treatment will be their provider. More

specific information would be provided to the adolescent and family on each of these topics once the treatment began.

Treatment Options

Finding thoroughly trained DBT-A providers can be difficult. Locating comprehensive DBT treatment in your area can be even more challenging. At present, there are several online resources for locating quality treatment providers in your area. The following websites provide access to providers specializing in DBT (in addition to other treatments):

- Association for Behavioral and Cognitive Therapies (ABCT): <http://www.abctcentral.org/xFAT/>
- The Linehan Institute - BehavioralTech: <http://behavioraltech.org/resources/crd.cfm>

In deciding on appropriate treatment for an adolescent, consultation with and among professionals is invaluable. To provide some additional and specified guidance, included below are some questions to consider when contemplating whether an adolescent might benefit from DBT-A:

- Are they chronically suicidal and/or engaging in NSSI?
- Are they chronically emotionally dysregulated?
- Are they engaging in repeated problematic, self-destructive impulsive behaviors?
- Do they have difficulty making or keeping interpersonal relationships?
- Have they had difficulty remaining in other standard types of therapy?

Additionally, here are some questions to keep in mind when choosing a provider and/or treatment program:

- Are they licensed to provide mental health treatment?
- What type of degree do they have?
- What is their DBT training (were they intensively trained and by whom)?
- Do they practice as part of a DBT Consultation Team?
- What components of DBT do they offer (individual, group, phone coaching)?

Choosing effective mental health treatment for adolescents remains a challenging and often confusing task. No formula exists for who might benefit from a particular type of therapy and many factors go into what makes a treatment ultimately effective. While this complexity is likely to persist, the importance of disseminating accessible information about what constitutes evidence-based DBT-A and for whom this treatment could be effective cannot be overstated. Hopefully, an increased understanding by practitioners and consumers will come along with this improved communication, and adolescents and families struggling with the problems addressed by DBT-A will begin to receive more effective and appropriate treatment.



Natalia Zervas, Ph.D., is a staff psychologist in outpatient and crisis services at Bradley Hospital specializing in the treatment of nonsuicidal self-injury and suicidality in adolescents. She is also a clinical assistant professor in the Department of Psychiatry and Human Behavior at the Alpert Medical School of Brown University.

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Late Talking

From page 1

diagnosis to determine whether the late talking is simply a developmental stage with

a high probability of spontaneous recovery or whether it is a symptom of long-lasting developmental disabilities such as autism. Key supplemental markers include non-verbal social skills, nonverbal intellectual abilities, and receptive language ability.

This means that it is essential to evaluate whether a late-talking child interacts with parents and others (within the broad constraints of their reduced or absent ability to produce meaningful speech); whether they are able to solve puzzles and engage in



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IN THIS ISSUE

Dialectical behavior therapy skills groups in schools: A review of empirical findings

Topics include cases of DBT use and future DBT applications

By Jordan Florillo ([http://www.apa.org/search.aspx?query=&fq=ContributorFilt:%22Florillo, Jordan%22&sort=ContentDateSort desc](http://www.apa.org/search.aspx?query=&fq=ContributorFilt:%22Florillo,%20Jordan%22&sort=ContentDateSort%20desc)) and Jaime Long ([http://www.apa.org/search.aspx?query=&fq=ContributorFilt:%22Long, Jaime%22&sort=ContentDateSort desc](http://www.apa.org/search.aspx?query=&fq=ContributorFilt:%22Long,%20Jaime%22&sort=ContentDateSort%20desc))

Dialectical behavior therapy (DBT) is an empirically supported treatment originally developed for female outpatients diagnosed with borderline personality disorder (BPD; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). Miller, Rathus, Linehan, Wetzler, and Leigh (1997) and Miller, Rathus, DuBose, Dexter-Mazza, and Goldklang (2007a) adapted DBT to treat suicidal adolescents (DBT-A). DBT-A has a growing evidence base that suggests it may be a powerful treatment modality for a variety of adolescent problem behaviors, including self-injurious behavior, BPD, bipolar disorder, eating disorders, oppositional defiant disorder, and learning disabilities. As it was designed by Miller, Rathus, & Linehan (2007b), DBT-A is a multimodal approach, consisting of 16 weeks of individual therapy, group skills training, family and individual phone consultation, and a therapist consultation group. Caretakers are generally included in group skills training and some individual therapy sessions.

This paper summarizes and critiques studies that used DBT group skills training with adolescents without family participation. Authors of this review explore the implications of using skills groups in school settings or in settings where caregiver participation is unavailable, as many are unable or unwilling to participate in treatment programs. We examine the feasibility of DBT as a treatment that can change the behavior of the adolescent without having to rely on family change. Finally, we discuss how DBT can be used for a wider variety of applications, and future research recommendations are provided. Structure of Dialectical Behavior Therapy Muehlenkamp (2006) stated that the major principle behind DBT is to achieve equilibrium of behavior change and self-acceptance. DBT embraces elements of Western behavior, cognitive, and client-centered therapeutic approaches, as well as principles from Zen Buddhism. DBT group training, as originally designed by Linehan (1993a), entails sessions of learning and practicing the skills of Mindfulness, Distress Tolerance, Emotion Regulation, and Interpersonal Effectiveness. Mindfulness teaches clients to turn attention inward and observe themselves non-judgmentally; Distress Tolerance focuses on teaching the client how to better handle distress; Emotional Regulation increases the client's control over his or her emotions; and Interpersonal Effectiveness builds skills in dealing with conflict, expressing wants and needs, and increasing self-respect (Linehan, 1993b).

DBT-A was designed to target the affective instability and difficulty in regulating emotions that are characteristic of suicidal and para-suicidal adolescents, and to address issues that can affect suicidal adolescents, such as depression, relationship issues, and school problems (Miller et al., 2007b). Skills groups with multiple families are preferred, as they allow parents and adolescents to learn skills with other families having similar difficulties. Single family therapy sessions are also commonly used to assist in generalization of skills and to help structure the home environment. To date, no comprehensive review of adolescent-only DBT studies exists, and the efficacy of adolescent DBT without parent participation remains unclear.

Analysis of the Literature

- Several recent studies have examined the feasibility of adolescent-only DBT. James, Taylor, Winmill and Alfoadari (2008) implemented an outpatient intervention utilizing the four primary skills components of DBT to address self-harm behavior in 16 females between the ages of 15 and 18 years. All participants showed symptoms associated with a diagnosis of Borderline Personality Disorder (BPD), and researchers indicated that all would have met criteria for BPD

had they been 18 years old. Treatment included one year of weekly individual therapy sessions and weekly skills group for 1.5 hours; telephone support was also available for participants.

At the end of treatment and at 8-month followup, participants reported reductions in depression and hopelessness, and clinicians reported decreased instances of self-harm and improved overall functioning. Notably, only half of participants were in "normal education or employment" (James et al., 2008, p. 150) pretreatment; upon completion, 13 of 15 (one unknown) were enrolled in school or working.

A second study by James, Winmill, Anderson, and Alfoadari (2011) offered outpatient DBT to 25 adolescents in the British "looked after care" (LAC) system, which is similar to the foster care system in the U.S. Eighteen adolescents completed the full course of treatment (15 females and 3 males) with a mean age of 15.5 years (range 12-18 years). Again, all participants would have met criteria for BPD had they been 18 years old. Treatment components were the same as those in the previous study, except that weekly group skills sessions were 2 (rather than 1.5) hours. Researchers also offered consultation for caretakers and referral agents of the LAC system and training and support for nurses and staff.

For 18 participants who completed treatment there was a significant reduction in self-reported depression and hopelessness, a reduced frequency of self-harm, and an increase in global functioning. At the end of treatment, 14 of 18 participants had totally stopped self-harming. Researchers found no significant changes in negative automatic thoughts or quality of life scores, but all returned to home or independent living from a position of homelessness or accommodation provided by the state.

Katz, Cox, Gunasekara, and Miller (2004) treated suicidal adolescents with 2 weeks of intensive DBT using an inpatient program that included the four core skills modules. Treatment was comprised of daily skills training groups, twice weekly individual psychotherapy, and a DBT milieu (with DBT-trained nursing staff) to facilitate skills generalization. The treatment team met regularly for consultation meetings, and a DBT consultant was used to evaluate staff adherence. The adolescents treated with DBT were contrasted with a group of inpatients who received treatment as usual (TAU), which consisted of a daily psychodynamic psychotherapy group, individual psychodynamic psychotherapy at least once per week, and a psychodynamically-oriented milieu.

Participants in both groups of the study had made a suicide attempt or had suicidal ideation severe enough to warrant admission to inpatient treatment, as determined by a psychiatrist. Thirty members were recruited per group and 1-year follow-up data were available on 26 DBT patients and 27 TAU patients. Participants were assigned to groups based on availability of beds at the time of admission, but no significant differences in demographic variables were found. Both groups showed substantial symptomatic improvement at discharge, with no differences on measures of depression, hopelessness, and suicidal ideation. Both groups also demonstrated a significant reduction in the absolute number of parasuicidal behaviors in the year following discharge. Interestingly, there was an absolute difference in the effect sizes between the DBT and TAU groups on self-reported depression ($1.67 - 1.05 = 0.62$), suicidal ideation ($2.12 - 1.36 = 0.76$), and hopelessness ($0.73 - 0.33 = 0.4$). Furthermore, DBT patients had significantly fewer behavioral incidents than the TAU patients and the DBT group had a 100percent retention rate for treatment.

Nelson-Gray and colleagues (2006) examined use of a DBT skills group for outpatient adolescents with diagnoses of oppositional defiant disorder (ODD). Fifty-four adolescents who met criteria for ODD were recruited and assigned to groups with 5 to 9 members for 16 weekly, 2 hour group skills sessions at either a clinic or a public high school. All core skills modules except Mindfulness were taught, and no individual treatment was offered. Sixty-nine percent of participants completed the full course of treatment, and 5 individuals opted to do a second round of DBT.

Researchers attempted to increase generalization of DBT skills through homework assignments and booster sessions, and provided participants with a pizza dinner and monetary rewards for homework completion. Transportation was provided to groups, and telephone calls and home visits were used to collect data from caregivers. Notably, this sample of 32 participants was more diverse than previous studies in age ($M = 12.6$, range = 10-15), racial characteristics (43percent African American, 40percent Caucasian, and 3percent Latino), and gender composition (27 males, 5 females).

All participants had diagnoses of ODD, based on parent report. For those who completed treatment, t-tests revealed a significant increase in interpersonal strength and reductions in ODD symptoms and externalizing behaviors from pre- to posttreatment. Furthermore, participant reports showed significant reductions in depressive symptoms and internalizing behaviors, and reductions in externalizing behaviors approached significance.

The reliable change index (RCI) was used to measure the clinical significance of change for all pre- and post-treatment measures. The RCI seeks to determine if change is clinically significant by taking into account the reliability of the measure, variability of scores in the group, and the individual's score change from pre- to post-treatment. Of participants who were in the clinical range on at least one caregiver-completed measure at pre-treatment, 77percent changed to the non-clinical range by the end of treatment. In addition, 71percent showed clinically significant improvement, while

- 13 percent of participants showed clinically significant deterioration from pre- to post-treatment on at least one caregiver-completed measure. For measures completed by participants, 91 percent of those who were in the clinical range at pre-test improved to the non-clinical range at post-test.

Sunseri (2004) implemented DBT in a residential facility with adolescent females. The sample consisted of 26 adolescents between the ages of 12-18 in treatment ($M = 15.2$ years, $SD = 1.3$), who were compared with a group of 42 residential patients prior to implementation of DBT ($M = 14.1$ years, $SD = 1.8$). Apart from the difference in age, groups were not significantly different on demographic or clinical variables. The group of clients treated with DBT had diagnoses of disruptive behavior disorders ($n = 13$, 50 percent), anxiety disorders ($n = 15$, 58 percent), eating disorders ($n = 1$, 4 percent), substance abuse disorders ($n = 10$, 39 percent), mood disorders ($n = 22$, 85 percent), and BPD ($n = 22$, 85 percent).

After DBT was introduced, individual therapy sessions were held at least weekly, and group skills training utilizing the four core modules was held twice per week for 90 minutes. After implementing DBT, there were no premature terminations due to suicide, and the number of inpatient days was significantly reduced, as was the length of time clients were held in restraints or seclusion. The authors also described DBT patients as being less dependent on punishment to change behavior, and noted that staff members worked more collaboratively with the clients and their families.

Critique of the Literature and Future Directions

No studies examining DBT-A (with or without parent participation) have been randomized controlled trials (RCTs); clearly, RCTs are needed to increase the quality of evidence for this treatment. For all studies of DBT-A, variations on how treatment was implemented complicates the interpretation of overall efficacy with adolescents. This inconsistency is evident in the studies contained in this review: some researchers included only group skills training, while others used group and individual treatment sessions. Furthermore, not all of the treatment modules were used in all studies, thereby making it difficult to compare results across empirical trials.

In the future, we recommend that researchers use a standardized format of treatment, perhaps with one format for family-based treatment and another format for adolescent skills groups only. In addition, there are usually high noncompliance and dropout rates in adolescent DBT programs (Miller et al., 2007b). Future researchers should seek to increase treatment adherence, as was done by Nelson-Gray et al. (2006), who used incentives for attendance and homework completion. Furthermore, larger studies with more varied samples are needed.

More studies exploring the optimal duration of DBT-A skill groups in a school environment are needed. Nelson-Gray et al. (2006) employed 16 week groups, but future studies could explore if shorter treatment options could work. Although the treatment setting was an inpatient facility, Katz et al. (2004) found significant improvements after only two weeks of treatment. If a 2 week skills group in a school could reduce symptoms and improve the personal skills of adolescents, it would be an extremely cost-effective and attractive treatment option. Only one published study explored using DBT-A in a school environment, and participants showed significant reductions in both internalizing and externalizing symptoms. (Nelson-Gray et al., 2006). Although the results have not been published in a peer-reviewed journal, Lincoln High School in Portland, OR reported initially promising results with ongoing skills groups (Hanson, 2012). The school developed a DBT program for course credit that included weekly group skills classes and individual sessions, as well as parent training and telephone consultation for the adolescents. The treatment included the four core modules of DBT and was offered in semester-long or year-long options. The treatment team consisted of the school psychologist, counselor, social worker, nurse, practicum students, and interns. Students in the five groups that have been completed were assessed pre- and post-intervention with the Behavior Assessment System for Children, Second Edition (BASC-2); results suggested that students experienced decreased anxiety, depression, social stress, and anger control, and demonstrated increased school attendance and GPA. Although this treatment was more comprehensive than skills-groups alone, it offers a treatment format that can be replicated and evaluated in future studies.

Recommendations for Practice

Taken together, findings from the studies reviewed herein suggest that DBT skills groups that do not include parent participation have potential for reducing self-harm and oppositional behavior, as well as for improving symptoms of depression and general functioning. There appears to be potential for meaningful improvements without parent involvement, which may increase the settings where DBT-A can be offered, including schools.

While the aforementioned variety of treatment settings should be explored in future research, conducting DBT groups in schools appears to be a particularly promising way to treat a large number of adolescents. Substance Abuse and Mental Health Services Administration (SAMHSA, 2012) found that youth aged 12 to 17 are most likely to receive mental health care in an educational setting, with 2.9 million children receiving treatment in schools in 2010. Treatment in a group format is cost-effective, and school-based DBT groups can target a large number of students in the setting in

which they are already most likely to receive counseling. Skills groups could easily be held during one class period and integrated into the school day, and students could receive course credit for participation, as was provided by Hanson (2012). Furthermore, DBT-A is largely manualized, making standardized implementation easier, such that a variety of professionals or interns could implement the programs.

Conclusion

DBT-A is a treatment that is well-suited to address many of the common concerns of adolescents, and it has shown promise in treating psychological symptoms and disorders. However, more robust studies, in particular RCTs, are needed to test the efficacy of the treatment. Future research studies may also wish to identify which skill modules are most useful in addressing adolescent concerns, and seek to develop the most efficient use of DBT by exploring shorter treatment sequences. Despite the limited number of studies available to date, this review of empirical literature suggests that DBT skills groups for adolescents may be a promising prevention and treatment tool in school settings. School-based skills groups for adolescents can be administered to a large number of middle and high school students, even those who are not diagnosed as having a disorder, and can be facilitated by trained school personnel. Taken together, findings from the existing evidence base suggest that DBT skills groups in schools have the potential to be a powerful intervention that may prevent the development of serious disorders or even suicide.

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About the Authors

Jordan Florillo, MA, is a fourth year graduate pursuing a doctoral degree in school psychology at The University of Montana and is the current president of the Psychology Graduate Student Association and treasurer of the School Psychology Student Organization at The University of Montana.

Jaime Long is a fourth year graduate student in school psychology at the University of Montana. Jaime recently completed her masters project on depression, academics, and online social networking usage in adolescents. She is an adjunct faculty member and enjoys teaching introduction to psychology online.

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Dialectical Behaviour Therapy with Adolescents: A Review

Sameena Groves¹, Hilmar S. Backer², Wies van den Bosch³ & Alec Miller¹

¹Montefiore Medical Center, Child Outpatient Psychiatry, 3340 Bainbridge Avenue, Bronx, New York 10467, USA. E-mail: amiller@montefiore.org

²Ministry of Justice, The Netherlands

³Psychiatric Hospital Pro Persona, Psychology Department, Arnhem, Netherlands

Background: Dialectical behaviour therapy (DBT) is the first empirically validated treatment for chronically suicidal patients diagnosed with borderline personality disorder (BPD). Numerous randomised clinical trials conducted with adults with BPD have demonstrated that DBT is effective in reducing suicidal and non-suicidal self-injurious (NSSI) behaviours. Other research on the use of DBT for adults has shown that the treatment is effective in reducing a variety of problem behaviours in a range of therapeutic settings. In the last decade, a number of studies have evaluated DBT as a promising treatment for adolescents with different psychological disorders and behaviours, including borderline personality disorder (BPD), eating disorders, externalising disorders, and suicidal and NSSI behaviours. This article reviews the literature on the use of DBT with adolescents. **Results:** Overall findings indicate some empirical support for the conclusion that DBT is a promising treatment for adolescents with BPD symptomatology, suicidal ideation and comorbid depression, bipolar disorder, disordered eating behaviours and aggressive and impulsive behaviours. Adolescents in these studies were also hospitalised less frequently when treated with DBT. Moreover, studies conducted with these populations suggest that DBT may be adapted for use in outpatient, inpatient, community, and residential treatment settings. **Conclusions:** The authors conclude that DBT may be effective in treating adolescents with additional disorders and dysfunctional behaviours not yet examined. Data from soon to be completed randomised controlled trials need to be published.

Key Practitioner Message:

- Dialectical behaviour therapy (DBT) is the first empirically validated treatment for chronically suicidal patients diagnosed with borderline personality disorder (BPD)
- A number of studies have evaluated DBT as a promising treatment for adolescents with eating disorders, externalising disorders, and suicidal and NSSI behaviours
- There is empirical support for the conclusion that DBT is a promising treatment for adolescents with a range of psychopathology, and who receive treatment in a variety of settings
- Future studies must address methodological shortcomings by increasing sample size and diversity, implementing adherence coding and control groups, and using consistent terminology

Keywords: Dialectical behaviour therapy; adolescents; adolescent problem behaviour; suicide attempt; self-injurious (parasuicidal) behaviour

Introduction

Dialectical behaviour therapy (DBT) is the leading evidence-based treatment for suicidal adult women diagnosed with Borderline Personality Disorder (BPD). DBT is a comprehensive treatment that targets the interpersonal and environmental factors that maintain clients' suicidal behaviours; it uses a number of key principles and strategies derived from behaviour therapy, dialectical philosophy and Zen practice. Multiple randomised controlled trials have demonstrated DBT's superiority to treatment as usual for problems associated with BPD (Linehan et al., 1991; Linehan, Heard, & Armstrong, 1993; Koons et al., 2001; Verheul et al.,

2003; van den Bosch et al., 2005; Linehan et al., 2006). The treatment has been shown to improve treatment adherence rates, decrease inpatient psychiatric days, and reduce frequency and severity of suicide attempts, non-suicidal self-injurious behaviours, and suicidal ideation (Linehan et al., 1991, 2006; Koons et al., 2001; Verheul et al., 2003; van den Bosch et al., 2005; Bohus, Haaf, & Simms, 2004; Lynch et al., 2003). A review of this research can be found in Scheel (2000), Robins and Chapman (2004), and Lynch et al. (2007).

Research on DBT has been conducted with various adult populations, including outpatient (Linehan et al., 1991, 1993, 2006; Verheul et al., 2003; van den Bosch et al., 2005), inpatient (Barley et al., 1993; Linehan

et al., 1999; Bohus et al., 2000; Koons et al., 2001; Bohus et al., 2004; Simpson, Pistorello, & Begin, 1998) and forensic populations (Evershed et al., 2003; Bradley & Follingstad, 2003; Berzins & Trestman, 2004). DBT has been shown to have applications for adults with comorbid BPD and substance abuse problems (Linehan et al., 1999; Linehan et al., 2002; van den Bosch et al., 2005), comorbid BPD and eating disorders (Palmer et al., 2003), as a treatment for eating disorders (Safer, Telch, & Agras, 2001; Telch, Agras, & Linehan, 2001), and as a treatment for geriatric depressed outpatients with mixed personality features (Lynch et al., 2003; Lynch, 2000). Research on the use of DBT with various adolescent populations has started to expand and diversify, indicating that the treatment also has applications for a number of problem behaviours among adolescents. The purpose of the following review is to survey this area of research and to highlight considerations for researchers and practitioners applying DBT to various adolescent populations.

DBT with adolescents

A total of 12 outcome studies published between 1997–2008 are included in the current review. None of these studies, however, are randomised controlled trials (RCTs), although the last author is consultant to two RCTs that are currently in progress. Lars Mehlum is the principal investigator of the first adolescent DBT RCT being conducted in Oslo, Norway, while the second adolescent DBT RCT is being conducted in New Zealand under the direction of Emily Cooney.

DBT was first adapted for use with suicidal adolescents by Miller and colleagues (Miller et al., 1997). Although the core tenets and modes of the treatment were retained, several changes were made by the authors to make Linehan's original textbook and treatment manual appropriate for this younger population. For example, treatment length was decreased from 12 months to 16 weeks, age-appropriate terminology was incorporated, and family members were included in the weekly skills training groups (Miller et al., 1997; Miller, Rathus, & Linehan, 2007). Likewise, a fifth skills training module, 'Walking the Middle Path', was added in an effort to help adolescents and their families navigate impasses by learning validation skills, behavioural principles, and dialectical thinking and acting.

DBT and suicidal, multi-problem adolescents

Two quasi-experimental studies on DBT with adolescents have been conducted to date, with both indicating that the treatment is promising in reducing several behaviours found among suicidal, multi-problem multiply diagnosed youth. Rathus and Miller (2002) compared depressed and suicidal adolescents treated with DBT to treatment as usual (TAU) in a 12-week outpatient program (see Table 1 for details). Despite having more severe psychopathology at baseline (92% of the group had a comorbid depressive disorder at the outset of treatment), adolescents treated with DBT were significantly more likely to complete treatment (60% versus 38%) and had significantly fewer psychiatric hospitalisations (0% versus 13%). DBT was also associated with significant reductions in depressive

symptoms and suicidal ideation. No statistically significant differences were found between the number of suicide attempts in the two conditions (0% versus 9%), yet this probably reflects the low frequency of this behaviour during the 12-week study. Within the DBT group at post-treatment, adolescents reported significant reductions in all four problem areas targeted in DBT (i.e. confusion about self, impulsivity, emotional dysregulation, and interpersonal problems) as measured by the Life Problems Inventory, a measure highly correlated with the borderline personality disorder subscale of the SCID-II (Rathus & Miller, 2002; Rathus, Wagner, & Miller, 2005). Moreover, reductions in anxiety, depression and suicidal ideation were found among DBT participants at post-treatment (Rathus & Miller, 2002).

Katz and colleagues (2004) used a similar design when comparing outcomes between adolescents treated with DBT vs. TAU for 2 weeks in an inpatient setting (initial $n=62$; see Table 1). All participants had been hospitalised for recent suicide attempts or suicidal ideation and were admitted to one of two inpatient units; one unit used a DBT protocol and the other unit relied on TAU. Those who received DBT attended individual therapy twice weekly and skills training groups 5 days per week, and were able to request and receive skills coaching by milieu staff on the unit. The DBT unit held a weekly therapist consultation meeting and staff from evening shifts were able to 'participate' as well by leaving and receiving notes related to consultation questions or concerns they had. DBT was superior to TAU in reducing behavioural incidents (including NSSI behaviours) and increasing adherence to treatment, including medication compliance, during the hospitalisation. Upon discharge, all patients in both conditions were referred for outpatient treatment and assessed one year later. Both groups (DBT $n=26$ and TAU $n=27$ at follow-up) demonstrated a significant reduction of suicidal ideation, non-suicidal self-injurious behaviour, and depressive symptoms. Although the effect sizes were greater for DBT than TAU with respect to self-report ratings of depressive symptoms and suicidal ideation, differences were not statistically significant, perhaps due to the small sample size. Additionally, it is possible that the pattern of results in both of these quasi-experimental studies was affected by the nature of the TAU treatment delivered, which was noted to vary in content between adolescents.

Several additional studies have examined the effectiveness of DBT for adolescents with features of BPD, including NSSI and suicidal behaviours; in general, these studies evaluate pre- and post-treatment outcomes in the absence of control groups and randomisation (James et al., 2008; Sunseri, 2004; Fleishhaker, 2006; Woodberry & Popenoe, 2008). Fleishhaker and colleagues (2006) evaluated DBT treatment outcomes for 16 older female adolescents with at least 6 months of 'severe and persistent deliberate self-harm' (DSH). Of note, the authors defined DSH after Hawton et al. (2002), whose definition problematically does not distinguish non-suicidal self-injurious behaviours from suicide attempts. Adolescents were seen at a DBT clinic twice a week, once for an hour-long individual session and once for a 90-minute skills training group, and received telephone coaching. Overall, post-treatment assessments,

Table 1. Articles on the use of DBT with adolescents

Authors	N	Design/ Setting	Key criteria for DBT inclusion	% of N who completed treatment	Total # DBT sessions individual/ group	Modes	Outcome measures
Rathus & Miller (2002)	DBT = 29 TAU = 82 F/M = 27/2	Quasi- experimental Outpatient	(a) Suicide attempt in last 16 weeks or current suicidal ideation; and (b) at least 3 BPD features	DBT=60% TAU=38%	12/12	DBT: I/G/CT TAU: Twice weekly individual (psychodynamic/ supportive) and family sessions Family: Yes	Beck Depression Inventory (BDI) Life Problems Inventory (LPI) Scale for Suicidal Ideation (SSI) Symptom Checklist 90-Revised (SCL-90-R) # of Psychiatric hospitalizations and suicide attempts during treatment (clinician records)
Katz et al., (2004)	DBT + TAU = 62 F/M = 52/10	Quasi- experimental Inpatient	Recent suicide attempt or suicidal ideation	-	4/10	I/G/CT TAU: individual (psychodynamic) therapy at least once per week and (psychodynamic) group therapy five days a week Family: No	Number of incident reports during admission (based on staff records) Beck Depression Inventory (BDI) Kazdin Hopelessness Scale for Children (KHS) Reynolds Suicidal Ideation Questionnaire-Jr. (SIQ) Lifetime Parasuicide Count (LPC) # of ER visits secondary to parasuicidal behavior/ideation and of psychiatric readmissions to the hospital (based on hospital charts and parent report)
James et al. (2008)	16 F/M = 16/0	Pre-post Community Clinic	History of at least 6 months of persistent deliberate self-harm*	87.5%	24/24	I/G/CT Family: No	Beck Depression Inventory (BDI) Beck Hopelessness Scale (BHS) Global Assessment of Functioning (GAF) Episodes of Deliberate Self-Harm
Fleischhaker et al. (2006)	12 F/M = 12/0	Pre-post Outpatient	(a) Deliberate self-harm (suicide attempt or NSSI) in last 16 weeks or current suicidal ideation; and (b) at least 3 BPD features	75%	16-24/16-24	I/G/CT Family: Yes	Symptom Checklist-90-Revised (SCL-90-R) Child Behavior Checklist (CBCL) Youth Self-Report (YSR) Inventory zur Erfassung der Lebensqualität bei Kindern und Jugendlichen (ILK) Assessment of life quality Clinical Global Impressions (CGI)

Table 1. Continued

Authors	N	Design/ Setting	Key criteria for DBT inclusion	% of N who completed treatment	Total # DBT sessions individual/ group	Modes	Outcome measures
Woodberry & Popenoe (2008)	45 F/M=41/5	Pre-post Community Clinic	History of suicide attempts, self-injury, and/or intense and unstable affect or relationships w/in past 3-6 months	61%	15/15	I/G/CT Family: Yes	Reynolds' Adolescent Depression Scale (RADS) Behavior and Symptom Identification Scale (BASIS-32) Adult Attachment Scale (AAS) Trauma Symptom Checklist for Children (TSCC) Child Behavior Checklist (CBCL) Beck Depression Inventory (BDI) (parent rating)
Sunseri (2004)	68 F/M=68/0	Pre-post Residential Treatment Facility	Resident at facility; must make commitment to TX	-	~52/~104	I/G/CT Family: No	# Premature terminations (determined by staff records) # Inpatient days Duration of physical restraints and seclusions (staff records)
Goldstein et al. (2007)	10 F/M=6/2	Pre-post Specialty Outpatient Clinic	Diagnosis of Bipolar I, II or NOS w/in acute manic, mixed, or depressive episode w/in the last 3 months	90%	18/18	I/G/T Family: Yes	Modified Scale for Suicidal Ideation (MSSI) Select items from Schedule for Affective Disorders and Schizophrenia for School-Age Children-Present and Lifetime version (K-SADS-PL) Children's Affective Liability Scale Matson Evaluation of Social Skills with Youngsters (MESSY) Treatment satisfaction questionnaire
Trupin et al. (2002)	DBT=45 TAU=45 F/M=45/0	Pre-post with control group Juvenile Detention Facility	Offenders living on either Mental Health Unit or General Population Unit	-	0/20-40	G/C/T? Family: No	# Youth behavior problems (tallied from daily behavior logs (completed by staff)) # Staff punitive actions (based on staff records) Rates of participation in various on-campus programs (based on staff records) Community Risk Assessment (CRA) Scores (calculated by Juvenile Rehabilitation Administration) Massachusetts Youth Screening Instrument (MAYSI)

Table 1. Continued

Authors	N	Design/ Setting	Key criteria for DBT inclusion	% of N who completed treatment	Total # DBT sessions individual/ group	Modes	Outcome measures
Nelson-Gray et al. (2006)	54 = Initial 32 = Retained F/M=5/27	Pre-post Outpatient	Diagnosis of Oppositional Defiant Disorder	69% (32 participants plus 5 who elected to repeat group)	0/16	G Family: Yes*	Diagnostic interview schedule for children, parent version (DISC-P) Child Behavior Checklist (CBCL) Youth Self-Report (YSR) Behavioral and Emotional Rating Scale (BERS) Child Depression Inventory (CDI)
Salbach, Klinkowski, & Pfeiffer (2007)	31 Anorexia (n=23) Bulimia Nervosa (n=8) F/M=31/10	Pre-post Inpatient	Diagnosis of Anorexia or Bulimia Nervosa	97%	24/12 Plus family meetings on weekly or bi-monthly basis	I/G/C/T Family: Yes	Eating Disorder Diagnosis (SIAB-EX) Body Mass Index (BMI) Binge eating frequency Vomiting frequency Use of laxatives Food restriction Eating Disorders Inventory -2 (EDI-2) Global Severity Index (GSI)
Safer, Lock, & Courtier (2007)	1 F/M=1/0	Single case Outpatient Specialty Clinic	Diagnosis of Binge Eating Disorder	100%	21/0 Plus 4 family meetings	I/T Family: Yes	Eating Disorder Examination (EDE) Body Mass Index (BMI) Objective binge eating frequency (self-report on diary card)
Salbach-Andrae et al. (2008)	12 Anorexia (n=6) Bulimia Nervosa (n=6) F/M=12/0	Case series with pre-post measures Outpatient	Diagnosis of Anorexia or Bulimia Nervosa	92%	25/25	I/G/C/T Family: Yes	Eating Disorder Diagnosis (SIAB-EX) Body Mass Index (BMI) Binge eating frequency Vomiting frequency Use of laxatives Food restriction Eating Disorders Inventory -2 (EDI-2) Global Severity Index (GSI)

I= Individual therapy; G=Group skills training; C=Consultation team; T=Telephone consultation
* Parent did not participate in skill groups

conducted 8 months after treatment concluded, indicated that participants completed more than 78% of sessions and evidenced a significant increase in participants' general functioning, as well as a marked reduction in self-report of depression, hopelessness, and episodes of DSH. Importantly, it is not possible to separate out the effects of the treatment for non-suicidal self-injurious behaviour versus suicide attempts, as these two classes of behaviours are grouped together in the definition of DSH. Nevertheless, all of the improvements observed at the end of treatment were maintained at follow-up, suggesting that DBT with multi-problem adolescents may produce long-term effects. Linehan and colleagues (2006) conducted a large-scale study of adult patients over a 2-year period that demonstrated that patients treated with DBT, as compared to treatment by non-behavioural experts in the community (TBE), had lower rates of suicide attempts, re-hospitalisation, and treatment attrition. More research is needed to determine if such findings can be replicated with an adolescent population.

Other studies have found similar support that DBT improves functioning and decreases life-threatening behaviours among adolescents. In a partial replication of the Rathus and Miller (2002) study, Fleischhaker et al. (2006) assessed DBT treatment outcomes in an outpatient sample of 12 adolescents using similar inclusion criteria as Rathus and Miller (2002). Prior to the start of treatment, 67% of participants in the study had at least one suicide attempt and all had engaged in NSSI during their lifetimes. Post-treatment measures indicated that deliberate self-harm incidents and number of hospitalisations decreased significantly over time, as did other indices of psychopathology, including depressive symptoms. Furthermore, there were no suicide attempts among adolescents during the course of the study.

Similarly, Woodberry and Popenoe (2008) found positive treatment outcomes in a group of suicidal and non-suicidal self-injuring adolescents and their caregivers treated in an open 15-week trial of DBT in a community outpatient clinic. In particular, improvements were seen in adolescent-reported depressive symptoms, anger, dissociative symptoms, and indices of NSSI and suicidal ideation. Parents reported changes in adolescent internalising, externalising, and total problem behaviours (see Table 1 for specific outcome measures). Moreover, parents reported a considerable decrease in their own depressive symptoms at the conclusion of treatment. This finding highlights the transactional nature of psychopathology in families and the broad impact a comprehensive adolescent DBT treatment program may have on other family members.

Sunseri (2004) adapted DBT for use in a residential treatment facility and reported outcomes indicating that the treatment was useful in helping the severely impaired adolescent population. Over a period of 5 years, all 68 adolescent girls served by the treatment facility underwent DBT. Results from this uncontrolled open-trial indicated that DBT contributed to a reduction in number of premature terminations, which was defined as 'a client who engaged in self-harm and was admitted to a psychiatric hospital; subsequently refusing to return to treatment'. It is not clear what 'self-harm' behaviour includes; nevertheless, it was noted that clients were typically referred for hospitalisation

subsequent to a 'parasuicidal event (i.e. cutting, burning, overdose attempts) or the expression of suicidal ideation'. Significant reductions were also observed in the number of days spent in psychiatric hospitals due to 'self-injurious behaviours', and length of time patients were held in restraints or seclusion. Although this sample was more heterogeneous than the ones cited thus far, consisting of adolescents with a variety of diagnoses and problem behaviours, the data suggest that DBT may be useful in preventing such multi-problem adolescents from requiring a higher level of care beyond their residential providers. Of course, without a control group, it is not possible to draw any firm conclusions about the specific effects of the treatment provided.

DBT has also been adapted for use with adolescents diagnosed with bipolar disorder. Like BPD, bipolar disorder is associated with difficulties in emotion regulation coupled with high rates of impulsive behaviours. Goldstein and colleagues (2007) conducted a year-long open trial of DBT with 10 outpatient adolescents diagnosed with bipolar disorder, most of whom had a history of at least one suicide attempt and many of whom had intermittent suicidal ideation. The authors made some modifications to Miller, Rathus and Linehan's adolescent multi-family skills training manual (2008), including adding a module containing two sessions of psychoeducation on bipolar disorder and decreasing the length of the five core skills modules. The study also varied from standard DBT for adolescents in that participants received 24 weekly 60-minute sessions, alternating between individual therapy and skills training conducted within individual family units rather than in a larger group setting. The continuation phase of treatment consisted of 12 total sessions, also alternating between family skills training and individual therapy sessions, and tapering in frequency through one year. A major limitation of the study was the absence of a therapist consultation team, as the study's first author was the only DBT-trained clinic staff member and provider.

Results indicated that retention among participants was extremely high (i.e. 90%), with one patient moving away and the remainder completing treatment. In addition, patients exhibited significant improvements at post-treatment in suicidal ideation, emotion dysregulation, and depressive symptoms. Although non-suicidal self-injurious behaviours decreased over the course of treatment, the change was not statistically significant. Lastly, both patients and parents indicated a high degree of satisfaction with the DBT approach and the progress that the adolescents made during treatment. These high acceptability and satisfaction ratings are consistent with patient's treatment acceptability and satisfaction in an adult DBT treatment study (Linehan et al., 2006). Thus, the DBT treatment (i.e. individual therapy and family skills training) was well tolerated by the patients and their families in that they 'liked' the therapy and would refer others in need to such a program.

DBT and externalising disorders

Many researchers have started conducting DBT treatment outcome studies with adolescents who exhibit

problems and symptoms other than those associated with BPD and mood disorders. For example, two studies found some support for the use of DBT to treat adolescents with externalising behaviours (Trupin et al., 2002; Nelson-Gray et al., 2006). Trupin and colleagues (2002) implemented a DBT treatment program with 90 incarcerated female juvenile offenders. DBT was employed on two units: a mental health unit, in which staff members had received 80 hours of DBT training (i.e. 10-day gold standard intensive training), and a general population unit, in which staff members had received 16 hours of DBT training (two-day workshop). Both of these units were compared to adolescents on a third unit receiving treatment as usual from clinicians with no training in DBT. Adolescents assigned to the mental health unit had higher rates of externalising disorders and internalising disorders than adolescents assigned to either the general population or the TAU units. Behaviour problems – the composite of classroom disruption, aggression, and parasuicidal acts (including self-mutilation, suicide attempt, and threatened suicide) – were recorded by staff members on a daily basis for all adolescents and compared to incidents occurring in the year before the DBT intervention began. Results indicated that adolescents on the mental health unit showed a statistically significant reduction in behaviour problems during the 10-month period of the study and exceeded the changes seen in the other units. Moreover, interventions by staff who had received the intensive DBT training (i.e. those on the mental health unit) were significantly less punitive than in the year before the intervention began. By comparison, no adolescent behaviour changes or changes in staff members' responses were observed in the general population unit. This finding highlights the value and impact intensive training has on staff behaviour and client outcomes as compared to less intensive training. Comparisons between pre-and-post treatment for the group receiving TAU were not measurable on account of the group's fewer problems at baseline.

Nelson-Gray and colleagues (2006) conducted a 16-week trial of group-based, outpatient DBT skills training for 54 non-suicidal adolescents diagnosed with oppositional defiant disorder (ODD), 32 of whom completed the treatment program. Analyses indicated that those participants who dropped out of the treatment evidenced more comorbid psychopathology at baseline than those who completed the program. Notably this study differs from others discussed thus far in that adolescents received only weekly adolescent-only group skills training and therefore received no individual therapy or telephone consultation. Treatment protocols were based on Linehan's (1993) manual, with modifications made to make the material more age-appropriate and to encourage homework compliance through financial incentives. The authors reported post-treatment decreases in oppositional-defiant disorder criteria and externalising behaviour problems according to parent reports. Parent ratings also indicated reductions in depressive symptoms and increases in positive behaviours. Again, while there is no control group it is hard to make definitive statements about these findings; however, it does raise the question as to whether comprehensive DBT, which is typically recommended for multi-problem multi-diagnostic youth, is necessary

for youth who present with a single diagnosis (e.g. ODD).

DBT and eating disorders

Finally, a handful of studies have examined the effectiveness of DBT for adolescents with eating disorders (Salbach-Andrae et al., 2008; Salbach et al., 2007; Safer et al., 2007). Salbach and colleagues (2007) published results from a pre-post treatment study of 31 inpatient adolescent girls with anorexia ($n=23$) and bulimia nervosa ($n=8$), many of whom were also diagnosed with a depressive disorder, an anxiety disorder, and/or a personality disorder. The authors modified Miller and colleagues' (1997, 2007) treatment model by making several changes, including shortening the duration of treatment while increasing the frequency of sessions; adding content specific to eating disorders; using both therapists and nursing staff trained in DBT to deliver treatment; and adding weekly groups that focused on issues of weight and eating. Outcome measures indicated that overall retention in treatment was high (only one participant dropped out). Significant improvements were seen with respect to depressive symptoms and eating disordered behaviour, including restriction of intake, excessive exercise, and use of weight-loss substances. Body mass index (BMI) scores in the patients with anorexia also increased strongly and significantly. Salbach-Andrae and colleagues (2008) reported a similar pattern of findings with adolescents treated with DBT for eating disorders on an outpatient basis. Namely, treatment with DBT was associated with a decline in the behavioural symptoms of eating disorders and symptoms of general psychopathology. As is the case in many of the studies reviewed here, the authors noted the possibility that patients' improvement was due to factors other than DBT that were not controllable within their study design.

Safer and colleagues (2007) made adolescent-specific modifications to standard DBT for adults with binge eating disorder and published a single case study of a 16 year-old female showing preliminary support for their revised treatment manual. DBT for binge eating disorder is based on the affect-regulation model of binge eating, which posits that binge eating is a behavioural attempt to modify painful emotional states. The authors adapted a manualised version of DBT for binge eating disorder in adults (Telch, 1997) by adding an Interpersonal Effectiveness module, changing the order in which skills were taught by presenting the Distress Tolerance skills first, and introducing family sessions as needed. In this case study, four family sessions were scheduled as adjuncts to individual sessions during the course of the 21-week treatment program for a total of 24 therapy hours. The authors reported that the frequency and severity of their patient's binge eating was reduced at post-treatment, but cautioned that additional case studies and case series are needed before justifying a randomised controlled trial of DBT for binge eating disorder. In sum, the results of these studies indicate that DBT may be a promising treatment for a variety of eating disorders and that well-controlled studies with more robust designs are warranted.

Discussion

Twelve studies on the effectiveness of DBT with adolescents in the period between 1997-2008 were found (Table 1). It is difficult to compare findings across these studies because there is considerable variability in populations, settings, structure, and format of treatment. There is also wide variation in the design of the studies, with the majority consisting of a pre-post treatment design and none including a randomised controlled design. Furthermore, some studies provided clear and detailed descriptions of their fidelity to (or divergence from) the original DBT protocol, whereas other studies were more vague. Taken together, these many areas of discrepancy do not permit direct comparisons between studies. At the same time, research evaluating complex interventions such as DBT must be flexible and endeavour to ask whether the intervention works in everyday practice (Medical Research Council, 2008). The studies reviewed here provide important information about practical effectiveness, and many of the findings indicate that DBT has a range of therapeutic effects for adolescents.

Wide-ranging improvement in functioning

Although these 12 studies lack commonality in method and design, nevertheless the adolescents treated with DBT made improvements on a variety of measures of functioning across a wide range of treatment settings. For example, adolescents with BPD features reported significant reductions in impulsivity, emotional dysregulation, confusion about oneself and interpersonal difficulties after a short 12-week comprehensive outpatient intervention (Rathus & Miller, 2002). Incarcerated juvenile offenders were found to have fewer acts of aggression, classroom disruptions and 'parasuicidal' acts when treated with DBT (Trupin et al., 2002); bipolar adolescents and their families indicated that DBT was a highly satisfactory treatment that contributed to reductions in suicidal ideation, NSSI, emotional dysregulation, and depressive symptoms (Goldstein et al., 2007); and adolescents with anorexia or bulimia demonstrated significant improvements in behavioural indices of disordered eating and general psychopathology when treated with DBT on an outpatient basis (Salbach-Andrae et al., 2008). Moreover, DBT was shown to have some clinical utility in settings where comprehensive treatment is often less feasible or very difficult to implement, such as a residential treatment facility (Sunseri, 2004), community outpatient clinic (Woodberry & Popenoe, 2008), and rehabilitation facility for juvenile offenders (Trupin et al., 2002). This suggests that the treatment's theoretical underpinnings and clinical approach have value for clinicians working with multi-problem youth who have difficulty regulating their emotions and behaviours.

Treatment acceptability

As with adult studies comparing DBT to treatment as usual or to treatment by experts (Linehan et al., 1991, 1999, 2006), many of the studies reviewed here suggest that DBT is a well-tolerated treatment for the adolescents and family members involved (Rathus & Miller, 2002; Goldstein et al., 2007; Woodberry & Popenoe, 2008). Thus, those teens and parents participating in

DBT complete the treatment more often than the control subjects and also report 'liking' the treatment and would consider referring others in need to such a program. The DBT approach was particularly well-tolerated in the Goldstein et al. (2007) study, in which participants attended 90% of scheduled sessions. Satisfaction ratings indicated that both adolescents and their parents were highly satisfied with the intervention and the visible gains made by the adolescents during the course of treatment. Future studies should continue to assess acceptability and satisfaction among adolescent and family members treated with DBT, as it provides an important index of the treatment's effectiveness. Clinicians could use such data to help educate potential patients about DBT and to build commitment among those starting in treatment.

Treatment retention

Treatment retention is one indicator of an intervention's tolerability and acceptability; across the studies reviewed here, participants frequently completed the DBT program provided. This is particularly compelling not only because DBT often involves a high degree of commitment and involvement on the part of adolescents and their parents, but also because the types of adolescents followed in these studies are often considered the most difficult to engage and retain in treatment. Suicidal adolescents and patients with BPD frequently drop out of treatment prematurely, which in turn increases their risk for multiple negative outcomes including repeated hospitalisations and/or suicide.

Treatment retention was lowest in the studies by Woodberry and Popenoe (2008) and Nelson-Gray and colleagues (2006), and the differences between the studies suggest some key considerations for future research. In the Woodberry and Popenoe (2008) study conducted in a community outpatient clinic, 63% of the 46 adolescents who initially consented to treatment completed the 15-week program. Among non-completers, the most common reason for drop-out was 'external' factors, such as transportation difficulties or lack of parental support. This finding highlights the challenges inherent in working with a multi-problem population in a community setting.

In the study by Nelson-Gray et al. (2006), pre-treatment differences in comorbidity may have contributed to the 69% retention rate. The absence of the individual DBT therapy modality may have contributed to the relatively smaller retention rate when compared to other multi-modal studies reviewed. Overall, findings from the study indicated that the treatment was portable in the community and replicable across graduate student therapists; nevertheless, it remains to be seen whether DBT group skills training is an effective stand-alone treatment for adolescents. In an unpublished study by Linehan, Heard and Armstrong (cited in Linehan et al., 1993), group skills training alone was not effective when paired with treatment-as-usual individual therapy with adult women diagnosed with BPD. Given the dearth of published findings in this area, future research is needed to determine whether group skills training alone may be effective for some adolescent populations, including those with a single diagnosis or those with severe restrictions that limit frequent

attendance, such as those with comorbid medical problems.

Considerations for future research

Future research on the use of DBT with adolescents must address the methodological shortcomings observed in the studies. First, researchers must be clear, precise, and consistent when defining the inclusion criteria and outcome measures for their samples. The inconsistencies in terminology used to describe NSSI and suicidal behaviour make it impossible to compare inclusion criteria and findings across some of the studies reported here. Until relatively recently in the US, researchers used the term suicidal behaviour, suicide attempts, suicidal gestures, parasuicide, and deliberate self-harm (DSH) interchangeably to describe both suicide attempts and non-suicidal self-injury; however, research has demonstrated empirical support for the importance of separating suicidal from non-suicidal self-injurious behaviours (Jacobson et al., 2008). Many European authors continue to use the DSH terminology, which makes it difficult to know what effect DBT may have on non-suicidal self-injurious behaviours with no intent to die vs. suicidal behaviours with at least some intent to die. To increase the reliability and validity of future studies of DBT for adolescents, we urge researchers and clinicians to consider using the same language to describe the same behaviours.

Second, researchers must improve the internal validity of their studies by including control groups and adherence coding. Few of the studies reviewed here included a control group and those that did (Rathus & Miller, 2002; Katz et al., 2004) were quasi-experimental. Without control groups, it is not possible to make strong inferences about the effectiveness of the intervention provided. Fortunately, two randomised controlled trials are underway, the findings from which should answer some of the questions raised, as well as posing new questions for future research. In addition, it would be helpful for researchers to record and report on any events or factors that may influence their outcomes, such as adverse events on an inpatient unit or community violence in outpatient settings. Very few of the studies reviewed here comment explicitly on issues of internal validity beyond stating the need for a control group.

Adherence coding will also permit greater clarity about the nature of the intervention provided. Adherence coding refers to the process of recording treatment sessions and rating therapists' interventions according to the criterion specified in the original model. Therapists who delivered DBT in the studies described varied in profession, training, years of experience, and whether they had the support of a consultation team. Although many had sought training through intensive DBT workshops and other reliable methods of training, very few studies mentioned whether any steps had been taken to ensure therapists' adherence to the DBT protocol (see Woodberry & Popenoe, 2008 for an exception). These sources of variance inevitably make it more difficult to compare the treatments being delivered to patients across studies and to determine whether these patients were actually receiving DBT (as measured by a reliable adherence measure).

A related recommendation involves researchers stating explicitly the ways in which their treatment interventions adhered to, or deviated from, Miller and colleagues' (2007) DBT protocol. Guidelines on conducting effectiveness research, such as those proposed by the Medical Research Council (2008), highlight the value of making modifications and flexible adaptations of an original treatment protocol in order to maximise a treatment's utility. In the process of doing so, however, it is crucial that researchers and clinicians record all ways in which their treatment was delivered. Such information will permit a more nuanced understanding of DBT's essential components for particular populations.

Third, efforts should also be made to maximise the generalisability of findings to new populations. For example, many of the studies reviewed included small samples that were predominantly female, with the exception of the study conducted by Nelson-Gray et al. (2006), in which 85% of their adolescent sample was male. Small samples and the over-representation of females limit the applicability of findings to other groups. Similarly, DBT has only recently begun to be applied to populations other than the one it was originally developed for, and thus there are not yet enough studies to make comparisons between DBT interventions for the same disorder (i.e. bipolar disorder) or the same setting (i.e. residential treatment facility). As research on the use of DBT with adolescents proliferates, we will be able to make stronger comparisons between groups.

In conclusion, the research to date on DBT with adolescents is both very limited on the one hand and quite promising on the other. Many of the studies contain methodological weaknesses that decrease the internal and external validity, and the reliability of the findings. Only two studies (Rathus & Miller, 2002; Katz et al., 2004) compared DBT to a comparison group using a quasi-experimental design; the next step is to evaluate DBT in randomised controlled trials. Two such trials are currently underway and will undoubtedly contribute to the treatment literature in important ways. At the same time, the research reviewed here has yielded several promising findings and suggests that DBT may help improve the lives of adolescents and their families. One particularly encouraging finding was that parents participating in Woodberry and Popenoe's (2008) study reported a large change in their own depressive symptoms, suggesting that DBT may change the overall health of a family system from multiple angles. Research on DBT has only recently started to investigate specific factors associated with outcome (Robins & Chapman, 2004) and future studies should continue to do so, particularly given the many questions raised by the findings discussed in this article. Finally, by having more consistent terminology to describe our independent variables and by having more robust study designs, future research will build on the foundation outlined by these 12 studies.

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WESTPORT PUBLIC SCHOOLS

ELLIOTT LANDON
Superintendent of Schools

110 MYRTLE AVENUE
WESTPORT, CONNECTICUT 06880
TELEPHONE: (203) 341-1010
FAX: (203) 341-1025

To: Members of the Board of Education
From: Elliott Landon
Subject: Student and Faculty Calendar / 2016-17 School Year
Date: March 16, 2015

As has been our practice, the Board of Education discusses and approves a student and faculty calendar two years in advance of implementation. It will be necessary, therefore, for the Board to consider and approve a student and faculty calendar for the 2016-17 school year.

For the first time, and consistent with Public Act 13-247 approved by the Legislature of the State of Connecticut, our Board of Education will be required to adopt a calendar that is consistent in its essential components with that of the "Uniform School Calendar" adopted by our Regional Educational Service Center, Cooperative Educational Services. The essential components for the uniform school calendar are as follows:

1. At least 180 days of actual school sessions during each school year (The Westport Public Schools require students to be in attendance for 182 days).
2. A uniform start date as determined by Cooperative Educational Services
3. Uniform days for professional development and in-service training for certified employees (The Cooperative Educational Services uniform regional calendar includes 2 such days; the Westport Public Schools require 6 of these days for its certified employees).
4. Not more than 3 uniform school vacation periods during each school year, not more than two of which shall be a one week school vacation period and one of which shall be during the summer.

With these guidelines determining the nature of our 2016-17 school calendar, a calendar has been prepared that is consistent in every way with the essential components required in the "Uniform School Calendar" adopted by Cooperative Educational Services, but also provides for the nuances required by the Westport Board of Education, as follows:

1. 182 days of actual school sessions for students (Same as the uniform calendar plus 2).
2. 6 staff development days for certified employees (Same as uniform calendar plus 4).
3. Starting date for students of September 1, 2016 (Same as uniform calendar starting date).
4. One week vacation in December; one week vacation in April (Same as uniform calendar).

ADMINISTRATIVE RECOMMENDATION

Be It Resolved, That upon the recommendation of the Superintendent of Schools, the Board of Education adopts the Student and Faculty Calendar for the 2016-17 school year, a calendar that is consistent with the guidelines of Public Act 13-247 as approved by the legislators of the State of Connecticut and the policies of the Westport Board of Education.



SCHOOL CALENDAR 2016 - 2017
APPROVAL - March 16, 2015

<p>JULY 2016 (0)</p> <table border="1"> <thead> <tr><th>S</th><th>M</th><th>T</th><th>W</th><th>Th</th><th>F</th><th>S</th></tr> </thead> <tbody> <tr><td></td><td></td><td></td><td></td><td></td><td>1</td><td>2</td></tr> <tr><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> <tr><td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td></tr> <tr><td>17</td><td>18</td><td>19</td><td>20</td><td>21</td><td>22</td><td>23</td></tr> <tr><td>24</td><td>25</td><td>26</td><td>28</td><td>28</td><td>29</td><td>30</td></tr> <tr><td>31</td><td></td><td></td><td></td><td></td><td></td><td></td></tr> </tbody> </table> <p>4 Independence Day</p>	S	M	T	W	Th	F	S						1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	28	28	29	30	31							<p>AUGUST 2016 (0)</p> <table border="1"> <thead> <tr><th>S</th><th>M</th><th>T</th><th>W</th><th>Th</th><th>F</th><th>S</th></tr> </thead> <tbody> <tr><td></td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td></tr> <tr><td>7</td><td>8</td><td>9</td><td>10</td><td>11</td><td>12</td><td>13</td></tr> <tr><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td>20</td></tr> <tr><td>21</td><td>22</td><td>23</td><td>24</td><td>25</td><td>26</td><td>27</td></tr> <tr><td>28</td><td>*29</td><td>*30</td><td>*31</td><td></td><td></td><td></td></tr> </tbody> </table> <p>*29-31 Staff Development Days</p>	S	M	T	W	Th	F	S		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	*29	*30	*31				<p>September 2016 (21)</p> <table border="1"> <thead> <tr><th>S</th><th>M</th><th>T</th><th>W</th><th>Th</th><th>F</th><th>S</th></tr> </thead> <tbody> <tr><td></td><td></td><td></td><td></td><td>(1)</td><td>2</td><td>3</td></tr> <tr><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td></tr> <tr><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td></tr> <tr><td>18</td><td>19</td><td>20</td><td>21</td><td>22</td><td>23</td><td>24</td></tr> <tr><td>25</td><td>26</td><td>27</td><td>28</td><td>29</td><td>30</td><td></td></tr> </tbody> </table> <p>1 Student's First Day 5 Labor Day</p>	S	M	T	W	Th	F	S					(1)	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30						
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Students - 182 days

*Teachers - 188 days

Staff Development Days: August 29-31, November 8, January 13 and February 16.

Students'/Teachers' Last Day will be June 14. Snow/Emergency School Closing Days will be added after June 14.

If there are no snow/emergency days, Students'/Teachers' Last Day will be June 14

WESTPORT PUBLIC SCHOOLS

ELLIOTT LANDON
Superintendent of Schools

110 MYRTLE AVENUE
WESTPORT, CONNECTICUT 06880
TELEPHONE: (203) 341-1010
FAX: (203) 341-1029

To: Members of the Board of Education
From: Elliott Landon
Subject: Capital Expenditure Request: Bedford Middle School Gymnasium Floor
Date: March 16, 2015

All materials related to the replacement of the Bedford Middle Gymnasium Floor may be found as an attachment to this memorandum. You will note that Elio Longo and Ted Hunyadi have made arrangements first to cut out and remove the existing urethane floor system at all concrete expansion joints where the floor is torn and/or delaminating so as to be properly filled with new urethane. Secondly, the 85% of the existing floor surface will be removed and prepared to an acceptable level so that a new coat of urethane can be spread over the entire floor. Third, a Robbins Sports Surfaces Pulastic Classic 110 Floor System will be installed over the urethane with a 9mm underlayment shock pad. Finally, game lines and artwork will be applied to the new floor surface to match current markings.

This project is being undertaken as a sole source procurement project because this floor covering is available only from a single supplier. The manufacturer, Robbins Sports Services, is a part of National Joint Powers Alliance (NJPA), a purchasing consortium to which we have belonged since 2007.

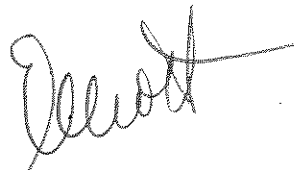
It is essential that this project be "fast forwarded" to the Board of Finance for approval, if the work required is to be completed during the upcoming recess during the summer 2015. Should the Board of Finance approve of this appropriation, we shall make an immediate request to the RTM for its consideration.

Since the safety of the gymnasium floor for students is essential for school and Parks and Recreation use throughout the school year and throughout the summer months, it is essential that the Board of Education approve this project and authorize the Superintendent of Schools to bring it forward to the Board of Finance and the RTM.

ADMINISTRATIVE RECOMMENDATION

Be It Resolved, That upon the recommendation of the Superintendent of Schools, the Board of Education authorizes the Superintendent of Schools to request of the Board of Finance an appropriation in the amount of \$139,847 for a comprehensive renovation of the floor of the gymnasium at Bedford Middle School, and

Be It Further Resolved, if approved by the Board of Finance, authorization for the Superintendent of Schools to request of the Representative Town Meeting financing as approved by the Board of Finance.





45 Nutmeg Rd. So., South Windsor, CT 06074-0145

PROPOSAL

www.DaleneFlooring.com
Ph: 860-289-4305 Fax: 860-290-3774

To: Westport Public Schools
Address: 110 Myrtle Avenue
Westport, CT 06880
Phone: 203-341-1271
Fax: 203-341-1277
Email: thunyadi@westport.k12.ct.us

Project Name: Bedford Middle School
Gymnasium Floor Renovation
Address: 88 North Avenue
Westport, CT 06880
Contact: Theodore Hunyadi
Director of Facilities and Security
Date: March 11, 2015

We propose to furnish and install the following items according to plans and specifications as noted below.

OPTION #2: RESURFACING OF EXISTING SYNTHETIC FLOOR SYSTEM Robbins Sports Surfaces Pulastic FL-E Overpour System

- 1 Cut out and remove existing urethane floor system at all concrete expansion joints where floor is torn and/or delaminating and properly infill with new urethane.
- 2 Rough sand existing floor surface removing approximately 85% of existing top coat and profile to provide acceptable sub-surface to apply new lift of urethane.
- 3 Supply and install Robbins Sports Surfaces Pulastic Classic 110 floor system with 9mm underlayment shock pad in color as selected by Owner.
- 5 Apply all game lines and artwork to new floor surface to match current markings.
- 6 Supply and install Johnsonite 4" vinyl cove base on all perimeter walls.
- 7 Remove existing volleyball cover plates and replace with new brass volleyball cover plates in all locations.

For The Sum Of: \$ 131,378.00

dd Alternate: Remove Bleachers, installed floor system underneath and reattach bleachers

Add The Sum Of: \$ 8,469.00

Bleachers should be inspected to determine if this option should be done. Many times, bleachers sink into the existing synthetic floor making operation difficult. When adding the elevation of the new floor system to this condition, it can aggravate the issue.

- Notes: This project is tax exempt and carries prevailing wage rates.
Work will take approximately three and one half weeks to complete.
All necessary reducers at bleachers and doors are included.
Owner is responsible to supply dumpster for disposal of jobsite waste.

Dalene Flooring State Contract#12PSX0307AG / Core Vendor ID: 0000067711

We hereby propose to furnish labor and materials complete in accordance with the above specifications For The Sum Of:

TERMS: NET 10 DAYS FROM DATE OF INVOICE

All material is guaranteed to be as specified. All work to be completed in a workmanlike manner according to standard practices. Failure of the contractor/customer to make payment to DALENE HARDWOOD FLOORING CO., INC. as they become due shall excuse DALENE HARDWOOD FLOORING CO., INC. from performance of any additional portion of this contract at its option, but DALENE HARDWOOD FLOORING CO., INC. shall be entitled to all payments due for work performed to date. All agreements contingent upon strikes, accidents, or delays beyond our control. Owner to carry fire, tornado and other necessary insurance. Our workers are fully covered by Workmen's Compensation insurance. Interest shall be charged at the rate of 1-1/2" PER MONTH (18% ANNUALLY) on the entire account if not paid when due as specified above. All costs, disbursements and attorney's fees made or incurred in collecting payment of this account shall be included and paid as part of the debt due hereunder. This proposal is valid for a period of thirty (30) days.

Authorized Signature

Gordon Crunden
cn=Gordon Crunden, o=Dalene Hardwood
Flooring Co. Inc., ou,
email=gcrunden@daleneflooring.com,
c=US
2015.03.11 12:38:36 -0400'

Acceptance of Proposal

The above prices, specifications and conditions are satisfactory and are hereby accepted. You are authorized to do the works as specified. Payment will be made as outlined above.

Accepted:

Date: _____

South Windsor, CT

West Hartford, CT

Manchester, CT

Southington, CT



Commercial Division:
Phone: 860-289-4305

45 Nutmeg Road South, P.O. Box 145, South Windsor, CT 06074
Fax: 860-290-3774

Date: March 11, 2015

Mr. Theodore Hunyadi
Director of Facilities and Security
Westport Public Schools
110 Myrtle Avenue
Westport, CT 06880

Re: Bedford Middle School, Gymnasium Floor Renovation

Dear Mr. Hunyadi,

This letter is to confirm that Dalene Hardwood Flooring Co., Inc. is the exclusive Dealer/Installer for Robbins Sports Surfaces in Connecticut. As part of this arrangement, our sales staff, project management team, and installation team go thru periodic training and certification of Robbins products and services to optimize the overall process for the end user and ensure longevity and the achievement of project expectations.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read 'Gordon Crunden', written over a large, light-colored circular scribble.

Gordon Crunden
Director

Cc: Rick Onslager, Robbins Sports Surfaces
File

South Windsor
45 Nutmeg Rd. So.

Southington
832 Queen Street

Manchester
91B Hale Rd.

W. Hartford
588 New Park Ave.



Sports Surfaces

Robbins, Inc.
4777 Eastern Ave.
Cincinnati, OH 45226-2339
Tel: 513-871-8988
Fax: 513-871-7998

March 11, 2015

Mr. Gordon Crunden
Dalene Hardwood Floors
45 Nutmeg Rd, South
South Windsor, CT 06074

To Whom It May Concern:

Dalene Hardwood Floors, located in *South Windsor, CT* is Robbins exclusive certified installer specializing in Sport Surfacing for many years. They have proven to be a very reputable installer/floor finisher in both the maple and synthetic flooring business. I am sure your company will find their work remarkable.

Should you have any further questions, please contact me.

Sincerely yours,

A handwritten signature in cursive script that reads "Robin Steinmetz".

Robin Steinmetz
Atlantic Region & Western Region
Senior CSR
ROBBINS, INC.



To: NJPA Members
From: John Ficks, National Sales Manager, Robbins Sports Surfaces
Re: Robbins NJPA Contract# 082114-RBI

Dear NJPA Member,

Thank you for your interest in Robbins Sports Surfaces. Both Robbins and your local Authorized Robbins Dealer appreciate the opportunity to present Robbins Sports Surfaces' NJPA contract pricing for your athletic flooring project.

Robbins NJPA pricing is designed to meet the needs of most projects in North America. As no two athletic facilities are the same, your Robbins dealer may present you with additional pricing options for ancillary solutions, also known as "sourced products and equipment", necessary for the completion of your project. These services may include special logos or graphics, threshold plate at doorways, a price modification based on local labor rates or an additional discount if you choose special pricing that may be offered by Robbins.

Robbins NJPA contract pricing satisfies the bid requirement that may be necessary for publicly owned facilities and is the result of a competitive public bid process with all records available for review.

[Click here for contract documentation.](#)

The NJPA contract offers its members the convenience of procuring Robbins products without having to spend time and money developing their own bid process as the bid requirement has already been satisfied.

If you are a coach, athletic director, school board member, or school business official, check with your purchasing department regarding your NJPA membership. Most likely your institution is already a member of NJPA and actively buying off of contracts. If your institution is not an NJPA member, please contact the NJPA and join, membership in this public entity is free.

If you or your purchasing department has any questions about how to acquire Robbins solutions through the NJPA contract, please contact the NJPA directly at (888) 894-1930.

If you have any questions about NJPA, Robbins or project pricing, please feel free to contact me, the local Robbins Regional Sales Manager or your local Authorized Robbins Dealer.

Sincerely,

John Ficks
jficks@robbinsfloor.com
National Sales Manager
Robbins Sports Surfaces



Robbins Inc.



Contract#: 082114-RBI

Category: Athletic Surfaces & Equipment, Ice Arenas & Event Seating

Description: Hardwood and Synthetic Sports Flooring Systems

Maturity Date: 09/16/2018

Overview

Contract Documentation

Pricing

Marketing Materials

NJPA Contact Information

HOW TO PURCHASE



Our step-by-step guide

Vendor Contact Info

John Ficks

Direct Phone: (513) 871-8988

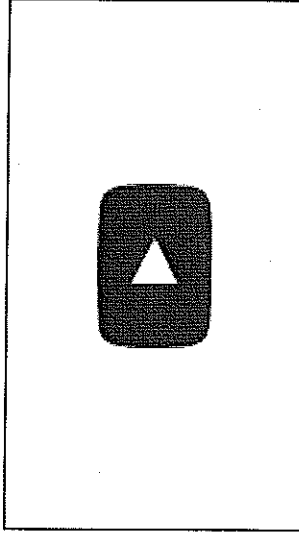
x5975

jficks@robbinsfloor.com

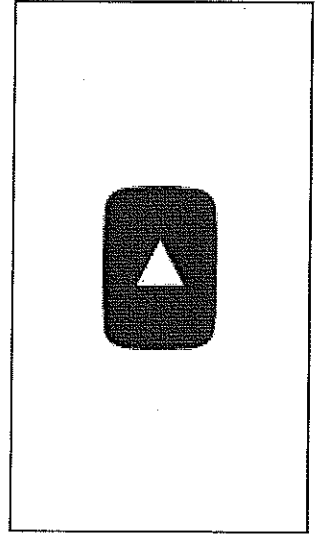
www.robbinsfloor.com

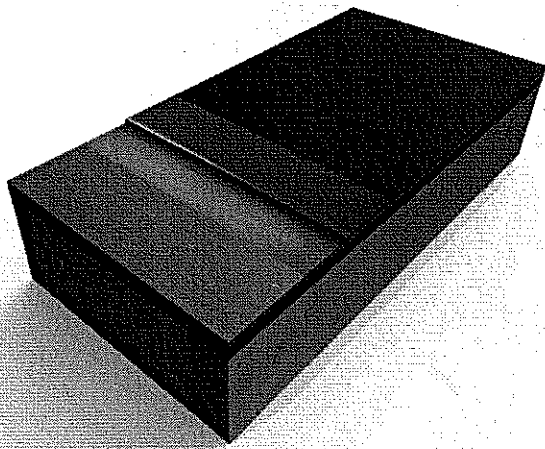
Robbins Sports Surfaces, a family owned business, is the premier supplier of high performance maple and synthetic sports flooring systems to the NBA, WNBA, NCAA, arena, education, religious and fitness markets. In more than 65 nations on six continents, athletes compete and practice on millions of square meters of Robbins' sports surfaces. Professional and amateur alike know that when they play on a high performance Robbins' system they'll be able to play at peak levels, safely and comfortably.

Robbins Floor Customer Testimonial - Friar's Club of Cincinnati



Robbins Customer Testimonial - University of Cincinnati Recreation Center





PULASTIC FL systems are resurfacing systems for existing polyurethane floors. Pulastic FL offers options for rehabbing, restoring, and enhancing existing Pulastic floors, and offers enhancement options for other non-Pulastic resilient and full-depth polyurethane floors .

Benefits to choosing a Pulastic FL system include:

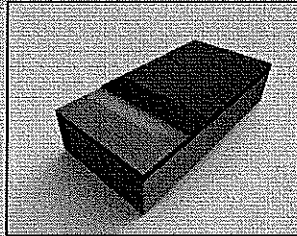
- ① *Reduced costs in comparison to a new floor*
- ① *Improves friction characteristics*
- ① *Water based finish for very low odor during renovation and maximum indoor clean air protection during use*
- ① *Helps maintain color stability*
- ① *Strengthens wear resistance for optimal life cycle cost and maximum usability*
- ① *Easily update colors & graphics to match facility preferences*

PULASTIC®

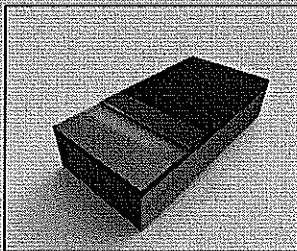
INDOOR | MULTI-PURPOSE | BASKETBALL | TENNIS | VOLLEYBALL
TRAINING FACILITY | COMPETITION LEVEL | GYMNASTICS

CHOOSE THE BEST FIT FOR YOUR FACILITY
Pulastic FL has three options to choose from:

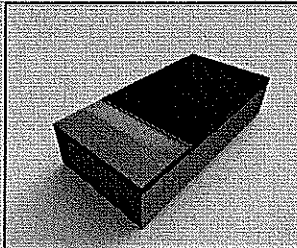
PULASTIC FL (FACELIFT) is a resurfacing system designed exclusively for existing Pulastic polyurethane floors. Pulastic FL will restore and enhance existing Pulastic floors to their original beauty, extending the life of the floor even more.



PULASTIC FL-E (ENHANCED) is an "enhancement" system for resurfacing existing full depth and resilient polyurethane floors. Utilizing GM2500 compound, FL-E will provide a stronger, better looking surface possessing the proper friction characteristics of standard PULASTIC systems.



PULASTIC FL-R (RESTORE) is a "restoration" system for resurfacing existing Pulastic floors. This affordable process is designed to fully restore the floor to its original condition. Please note that FL-R should not be used to resurface non-Pulastic floors.



16 Classic Colors to Choose From




*Custom color options available. Due to printer variation, actual floor colors may be slightly different from colors above. Consult your dealer for color accuracy.

robbinsfloor.com | 1.800.543.1913

Robbins, Inc. | 4777 Eastern Avenue | Cincinnati, OH 45226

INTEROFFICE MEMORANDUM

TO: Elliott Landon, Superintendent
FROM: Elio Longo, Jr. 
Director of School Business Operations
SUBJECT: 2015-2020 Transportation Contract
DATE: March 12, 2015
Cc: S. Evangelista, File

I am pleased to inform you that we have completed the Request for Proposal (RFP) process for the five-year contract award for our school transportation services. Two contractors (DATTCO and First Student) submitted comprehensive proposals. Careful consideration was given to both proposals. These two RFP submittals ranged between 14-16% (Year 1) increase over current rates; well-exceeding the Board's FY16 proposed budget allocation. Through a Final and Best Offer negotiation process the District was able to secure significantly reduced rates and remain within FY16 budget expectations. DATTCO's proposal on a comparative cost basis will result in a 5-year savings estimated at \$408,570. DATTCO also offered more favorable terms in fleet, field trips, credits and overall compliance with our proposed contract terms. Therefore, based on all of the aforementioned, I am recommending that the contract be awarded to DATTCO, Inc., our current provider.

HIGHLIGHTS OF THE RFP PROCESS

- The RFP process began by hiring Mark Walsh, President of Transportation Advisory Services (TAS), who is a highly regarded transportation consultant.
- Mark worked with Sandra Evangelista to review the current transportation program in order to provide a basis for the program description to be included in new RFP specifications.
- Prior to release, the content of the RFP was reviewed by our attorneys and insurance consultant.
- Potential contractors were notified of the proposal opportunity through letters and e-mails from TAS. Additionally, the WPS Business Office placed a legal ad in The Norwalk Hour newspaper.
- A pre-proposal meeting was held on December 18, 2014. Eight (8) contractors, one (1) drivers' union representative and one (1) school bus sales representative, attended the meeting along with District and TAS representatives.
- Two proposals were submitted to the Business Office on January 15, 2015. The District's current contractor DATTCO, and First Student, submitted comprehensive proposals.
- Both TAS and the Business Office performed extensive reviews of both proposals including the development of detailed spreadsheets to allow for a fair and representative cost comparison.
- Both contractors were offered an opportunity to meet with Elio Longo and Sandra Evangelista to discuss their proposals, answer questions about the submittal, and provide a modified proposal if

they so chose (a Final and Best Offer process). This meeting also provided the District with the opportunity to ask specific questions about the planned operations. The District met with both contractors.

- Subsequent to the FABO meetings, both contractors revisited their proposals and responded to the District with additional information and/or modified proposals.
- Both proposers submitted a proposal in accordance with RFP fleet mandate.

Included with this letter are two (2) cost analysis spreadsheets and one (1) FABO comparative cost analysis. The below chart highlights the two competing vendor FABOs.

COMPARATIVE SUMMARY		
	DATTCO	FIRST STUDENT
Fleet	26 new Type I rear-engine (2015-2016). Replacement schedule: the fleet will average less than 3.5 years old.	100% new vehicles. Type I front-engine.
Prepayment Discount	1.5%	1.5%
Annual Inflation (%)	9.0/9.0/5.0/5.0/5.0	9.0/12.0/4.5/4.5/4.5
Coach-Style buses for field trips	Prices provided. Vehicles available.	No bid.
Facility	Use current site and current Bridgeport site.	Use current site and Norwalk site.
Annual Parking Credit	\$100,000	None
Annual Facility Credit	\$204,690	\$240,000-\$264,915
Proposal Exceptions	None	Several requested changes to specification provisions.
Est. 5 Yr Cost	\$23,972,668	\$24,381,238

FINAL BEST OFFER COMPARATIVE COST ANALYSIS

	YEAR 1 2015-2016	YEAR 2 2016-2017	YEAR 3 2017-2018	YEAR 4 2018-2019	YEAR 5 2019-2020	5 YEAR TOTAL
DATTCO	\$ 4,207,181	\$ 4,585,827	\$ 4,815,118	\$ 5,055,874	\$ 5,308,668	\$ 23,972,668
FIRST STUDENT	\$ 4,209,778	\$ 4,714,951	\$ 4,927,124	\$ 5,148,844	\$ 5,380,542	\$ 24,381,238
<i>difference</i>	\$ (2,597)	\$ (129,124)	\$ (112,005)	\$ (92,970)	\$ (71,874)	\$ (408,570)

DATTCO FINAL BEST OFFER COST ANALYSIS

TYPE I	CAT	#	DAYS	YEAR 1			YEAR 2			YEAR 3			YEAR 4			YEAR 5			
				2014-2015	2015-2015	2015-2016	2016-2017	2017-2018	2018-2019	2018-2019	2019-2020	2019-2020	2019-2020	2019-2020	2019-2020	2019-2020	2019-2020	2019-2020	
				PRICE/DAY	INCREASE	TOTAL COST	PRICE/DAY	INCREASE	TOTAL COST	PRICE/DAY	INCREASE	TOTAL COST	PRICE/DAY	INCREASE	TOTAL COST	PRICE/DAY	INCREASE	TOTAL COST	
HOME/SCHOOL	4.25 hr	15	182	2,512	9%	\$ 417.85	\$ 1,215,323	9%	\$ 454.81	\$ 1,304,703	5%	\$ 477.66	\$ 1,460,485	5%	\$ 501.84	\$ 1,539,509	5%	\$ 526.62	\$ 1,599,509
HOME/SCHOOL	4.50 hr	28	182	4,185	9%	\$ 405.47	\$ 1,781,000	9%	\$ 438.76	\$ 1,943,112	5%	\$ 466.95	\$ 2,098,377	5%	\$ 511.30	\$ 2,247,311	5%	\$ 536.86	\$ 2,402,296
KINDERGARTEN	4.50 hr	20	5	200		\$ 30.00	\$ 3,000	9%	\$ 32.70	\$ 3,270	5%	\$ 34.34	\$ 3,454	5%	\$ 36.05	\$ 3,605	5%	\$ 37.85	\$ 3,764,605
						\$ 2,782,526			\$ 3,285,224			\$ 3,462,769			\$ 3,804,366			\$ 4,149,495	
TYPE II	4.00 hr	5	182	910	9%	\$ 367.89	\$ 394,766	9%	\$ 400.88	\$ 418,885	5%	\$ 421.03	\$ 440,297	5%	\$ 442.08	\$ 464,429	5%	\$ 464.19	\$ 487,724
TYPE II	4.25 hr	5	182	910	9%	\$ 375.96	\$ 342,446	9%	\$ 409.62	\$ 374,989	5%	\$ 430.31	\$ 391,986	5%	\$ 451.83	\$ 411,166	5%	\$ 474.42	\$ 434,724
TYPE II	4.50 hr	4	182	728	9%	\$ 384.11	\$ 279,629	9%	\$ 418.67	\$ 304,795	5%	\$ 439.64	\$ 320,035	5%	\$ 461.39	\$ 336,097	5%	\$ 484.67	\$ 352,833
						\$ 956,841			\$ 1,042,629			\$ 1,094,761			\$ 1,149,495			\$ 1,206,974	
PRE-K		6	175	1,050	9%	\$ 30.00	\$ 31,500	9%	\$ 32.70	\$ 34,335	5%	\$ 34.34	\$ 36,052	5%	\$ 36.05	\$ 37,854	5%	\$ 37.85	\$ 39,747
TOTAL						\$ 5,660,785			\$ 6,062,249			\$ 6,464,561			\$ 6,866,876			\$ 7,269,191	
PRE-Prepayment Discount						\$ (59,243)			\$ (62,154)			\$ (65,065)			\$ (67,976)			\$ (70,887)	
NET TOTAL						\$ 5,601,542			\$ 5,999,995			\$ 6,399,496			\$ 6,798,899			\$ 7,198,304	
FED Summer	4.00 hr	5	25	145	9%	\$ 349.51	\$ 50,979	9%	\$ 380.06	\$ 55,240	5%	\$ 400.01	\$ 60,002	5%	\$ 420.01	\$ 69,762	5%	\$ 441.01	\$ 79,477
PRE-SKILLS/VOCATIONAL						\$ 30,000		9%	\$ 32.70	\$ 35,643	5%	\$ 34.34	\$ 37,415	5%	\$ 36.05	\$ 39,287	5%	\$ 37.85	\$ 41,159
AFT		26	1	26		\$ 30.00	\$ 780	9%	\$ 32.70	\$ 850	5%	\$ 34.34	\$ 925	5%	\$ 36.05	\$ 997	5%	\$ 37.85	\$ 1,074
PA RUNS						\$ 417.95	\$ 137,795	9%	\$ 454.91	\$ 150,121	5%	\$ 477.66	\$ 157,627	5%	\$ 501.54	\$ 165,508	5%	\$ 526.62	\$ 173,784
PRE II	4.00 hr	1	165	165	9%	\$ 367.88	\$ 60,699	9%	\$ 400.98	\$ 66,152	5%	\$ 421.03	\$ 69,470	5%	\$ 442.08	\$ 72,944	5%	\$ 464.19	\$ 76,911
PRE-Prepayment Discount						\$ (12,975)		1.5%	\$ (13,465)		1.5%	\$ (13,955)		1.5%	\$ (14,445)		1.5%	\$ (14,935)	
NET TOTAL						\$ 4,270,058			\$ 4,535,627			\$ 4,801,196			\$ 5,066,764			\$ 5,332,332	
UNAD TOTAL WPS						\$ 3,846,189			\$ 4,101,758			\$ 4,357,327			\$ 4,612,896			\$ 4,868,465	
IF YEAR COST						\$ 3,846,189			\$ 4,101,758			\$ 4,357,327			\$ 4,612,896			\$ 4,868,465	
IF Proposed FY2015-2016 Budget						\$ 3,940,964			\$ 4,195,739			\$ 4,450,714			\$ 4,705,689			\$ 4,960,664	
**S10 - Regular Ed						\$ 732,853			\$ 765,307			\$ 797,761			\$ 830,215			\$ 862,669	
**S11 - Special Ed - Internal						\$ 4,072,817			\$ 4,429,432			\$ 4,752,953			\$ 5,075,474			\$ 5,427,995	
IF: OEA Proposed Acct 510						\$ 256,241			\$ 269,610			\$ 282,979			\$ 296,348			\$ 309,717	
DIRECTION OVER(UNDER) BUDGET						\$ (62,877)			\$ (65,882)			\$ (68,887)			\$ (71,892)			\$ (74,897)	

WESTPORT PUBLIC SCHOOLS

SANDRA EVANGELISTA
*Coordinator of Transportation
and Other Business Services*

110 MYRTLE AVENUE
WESTPORT, CONNECTICUT 06880
TELEPHONE: (203) 341-1741

TO: Elio Longo, Jr.
Director of School Business Operations

SUBJECT: Status Update WPS Transportation 2014-15

DATE: March 12, 2015

There are approximately 60 days remaining of the 2014-2015 school year and I can report that the student transportation program/provider is meeting the districts mandates for on time consistency and continuous improvement.

The last update I provided referenced the solutions enacted to resolve many of the typical start up issues. The major areas of focus were drivers and routes. These issues were addressed and positive outcomes were experienced. A new focus was placed on reviewing local Dattco management, organization and communication with an interest to evaluate and improve current practices. This was a collaborative process with Dattco district management. As a result of this review staff and operation changes were made. A new terminal manager and dispatcher have been assigned to our location.

This new local management team has proven to be highly effective. The level of office organization and increased communication with the district and the drivers has created a positive culture change. The driver retention rate has remained high. There were only four routes with driver changes during this period of time. One driver is out long term and will return; the other routes had been covered by drivers from the Hartford district since the start of the school year and now have new permanent drivers assigned. These replacement drivers were trained for a minimum of 5 days prior to their assignment to the route thus reducing any negative impact of a change. Drivers continue to be trained by their peers to utilize alternate routes to avoid high traffic and road congestion due to multiple variables.

In spite of all the positive changes there were challenges experienced during this time period due to inclement weather and extreme low temperatures. The maintenance team at Dattco worked diligently to reduce the impact and avoid mechanical issues. The buses were started beginning at 4:30 am to warm and avoid the occurrence of fuel gelling as winterized diesel fuel is still prone to gel with single digit temperatures and can cause buses to run slow.

This winter was a difficult one and due to the amount of snowfall the road conditions required the buses to travel at slower speeds to ensure safety. This and the increased traffic due to parents choosing to transport children especially on the very cold days did impact the timeliness of the arrival of the buses. This was a challenge that was unavoidable and has resolved with the arrival of more spring like weather. I will continue to work with Dattco management to improve overall operations. The next goal is to focus on existing technology and route efficiencies.

Please let me know if you have any suggestions or require additional information.