FINAL REPORT: Year 2 Activities

Program Evaluation of the Positive Psychology through Happiness (PPH) Assessment and HAPPINESS Curriculum

2021-23 Research Partnership between the Children's Home Society of Florida and the School Mental Health Collaborative (SMHC): Research, Training, and Technical Assistance Center at the University of South Florida

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PROJECT BACKGROUND AND RATIONALE

Behavioral health counseling service providers ("providers") working on behalf of the Children's Home Society (CHS) of Florida meet families at the crossroads of success and struggles. The bulk of attention in psychology research and practice has focused on how to identify and treat such families' emotional and behavioral problems. Accordingly, traditional counseling services focus on assessing and working to improve a client's negative cycle of stress, failure, and insufficiencies. During the 21st century, the growing field of positive psychology has shed light on evidence-based practices for monitoring and increasing happiness. Fostering a client's happiness (i.e., subjective well-being) is essential to ensuring optimal outcomes. In alignment with a modern lens of mental health, CHS aims to measure and guide families to a new cycle of happiness and joy. To achieve this goal, CHS created a new intake tool—Positive Psychology through Happiness (PPH) Assessment—and clinical intervention framework—HAPPINESS Curriculum—intended for eventual use by behavioral health counseling service providers throughout the agency. Widespread adoption of the refined PPH Assessment and HAPPINESS Curriculum (the "program") is pending empirical support for efficacy.

EVALUATION PLAN

To establish an evidence base for the newly developed PPH Assessment and HAPPINESS Curriculum, the School Mental Health Collaborative (SMHC) within the USF College of Education conducted a program evaluation that meets sufficient standards for rigor to permit designation as "Promising" at post-treatment. In Year 1 of the two-year partnership, the USF team conducted a pilot study of the PPH Assessment and HAPPINESS Curriculum and assisted in the refinement of the program in line with findings from the pilot. During Year 2, the USF team evaluated a refined version of the program (see Appendix A) as implemented in a randomized controlled trial (RCT) with a larger group of providers.

Throughout the partnership, we evaluated the feasibility, acceptability, and efficacy of the newly developed positive psychology program as used by CHS providers during 2021-23. Through qualitative data (e.g., feedback on implementation supports needed to provide the program with a satisfactory level of fidelity), review of quantitative data from ratings of client behavioral health (i.e., subjective well-being, mental health problems) and client satisfaction with clinical services, we examined changes in client well-being throughout behavioral health counseling services. We learned the outcomes of the new program in relation to the current way of work, as summarized in this technical report that conveys findings from the RCT. We offer recommendations for provider use of the new program to ensure high fidelity to the manual and support materials. Finally, we offer recommendations to the CHS leadership for additional research on the PPH.

COLLABORATORS

The research team from the University of South Florida (USF) College of Education, that collaborates with Children's Home Society of Florida (CHS) includes the following members of the "evaluation team":

A. Shannon Suldo, Ph.D., Principal Investigator and Psychologist
B. John Ferron, Ph.D., Consulting Methodologist
C. Graduate Research Assistants
    a. Frances Coolman, M.Ed., M.A.
    b. Camryn Legra, M.A.
    c. Radhika Sundar, M.S., M.A.

The team from CHS that collaborates with the USF evaluation team includes:

A. Julie Taylor, M.A. CBHCMS LMFT, Behavioral Health Intern and Training Program Coordinator
B. Rene Ledford, M.S.W., BCBA, LCSW, Qualified Supervisor, Senior Director of Research, Training, and Accreditation
C. Danielle Mohrbacher, B.S., Behavioral Health Training Manager
D. Murielle Pamphile, Ph.D, Senior Director of Community Partnership Schools
E. Wade Lijewski, Ph.D., Vice President of Practice Integration

All work was facilitated by the Children's Home Society of Florida.

PROJECT TIMELINE

A detailed timeline of project activities enacted to support the 2-year program evaluation plan is provided in Table 1.

Table 1. *Overview of Research Activities during Year 1 (2021-22) and Year 2 (2022-23)*

Date	Activity(s)
August 2021	Onboarding of CHS and USF staff; creation of USF/CHS team; CHS sent drafts of PPH and HAPPINESS curriculum ("intervention") for USF staff to review and edit
September 2021	CHS sent additional drafts of intervention to USF for feedback; USF revised and edited manual, and added literature and practices grounded in positive psychology
October 2021	PPH curriculum finalized with CHS and USF collaboration; USF team drafted all research materials needed for IRB submission (consent forms, exit interviews, data sharing agreement, recruitment procedures, acceptability survey, professional development evaluation forms, etc.); Initial identification of clinicians for pilot year use and feedback
November 2021	PPH manual finalized with USF and CHS collaboration; USF submitted IRB application with additional documents needed; Recruitment for pilot year clinicians and consent forms sent out; USF and CHS drafted professional development materials to be rolled out in December
December 2021	USF and CHS created PowerPoint presentations to guide both three-hour trainings; First professional development for PPH (workshop 1 of 2) held with pilot clinicians by USF and CHS; USF created and used surveys to assess: professional development acceptability, knowledge of positive psychology, acceptability/usage of intervention
January 2022	USF and CHS held second training (workshop 2 of 2) for pilot clinicians. Clinicians began to use PPH program with clients and provide fidelity/acceptability data on Qualtrics. USF remained in frequent contact with clinicians to check-in on use and survey completion.
March – April 2022	CHS led monthly supervision check-ins with clinicians for feedback and to answer any questions; USF recorded clinician responses. USF continued to collect acceptability and fidelity data through Qualtrics, and conducts weekly check-ins with clinicians via email.
May – June 2022	As clinician's start to complete treatment with some of their clients after using PPH and HAPPINESS, USF met with the clinician via Zoom to conduct exit interviews and receive feedback on program with each client.
May 2022	Power analyses conducted by USF informed minimum number of clinicians and clients needed for participation in the randomized controlled trial (RCT) during Year 2;
July 2022	USF compiled feedback from pilot clinicians to suggest edits for CHS to make before the RCT year to the virtual trainings and intervention manual. This data from the pilot guided the refinement of program, training, and evaluation procedures.

June – July 2022	CHS identified providers in region(s) to recruit for participation in RCT. For Cohort 1: Enrollment of clinicians; For participants, baseline assessment of clinician mental health, and random assignment to condition: treatment (PPH) or control (services as usual).
August - September 2022	Clinicians in treatment group (Cohort 1) completed initial training in the PPH through completion of three 2-hour workshops and successful completion of post-training knowledge quiz. Clinicians in both groups began administering the baseline assessment measures to new youth clients in their care. Clinicians in treatment group provided fidelity of implementation data by reporting the percentage of each session that they utilized the PPH.
October 2022	USF pre-registered RCT in OSF Registries (see https://osf.io/dgsqf).
November 2022	CHS identified providers to recruit for participation in Cohort 2 of RCT.
December 2022	For Cohort 2: Enrollment of clinicians; For participants, baseline assessment of clinician mental health, and random assignment to condition: treatment (PPH) or control (services as usual).
December 2022-January 2023	Clinicians in treatment group (Cohort 2) completed initial training in the PPH through completion of three 2-hour workshops and successful completion of post-training knowledge assessment. Clinicians in both groups began administering the baseline assessment measures to new youth clients in their care. Clinicians in treatment group provided fidelity of implementation data by reporting the percentage of each session that they utilized the PPH.
September 2022 – April 2023	Clinicians contacted weekly by USF team regarding client enrollment and procedures for collecting pre- and post-treatment data (both groups), reminder to report fidelity of PPH use (treatment group), and check for questions re: data collection (both groups) or PPH use (treatment group). Methodologists monitored fidelity of PPH use reports sent by CHS.
May 2023	Clinicians in both groups attended virtual meetings co-facilitated by CHS and USF to celebrate progress with study and discuss final steps necessary to conclude data collection; Clinicians in both groups completed second assessment (post-treatment) of clinician mental health.
June 2023	Post-treatment data collection from youth clients closed. Final data on PPH fidelity sent to USF team. USF team conducted analysis of treatment satisfaction data collected via Qualtrics.
July 2023	CHS compiled complete dataset with de-identified youth client outcomes data (youth mental health pre and post-treatment) and sent to USF team.
August – October 2023	Methodologists cleaned and merged datasets, completed preliminary analysis of quantitative data from clinicians, youth clients, and fidelity of use surveys.
November 2023	USF team provided preliminary results to CHS team.
December 2023-April 2024	USF team completed additional follow-up analyses with additional data received re: client demographic features and clinician employment status at CHS, and prepared final report summarizing study findings.

SUMMARY OF YEAR 1 ACTIVITIES, FINDINGS, AND NEXT STEPS

Throughout the 2021-2022 school year, six clinicians were fully trained in the PPH Assessment and HAPPINESS Curriculum. After completion of initial training, clinicians used the PPH Assessment and HAPPINESS Curriculum throughout this pilot year. After each session with a client in which any portion of the PPH had been used, clinicians completed surveys regarding the usage (i.e., which steps in the HAPPINESS Curriculum were used that session) and acceptability (rating of intervention materials on a 1 [*lowest*] to 5 [*highest*] response scale), and provided feedback on what seemed to work and not work. Through their time using this new program, CHS provided monthly supervision meetings that included additional training and sharing of new materials that were made iteratively through the feedback that was being received by the research team, and offered weekly office hours to support clinicians' use. Members of the evaluation team emailed individualized weekly check-ins to each clinician, reviewed responses to end-of-session surveys, and relayed clinician feedback to CHS. As clinicians terminated care of clients with whom PPH had been used, the evaluation team conducted exit interviews to learn more about their experiences regarding the entire PPH intervention. This included the initial training, weekly check-ins, monthly group supervision meetings, office hours, use of the program itself, clients' reactions to the program, and any additional thoughts. Data from this multi-method approach to assessing feasibility of use, and intervention acceptability, guided understanding of procedures to retain and revisions to consider to improve the intervention and training.

An interim report[1] summarizing Year 1 activities provides full details of the findings from Year 1 activities. In sum, clinician ratings on post-training surveys indicated high acceptability with the initial training (2 workshop series), and also provided suggestions for improvement. Regarding feasibility of initial and ongoing training, 100% of clinicians completed the initial training, whereas only 50% attended the monthly group supervision, and attendance was even lower at weekly office hours; clinicians cited time constraints as the primary barrier to taking advantage of opportunities for ongoing professional learning. The six clinicians ultimately used the PPH with a total of 28 clients. A total of 137 surveys of PPH session usage and acceptability were completed. Mean scores for each step in the HAPPINESS Curriculum exceeded the rating corresponding to both a neutral (3.0) and positive (4.0) affective appraisal, indicating high levels of satisfaction with the HAPPINESS Curriculum steps. Thematic findings from exit interviews completed with three clinicians included that: clinicians found using positive psychology as a clinical tool to be beneficial to their clients, clients seemed to enjoy answering questions from the PPH Assessment about their happiness, the PPH intervention often needed to be integrated with other evidence-based approaches appropriate for a client's needs, and clinicians independently applied principles of positive psychology to their personal lives and intended for continued use professionally and personally (Suldo, Coolman, & Legra, 2023).

The Year 1 pilot work yielded evidence of promise that a refined PPH merited use with a different, larger sample of clinicians in a rigorous program evaluation. The CHS-USF team affirmed that Year 2 (fall 2022 – summer 2023) of the project would involve evaluation of the RCT to assess client outcomes associated with receipt of the refined program (V2.0) and client

[1] Suldo, S. M., Coolman, F., & Legra, C. (2023). *Interim Report (Year 1 Activities): Program Evaluation of the Positive Psychology through Happiness (PPH) Assessment and HAPPINESS Curriculum*. University of South Florida, School Mental Health Collaborative (SMHC): Research, Training, and Technical Assistance Center.

perceptions of treatment satisfaction at end of treatment in both conditions. The team decided to also evaluate clinician mental health in the RCT to explore potential secondary benefits of the PPH on clinician mental health. The latter research direction was inspired by the finding that some clinicians in the pilot sample spontaneously described in exit interviews personal use of the positive psychology activities that they learned in the initial training and were contained in the PPH applied to clients. The team solidified a research plan for Year 2 that would enroll about 80 CHS providers across the state to complete baseline assessments of personal mental health and then be randomly assigned to treatment (PPH Assessment and HAPPINESS Curriculum) or services-as-usual (SAU) control conditions. The approximately 40 clinicians to be assigned to the treatment condition would receive professional development in PPH (using procedures developed in Year 1), and then use the program with 3-5 clients each (e.g., the next 3+ youth assigned to their case load). The approximately 40 providers in the control condition would continue their current way of work, but gather baseline and outcome data on their next 3-5 clients served. At the end of the 2023 school year, outcome data would be gathered on any youth clients still enrolled in treatment, and clinicians would complete the post-study assessment of their personal mental health. In sum, the research plan involved data collection on about 320 youth clients (i.e., 80*4) and 80 clinicians, split equally between treatment and control.

OVERVIEW OF ACTIVITIES COMPLETED (2021-23)

Year 1 of the program evaluation consisted of:

- Complete Version 1 of the electronic intervention manual (lead developer: Julie Taylor) to detail clinicians use of the PPH Assessment and HAPPINESS Curriculum
    - Julie Taylor created the program PPH Assessment and HAPPINESS Curriculum, with activities and assessment tools to be used by clinicians at CHS. Dr. Shannon Suldo helped edit and align this program to include some evidence-based practices from the positive psychology literature, to prepare the intervention for the pilot year. Frances Coolman stylized and formatted the manual to make it ready for electronic use.
- Create USF-CHS team members to be involved in initial pilot of the program
    - Established bi-weekly meetings as a full team, and weekly meetings with USF and Julie Taylor to finalize program and trainings.
- Finalize research plan for 2-year project, for inclusion in USF IRB application to complete a program evaluation of the PPH Assessment and HAPPINESS Curriculum
    - Created consent documents and data collection tools (e.g., exit interviews, measures that align with constructs) which were submitted to the USF IRB along with full research plan. The IRB reviewed the submission (study 003415) and determined it was not human subjects research due to the program evaluation nature of the project. USF team committed to enacting the project consistent with standards for any research study, for instance by using an active consent procedure to enroll clinicians as participants in the project.
- Enroll pilot sample of 3 – 6 clinicians in initial pilot of intervention training/professional development, use of manual (i.e., feasibility and fidelity of program implementation), and initial signs of program promise through exit interviews
    - Julie Taylor shared information with supervisors from multiple regions to recruit for pilot year. USF team sent follow-up consent forms to identified clinicians. Ultimately six initial clinicians were enrolled in the pilot of the PPH Assessment and HAPPINESS Curriculum program during the 2021-2022 school year (fall and spring implementation with follow-up interviews done in the summer 2022). Training for this program occurred over two three-hour sessions, the first taking place in December 2021 and the second taking place in January 2022. Acceptability data was collected after each training. Post training, clinicians started to use this new program with clients and provided acceptability data about the program after each session with a client. Feedback was gathered on each step and area of PPH Assessment and HAPPINESS Curriculum, which was compiled and later used to refine the manual to Version 2.0 for use in the RCT year.
- Create Version 1 of the initial professional development in the intervention, intended to ultimately support implementation of the program with high fidelity
    - The USF team collaborated with CHS to create the content for 6-hour workshop, broken into two 3-hour workshops. The USF team created and administered several assessment tools, including: (a) knowledge quizzes to assess clinician growth from pre- to post-training, (b) self-report surveys of clinician acceptability of training, and (c) checklists of the professional learning plan for use by observers to record fidelity of implementation (FOI) of the training.

- Modify/refine initial professional development based on findings from fidelity of training, clinician knowledge, and acceptability data
    - Based on data from acceptability surveys administered after each workshop, and qualitative comments from exit interviews, the USF team recommended to CHS following changes: spread professional development content over three two-hour sessions, add tips/information learned from clinicians who took part in the pilot year, add examples of completed curricular material and clinician experiences.
- Monitor the six clinicians use of the program with 0-10 clients per provider
    - Using Qualtrics, the USF team created a survey to gather clinician use and perspectives on usefulness of the PPH; after each session in which the PPH was used, clinician reported which step(s) of PPH was used, how much, and what other intervention(s) was used in the session. The portions of the survey focused on use were used to indicate FOI of the intervention, and the ratings and open-ended items in the survey (e.g., what worked, what did not work) were used to indicate clinician acceptability of intervention. Through individual exit interviews, the USF team collected data on clinician perceptions of client outcomes, and perceptions of PPH program and trainings.
- Analyze qualitative and quantitative data from clinician use of program
    - USF Team prepared and shared summary of findings from FOI tools, acceptability surveys, and exit interviews with the CHS team throughout the spring and summer 2022. These results are communicated in full in the interim report submitted to CHS in February 2023 (Suldo, Coolman, & Legra, 2023).
- Modify/refine intervention manual based on findings from use and accessibility data
    - Based on findings from acceptability surveys and interview data, USF team communicated to CHS recommendations for revision to PPH program materials. The CHS team created supplements for use by the pilot clinicians, which were presented to pilot clinicians during monthly check-ins. In the summer, supplements were integrated into the PPH manual 2.0.
- Complete power analysis to inform minimum number of providers and clients needed for participate in the randomized controlled trial (RCT) during Year 2
    - Statistical consultant John Ferron completed and conveyed results of power analysis that guided goal to recruit 80 clinicians in subsequent RCT year.

Year 2 of the program evaluation consisted of:

- Affirm USF-CHS team members to be involved in randomized controlled trial (RCT) to evaluate the program; maintain regular communication between USF and CHS
    - Continued meeting 2 – 4 times monthly as a full team via Zoom to discuss clinician participant enrollment, training for the intervention group, and progress with data collection (student and clinician outcomes).
- Pre-register study plan
    - USF team published the design plan (randomized controlled trial [RCT]) for the study "Evaluation of the PPH Assessment and HAPPINESS" in OSF Registries (see https://osf.io/dgsqf) on 10/6/22, prior to the completion of research activities.
- Recruit and enroll sample of approximately 80 clinicians in RCT throughout 2023-23
    - Julie Taylor contacted CHS clinicians and invited to attend a virtual meeting that described the project, and procedures for participants (data collection for all; PPH

training and usage for the intervention group). The USF team distributed consent forms (via email and DocuSign) to clinicians eligible for the study who attended the meeting (July 2022 for Cohort 1, December 2022 for Cohort 2), and clinicians provided indicated "yes" to enrollment (signed the consent form) or "no" (declined the consent form or did not respond) to participate in the RCT year.
    - At those virtual meetings, clinician participants who indicated "yes" to enrollment completed a confidential assessment of their personal mental health. Specifically, the USF team directed them to a Qualtrics survey that contained brief measures of life satisfaction, flourishing, positive and negative affect, and perceived stress.
- Train all clinician participants (prior to random assignment to treatment and control group) how to collect outcome mental health data at start and end of treatment with youth clients, and treatment satisfaction data at end of treatment
    - In virtual meetings and through follow-up email instructions, the USF-CHS team introduced clinicians to the outcomes assessment battery (SLSS, PANAS-C-10, BPM-Y), and explained how to administer and record item responses within the "PPH Pre/Post Assessment" in MyEvolv. Clinicians were instructed to administer the assessment at the start of treatment with up to 10 new youth clients. Clinicians were asked to administer the same assessment 3 months later, and/or at termination (when treatment was complete, or end of the school year- May 2023).
    - At termination, clinicians were encouraged ask their clients to complete the brief *Client Satisfaction Questionnaire (CSQ)* survey administered through a condition-specific Qualtrics survey, using the clinician's phone, iPad, or computer. The purpose of the survey was for the clients to complete their thoughts on counseling.
- Randomly assign clinician participants to one of two study conditions
    - After participant recruitment closed, John Ferron stratified the list of enrolled clinicians by geographic region of employment, and randomly assigned approximately half of the participants in each region to the treatment group (PPH training and use) and the other half to control group (services-as-usual [SAU]).
    - For Cohort 1, the 66 enrolled clinicians were assigned to treatment (n = 34) or control (n = 32). For Cohort 2, the 23 enrolled clinicians were assigned to treatment (n = 11) or control (n = 12).
- Train clinicians in treatment group in the PPH through initial professional development
    - Training for the PPH occurred over three two-hour workshops (August - September 2022 for Cohort 1; December 2022 - January 2023 for Cohort 2). Each 2-hour workshop was facilitated by Julie Taylor, with the support of USF team members who monitored attendance and facilitated data collection. For each workshop, a training date was announced in advance and those live sessions (held via Zoom) were recorded. Clinicians who could not attend the announced workshop date met with Julie Taylor separately for a 'make-up' and/or watched the recorded session. During the first workshop, clinicians received an electronic copy of the PPH intervention manual.
    - USF team members recorded fidelity of implementation (FOI) of the workshops using checklists of the critical training elements developed in the pilot (Year 1). The USF team administered several assessment tools, including: (a) knowledge quizzes to assess clinician growth from pre- to post-training, and (b) self-report surveys of clinician acceptability of training after each 2-hour session (satisfaction

with session) and the end of the 3-session series (satisfaction with entire training). Acceptability data was collected using surveys developed in Year 1 and administered through Qualtrics surveys that contained Likert-scale questions and open-ended questions. The pre/post knowledge quiz was developed in Year 1 (covered the PPH intervention and positive psychology content) and administered through Qualtrics surveys that contained multiple choice items. At post-training, clinicians who did not score an 80% or higher met with Julie Taylor to review content covered in the sessions, and then re-administered the knowledge quiz.
    - After completion of this initial training, clinicians were instructed to begin using the PPH assessment and HAPPINESS curriculum in their clinical care of new youth clients, and complete a brief fidelity form in MyEvolv after each session with an applicable youth client to report approximately what percentage of the session they used the PPH materials (e.g., 0%, 25%, 50%, 75, 100%).
- Provide clinicians in the treatment group ongoing implementation support in use of PPH
    - After the initial training, the USF team mailed a hard copy of the PPH intervention manual to each clinician's home address.
    - Julie Taylor sent group emails and meeting invitations to the treatment group, titled "PPH Voluntary Office Hours." These meetings provided a weekly opportunity for supervision of clinicians' experiences with the PPH through designated "office hours" held via Zoom. For instance, every Friday morning at 8:00 EST, Julie was available to meet on Zoom with any clinician in the PPH group who "has questions on the PPH curriculum, needs a case staffing, or help with treatment plans." Participation in these virtual meetings was optional, and clinicians could utilize them at their own discretion. Anecdotal reports were that they meetings were rarely utilized by the clinicians.
- Monitor number of youth clients in both conditions, which reflected the number of clients for whom clinicians had administered the baseline (pre-treatment) assessment battery
    - CHS provided the USF team with a weekly report of client IDs for whom clinicians had administered the PPH Pre/Post Assessment.
    - Weekly, Camryn Legra sent individualized emails to clinicians in both conditions. These emails listed the clients for whom they had administered the PPH Pre/Post Assessment, and offered technical support in the process of data collection. Especially in the event of no or low evidence of client outcome data, the messages (a) offered encouragement to begin or increase inclusion of their youth clients in the sample, which was dependent on clinician collection of pre-treatment outcome data, and (b) included two file attachments: a tutorial created by Julie Taylor that included step-by-step guidance on how to access the PPH Pre/Post Assessment in MyEvolv, and a copy of the PowerPoint slides from the Assessment training.
- Monitor fidelity of use of the PPH among the treatment group
    - CHS provided the USF team with monthly reports of the fidelity use of the PPH during sessions with their enrolled clients.
    - Radhika Sundar and John Ferron merged the data files to determine how many sessions for a given client a clinician had completed the fidelity measure.
- Collect post-treatment outcome data on clinician and client mental health

    - In May 2023, clinicians in both cohorts in both groups were invited to attend a virtual meeting co-facilitated by CHS and USF staff to conclude study activities. Meeting facilitators expressed gratitude for clinicians' participation, and reviewed activities required to conclude the study with an emphasis on data collection from the youth clients who completed the mental health outcomes assessment at pre-treatment. Also at this meeting, clinicians provided confidential data on their personal mental health. Specifically, the USF team directed them to a Qualtrics survey that contained brief measures of life satisfaction, flourishing, positive and negative affect, and perceived stress, the same survey they completed at the start of the study.
- Data analyses; Examine fidelity data on PPH usage in the treatment group, and change in youth client and clinician outcomes from pre to post treatment in both groups
    - In July 2023, CHS provided the USF team with a de-identified dataset that contained client outcome data (scores on the assessment battery at pre and post).
    - An overview of preliminary findings from results of outcome analyses were provided to CHS leadership in a virtual meeting in November 2023. Subsequent analyses were conducted and are communicated in full in this final report.

MEASURES USED IN YEAR 2 RCT

The evaluation team utilized several quantitative measures to assess client and clinician outcomes throughout the program evaluation, as well as surveys to assess treatment satisfaction, acceptability of training, and usage of the PPH among clinicians in the treatment group. Each of these measurement tools is described in more detail in Table 2.

Table 2. *Measures Used in Outcomes Evaluation, Training, and Intervention Implementation*

Measure	Purpose	Description	Sample Items
Client Mental Health Outcomes (*see Appendix B*)			
Students Life Satisfaction Scale (SLSS; Huebner, 1991)	Index the cognitive component of youth subjective well-being	The SLSS has 7 items that ask students to indicate their level of agreement with statements about quality of life on a scale ranging from 1 (*strongly disagree*) to 6 (*strongly agree*). A total score is calculated by reverse scoring negatively worded items (items 3 and 4) and then calculating the mean of all items.	• My life is just right • I have a good life • I wish I had a different kind of life (*reverse scored*)
Positive and Negative Affect Scale (PANAS-C-10; Ebesutani et al., 2012)	Index the affective component of youth subjective well-being	The PANAS-C-10 has 5 items that measure frequency of positive affect and 5 items that measure frequency of negative affect. Youth rate the degree to which they experienced various moods or feelings in the past few weeks on a response scale ranging from 1 (*very slightly* or *not at all*) to 5 (*extremely*). Positive affect and negative affect scores are determined by calculating the mean of the five items listing positive emotions and the mean of the five items listing negative emotions, respectively.	• Happy • Cheerful • Joyful • Sad • Scared • Mad
ASEBA Brief Problem Monitor (BPM)-Youth Self-Report (Achenbach & Rescorla, 2017)	Index youth mental health problems (internalizing, externalizing, and attention problems)	The BPM-Y contains 19 items that assess symptoms of internalizing problems (6 items), externalizing problems (7 items), and attention problems. The items are from the lengthier ASEBA Youth Self-Report, selected based on item response theory, factor analysis, and discriminant analyses of diagnostic groups. To complete the BPM-Y, youth read a list of items that "describe kids" and rate on a scale of 0 to 2 how much the item is not true of them (0), somewhat true (1), or very true (2) now or within the past six months. A Total Problems score is the sum of responses across all 19 items.	• I am too fearful or anxiety (Internalizing problems) • I disobey my parents (Externalizing problems) • I fail to finish things I start (Attention problems)
Client Treatment Satisfaction (*see Appendix C*)			
Client Satisfaction Questionnaire (CSQ; Larsen, Attkisson, Hargreaves, & Nguyen, 1979)	Client rating of satisfaction with treatment	The CSQ contains 8 items about satisfaction with clinical services received by the program. At the end of their clinical treatment at CHS, youth rated each item using a 4-point response	• How satisfied are you with the amount of help you have received?",

		scale. The anchors change across items; for some items, anchors range from: 1 = *Quite dissatisfied* to 4 = *Very satisfied*, or 1 = *Poor* to 4 = *Excellent.* After rating those 8 items, youth were prompted to provide written responses to 3 open-ended questions about what they liked best and least about the services they received.	• How would you rate the quality of service you received?
Clinician Mental Health (*see Appendix D*)			
Flourishing Scale (FS; Diener et al., 2010	Index adult psychological well-being	The Flourishing Scale contains 8 items that assess core aspects of social-psychological functioning and prosperity through relatedness, self-acceptance, competence, social relationships, and capability of activities that someone finds important (Diener et al., 2010). Respondents indicate agreement with each item using a 7-point response scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). SWLS scores range from 8-56, with higher scores representing higher levels of well-being, strengths, and resources (Diener et al., 2010).	• I lead a purposeful and meaningful life. • My social relationships are supportive and rewarding. • I am optimistic about my future.
Satisfaction with Life Scale (SWLS; Diener et al., 1985)	Index the cognitive component of adult subjective well-being	The SWLS consists of 5 items that assess global life satisfaction. Respondents indicate agreement with each item using a 7-point response scale ranging from 1 (*strongly disagree*) to 7 (*strongly agree*). SWLS scores range from 5-35. Scores between 5-9 represent extremely dissatisfied, 10-14 represent dissatisfied, 15-19 represent slightly dissatisfied, 20-24 represent slightly satisfied, 25-29 represent satisfied, and 30-35 represent extremely satisfied (Diener et al., 1985).	• In most ways my life is close to my ideal. • The conditions of my life are excellent. • I am satisfied with my life.
Positive Affect and Negative Affect Schedule (PANAS; Watson et al., 1998) with two sub-scales (Positive Affect and Negative Affect)	Index the affective component of adult subjective well-being	The PANAS contains 10 items that measure frequency of positive affect and 10 items that measure frequency of negative affect. Adults rate the degree to which they experienced various moods or feelings in the past few weeks on a response scale ranging from 1 (*very slightly* or *not at all*) to 5 (*extremely*). Positive affect and negative affect scores are determined by summing responses to the positive emotion items (Positive Affect scale), and summing responses to the negative emotion items (Negative Affect scale). Higher scores represent higher levels of positive affect and affect (Watson et al., 1988).	• Interested • Excited • Proud • Upset • Irritable • Guilty

Perceived Stress Scale (PSS; Cohen et al., 1983).	Index emotional distress in adults, namely perceived stress	The PSS contains 10 items that assess the degree to which one perceives aspects of their life as uncontrollable, unpredictable, and overloading. Respondents indicate how much they have felt a certain way during the last month, using a 5-point response scale ranging from 0 (*never*) to 5 (*very often*). A total score is calculated by reverse scoring negatively worded items (items 4, 5, 7, and 8) and then summing across all items. Scores from 0-13 represent low stress, scores from 14-26 moderate stress, and scores from 27-40 are considered high perceived stress (Cohen et al., 1983).	• How often have you felt nervous and "stressed"? • How often have you been upset because of something that happened unexpectedly? • How often have you felt that you were on top of things? (*reverse scored*)
Training in PPH Among the Treatment Group (*see Appendix E*)			
Acceptability of PPH Professional Development – Workshops 1 – 3	Gather participant perspectives of the usefulness of each workshop in the initial training for the PPH program	After each of the workshops for the initial trainings, the evaluation team asked participating clinicians to complete a Qualtrics survey that contained 5 items about usability and acceptability of the training, which participants rated from 1 (*strongly disagree*) to 5 (*strongly agree*), and 3 open-ended questions. This survey was developed, refined, and used successfully during the pilot year.	• The material in the workshop enhanced my knowledge of positive psychology interventions. • I am likely to use what I learned today with my clients. • What part of this workshop did you find the most interesting or useful?
Acceptability of PPH Professional Development - Full Training	Gather participant perspectives on the quality of their entire initial training for the PPH program.	After the final workshop in the initial training, the evaluation team asked participating clinicians to complete a Qualtrics survey that contained 20 items about their satisfaction with the entire training. Participants rated the first 17 items from 1 (*strongly disagree*) to 5 (*strongly agree*), then provided brief responses to 3 open-ended questions regarding most and least useful part of the training and what changes they would suggest. This survey was developed, refined, and used successfully during the pilot year.	• The logistics for the virtual training were well executed. • Facilitators presented the material clearly. • I feel prepared to implement the intervention in my setting. • What was the most useful part of this training?
Fidelity of Implementation of Initial Professional Development	Monitor the extent to which the trainers enacted the initial training in the PPH program as intended.	Checklists of key elements intended by the trainers to be included in each workshop were used to monitor FOI of training. The evaluation team observed each workshop and recorded whether each element occurred (yes/no). Activity start/end times were also recorded on this tool. These checklists were developed, refined, and used successfully during the pilot year.	• Before workshop 1, staff ensured that all participants are ready for first workshop. • Components of PPH reviewed. • Explanation of how the E-S-S steps transitions to the END of treatment.

Knowledge Quiz; Positive Psychology and PPH Intervention	Pre- and post-test of knowledge surrounding positive psychology and the PPH program.	Clinicians completed the same multiple choice quiz before any of the professional development trainings (just prior to Workshop 1), and again at the end of Workshop 3 to assess knowledge gains and ultimate proficiency in positive psychology interventions throughout training duration. This quiz was developed, refined, and used successfully during the pilot year.	• Positive psychology interventions primarily aim to increase which outcome? • The HAPPINESS curriculum contains all of the following components except:
Attendance Records	Record number of clinicians attending each Workshop in the initial training	Attendance was taken at each of the workshops, during monthly supervision meetings, and noted within records of clinician correspondence with research team and reported use of PPH.	• N/A
Fidelity of PPH Usage among the Treatment Group (*see Appendix F*)			
Fidelity of Use of PPH Assessment and HAPPINESS Curriculum	Monitor the extent to which the clinicians in the treatment group used the PPH in each session.	This 4-item survey housed within the MyEvolv system was to be completed after each time a clinician trained in PPH met with a client, to gather information on which components- if any- of PPH Assessment and HAPPINESS Curriculum were used in that session.	• Which step(s) in the HAPPINESS Curriculum did you access in today's session? (check all that apply) • Approximately how much of this session did you use the PPH Assessment and HAPPINESS Curriculum? (nearly all, most, about half, some, none)

ACCOMPLISHMENTS AND FINDINGS

HYPOTHESES

Traditional psychological services focus on ameliorating symptoms of distress. Positive psychology interventions focus on increasing happiness and other aspects of well-being. This program evaluation examined differences in mental health outcomes- self-report indicators of wellness and illness- associated with using a new positive psychology intervention (the PPH) in treatment vs. services as usual (SAU). The evaluation team anticipated that clinicians assigned the PPH treatment condition, and the clients they serve, would show more favorable mental health outcomes than those assigned to SAU control. More specifically, relative to the clients whose clinicians are assigned to SAU, those with clinicians assigned to the PPH treatment condition were anticipated to show higher subjective well-being (e.g., life satisfaction), lower levels of mental health problems, and greater satisfaction with clinical services. Relative to clinicians assigned to SAU, clinicians assigned to the PPH treatment condition were hypothesized to shower greater levels of life satisfaction, flourishing, and positive affect, while also showing lower levels of stress and negative affect.

DESIGN

This program evaluation used an experimental design, specifically a cluster randomized controlled trial (RCT). The cluster is the group of clients seen by a clinician. Clinicians were enrolled in two cohorts at the start or mid-point of the 2022-23 school year. The clinicians (mental health providers at CHS) were randomly assigned by a statistician from the evaluation team to PPH treatment or SAU control condition. The entire cluster of youth clients seen by the same clinician are thus assigned to the same treatment condition.

Prior to randomization, the clinicians were stratified by region of employment in Florida. Clinicians within each region were then randomly assigned to PPH or SAU. Specifically, for each cohort, a list of clinicians who enrolled in the study (i.e., reviewed and signed consent forms) was sorted into region. Within each region, clinicians were randomly ordered using the ranuni function within SAS, in which the system clock was used as the seed for the random number generation. Then all clinicians whose position on the list corresponded to an odd number (e.g., 1, 3, 5, .. 67) were assigned to PPH, whereas all clinicians whose position on the list corresponded to an even number (e.g. 2, 4, 6, … 66) were assigned to SAU. This ensured that across all regions, the total number of clinicians assigned to each treatment group was within 1, and also that within any specific region the number of clinicians assigned to each treatment group was within 1. For the second cohort, clinicians whose position on the list corresponded to an odd number were assigned to SAU, whereas those whose position corresponded to an even number were assigned to PPH.

This design plan was pre-registered in the OSF Registries. See https://osf.io/dgsqf for study “Evaluation of the PPH Assessment and HAPPINESS.”

SAMPLE

The evaluation team used the software program Optimal Design to conduct power analyses, and determined a sample size of 320 youth was reasonable from a power perspective.

Specifically, if the ICC is .10 and there were 80 clinicians with 4 clients, this study would have a power of .80 to find a standardized mean difference effect size of .36 without a pretest. With the addition of a pretest with an R-square of .5 with the posttest, the same situation would yield .80 power for a bit smaller effect (ES = .32). The evaluation team considered that the effect may be even smaller than .32, because the SAU condition includes high-quality care with well-supported practices. Thus, to increase the number of clinicians, the agency agreed to add a second cohort in winter 2022 to include new hires and those on leave in August.

Clinicians

Mental health providers ("Clinicians") were provided by CHS, an agency that employs community mental health providers who work in a variety of settings. All clinicians who worked for CHS were scheduled to participate in a mandatory Assessment training (see Appendix G) at the start of the 2022-23 school year (training repeated for new hires in November 2023), because assessment of client outcomes was being revisited and updated as per routine care in the agency. Through the course of the Assessment training, all clinicians were invited to volunteer for the CHS PPH program evaluation. All clinical counselors have a minimum of Master's Degree (M.A., M.S., M.S.W.). in Clinical Social Work, Mental Health Counseling, Psychology, or Marriage and Family Therapy, and are credentialed by the Florida Agency for Health Care Administration (AHCA). Clinicians vary in their experience and other characteristics. No volunteering clinicians were excluded.

A total of 89 clinicians at CHS agreed to take part in this study (66 in Cohort 1, 23 in Cohort 2), as indicated by signing an informed consent form (see Appendix H). The clinician participants were randomly assigned to PPH treatment group ($N = 45$; 34 in Cohort 1, 11 in Cohort 2) or SAU control group ($N = 44$; 32 in Cohort 1, 12 in Cohort 2). Clinician demographic details available to the evaluation team are restricted to age and region of employment. On average, clinicians who enrolled in the study were 43.02 years old ($SD = 13.07$). Mean ages were similar for clinicians assigned to the treatment group ($M = 42.91$, $SD = 13.46$) and control group ($M = 43.15$, $SD = 12.78$). Participants were drawn from regions with the following agency-provided acronyms: CF ($N = 6$; 3 treatment, 3 control), CF- Central Florida ($N = 2$; 1 treatment, 1 control), GL ($N = 10$; 5 treatment, 5 control), Lakeland ($N = 2$; 1 treatment, 1 control), NE- Day ($N = 9$; 5 treatment, 4 control), NE- Jax ($N = 32$; 16 treatment, 16 control), Ocala ($N = 1$; 0 treatment, 1 control), PB- Broward ($N = 6$; 3 treatment, 3 control), SC ($N = 3$; 2 treatment, 1 control), SE ($N = 5$; 2 treatment, 3 control), SE- Miami ($N = 2$; 1 treatment, 1 control), SE- Palm Beach ($N = 1$; 1 treatment, 0 control), and W ($N = 10$; 5 treatment, 5 control).

Table 3 presents participation in the study across time points, and illustrates attrition from the study throughout the 2022-23 year. Of the 89 enrolled clinicians, 84 completed baseline measures of personal mental health ($N = 44$ in treatment, 40 in control). Of these, 44 completed the measures at the end of the study.

Table 3. *Sample Size of CHS Clinicians Who Participated in the Study*

Condition	*N* Clinicians					
	Enrolled, Randomized to Condition	Completed Baseline MH Measures	Administered Baseline MH Measures to 1+ Client	Began PPH Training	Completed PPH Training	Completed Post-Study MH Measures
Treatment	45	44	23	32	30	19
Control	44	40	28	n/a	n/a	25
TOTAL	49	44	51	32	30	44

Note. MH = Mental Health. PPH = Positive Psychology through Happiness Intervention

PPH treatment group. Of the 45 clinician participants randomized to the treatment condition, 32 began the training and 30 completed it. Regarding the 13 participants who did not initiate training, 6 were identified by CHS leadership as actually ineligible to participate in the study (i.e., had roles at CHS such as supervisor in which they would not have access to a caseload with new youth clients to assess or treat with the PPH); an additional 5 left the agency, 1 withdrew participation from the study, and 1 went on FMLA in the period between enrollment and initial training. The two clinicians who began but did not complete the training left the agency between the first and third workshops. Of the 30 trained clinicians, 19 remained at CHS at the conclusion of the study and completed the post-test measures of clinician mental health (42.2% retention rate from randomization point). Of the 11 lost to attrition since training, 6 left the agency, 1 withdrew participation from the study, and 3 transitioned to roles at CHS such as supervisor or intake coordinator which interrupted access to a clinical caseload; no reason was provided for the remaining 1 trained clinician who was not present at the study conclusion.

SAU control group. Employment and participation data for the 44 clinician participants randomized to the SAU control condition indicated that 25 remained at CHS at the conclusion of the study and completed the post-test measures of clinician mental health (56.8% retention rate from randomization point). Of the 19 lost to attrition, 8 left the agency, 4 withdrew participation from the study, 1 was identified by CHS leadership as actually ineligible to participate in the study due to their role at CHS, and 3 more transitioned to roles at CHS such as supervisor or intake coordinator which interrupted access to a clinical caseload; no reason was provided for the remaining 3 clinicians who were not present at the study conclusion.

Youth Clients

Of the 89 clinicians enrolled in the study, 51 clinicians (57.3%)- 23 of 45 in the treatment group (51.1%) and 28 of 44 (63.6%) in the control group—proceeded to administer the baseline assessment battery to any youth client. These 51 clinicians ultimately administered the baseline assessment battery to 336 clients (125 treatment group, 211 control group). Two clients served by the same clinician in the treatment group were excluded because demographic data indicated they were not school age (> 21 years old), leaving 334 youth clients with baseline data (123 treatment, 211 control). Post-treatment data were gathered for 183 youth clients (69 intervention, 114 control); for five of these cases (2 treatment, 3 control), less than one month had passed since the date of pre-treatment data collection (specifically, 7 – 19 days between pre and post-test assessments), and the second assessment for these five cases was excluded from analysis. In sum, the final sample available for analyses about the impact of the PPH on youth client outcome

data included 178 youth clients (67 treatment, 111 control) who were in treatment during the 2022-23 school year. Of note, 2 clients in treatment and 2 in control were missing values on some outcomes, so in some cases the analysis used data from 167 youth as opposed to 171.

The client demographic features are summarized in Table 4. At post-treatment, the 67 clients in the treatment group were significantly younger (M = 10.87, SD = 2.78) than the 111 clients in the control group (M = 12.34, SD = 3.03), $t(176) = 3.23$, $p = .0015$, a difference that was also present for the larger group assessed at baseline, $t(332) = 3.21$, $p = .0015$. At post-treatment, a smaller proportion of clients in the treatment group were Hispanic or Latino (10%) than in the treatment group (23%), $X^2 = 4.66$, $p = .03$); there were no significant differences between treatment and control for client gender ($X^2 = 1.36$, $p = .24$) or race ($X^2 = 3.48$, $p = .48$).

Table 4. *Demographic Features of Youth Clients Administered Mental Health Assessments at Baseline and Post-Treatment*

	Treatment				**Control**			
	Baseline (N = 123)		Post-Treatment (N = 67)		Baseline (N = 211)		Post-Treatment (N = 111)	
Age (Years old)								
M	10.93		10.87		12.05		12.34	
SD	2.70		2.78		3.28		3.03	
Range	5-17		7-17		5-19		5-18	
	N	%	*N*	%	*N*	%	*N*	%
Gender								
Male	64	52%	35	52%	89	42%	48	43%
Female	59	48%	32	48%	121	57%	63	57%
Transgender	0	0%	0	0%	1	<1%	0	0%
Race								
White	54	44%	27	40%	100	47%	45	41%
Black	54	44%	35	52%	79	37%	48	43%
Multiracial	11	9%	4	6%	21	10%	10	9%
American Indian	1	1%	1	1%	0	0%	0	0%
Other	0	0%	0	0%	1	<1%	1	1%
Unknown	3	2%	0	0%	10	5%	7	6%
Ethnicity								
Non-Hispanic	111	90%	60	90%	171	81%	85	77%
Hispanic or Latino	12	10%	7	10%	40	19%	26	23%

Data on treatment satisfaction is available for a smaller number of youth clients. In particular, responses for 52 clients (20 treatment group, 32 control group) served by 22 clinicians (11 treatment, 11 control) were recorded in the Qualtrics database. No demographic data is available for this data that were collected anonymously within each condition.

PROCEDURES

To introduce clinicians to the program evaluation, CHS invited clinicians to attend a mandatory Assessment training that included an orientation to new measures available for use to assess client outcomes. These assessment trainings were held in July 2022 for Cohort 1, and

December 2022 for Cohort 2. The purposes of these meetings included (a) training in the assessment battery to be administered to youth clients to evaluate positive and negative indicators of mental health, (b) participant recruitment to the PPH program evaluation, and (c) clinician baseline survey of personal mental health. These meetings provided a description and rationale for the program evaluation, and procedures for participants including (1) data collection for all participants, and (2) training and usage of the PPH training for the treatment group.

Clinician Mental Health

During the aforementioned Assessment training, clinician participants who indicated "yes" to enrollment completed a confidential assessment of their personal mental health. Specifically, the evaluation team directed them to a Qualtrics survey that contained brief measures of life satisfaction, flourishing, positive and negative affect, and perceived stress. Ultimately, clinicians who enrolled in the study were invited to complete surveys regarding their personal mental health at two time points: (1) At the start of the study (Baseline/Pre; July, 2022 for Cohort 1; December, 2022 for Cohort 2), before randomization to group; and (2) At the end of the study (Post; May, June 2023). Clinician responses across time were linked by name and date of birth, and not shared beyond the evaluation team.

Youth Client Mental Health

During the aforementioned Assessment training, all clinician participants (prior to random assignment to treatment and control group) were asked to collect outcome mental health data at the start and end of treatment for youth clients, and treatment satisfaction data at end of treatment. Specifically, during the Assessment training, the evaluation team introduced clinicians to the outcomes assessment battery, and explained how to administer and record item responses within the "PPH Pre/Post Assessment" in the agency's client record system (MyEvolv). Regarding the assessment battery, clinicians were introduced to a dual-factor model of mental health, and asked to administer measures of well-being in addition to a traditional negative indicator of psychopathology symptoms. The measures of subjective well-being included indicators of life satisfaction (Students Life Satisfaction Scale; SLSS) and positive and negative affect (Positive and Negative Affect Scale; PANAS-C-10). The measure of psychopathology was the ASEBA Brief Problem Monitor (BPM)-Youth Self-Report, which yields the following composite scores: Internalizing behavior, Externalizing behavior, and Attention problems. Clinicians were asked to administer the assessment at the start of treatment with up to 10 new youth clients. The client enrollment period spanned from 8/30/22 through 4/15/23.

Clinicians were asked to administer the same assessment battery (and record responses within MyEvolv) at a post-treatment time point, operationally defined as:

- **Natural end of treatment.** This includes clients who discharge due to meeting treatment goals or reach the end of time-limited therapy, or are preparing to leave the agency. Examples include: the clinician administers post-assessment to a client at 3 months (e.g., after about 12 sessions) because that client met treatment goals. In another example, the clinician administers post-assessment to a client in the session that the client announces their family is moving the following week and thus will not return for therapy. In another

example, the clinician administers post-assessment to a client during the 6th/final session of their 6 sessions of planned time-limited therapy.

- **During the session that includes a treatment plan review.** This includes a mid-treatment assessment for long-term clients not anticipated to be discharged by end of school year, and/or during the session that is approximately three months after intake.
- **End of the program evaluation period**. This includes an assessment at the end of the study period, no matter where the client was in their treatment plan.

The client post-treatment period spanned from 10/19/22 through 6/21/23.

In addition to data collection training at the Assessment training, the evaluation team sent clinicians individualized emails that summarized the number and list of clients for whom they had administered the PPH Pre/Post Assessment, and reminded clinicians to administer the PPH Pre/Post Assessment again at post-treatment. These emails included offers of technical assistance with the data collection process. In the event of no or low evidence of collection of initial client outcome data, the email messages encouraged clinicians to begin or increase inclusion of their youth clients in the sample, which was dependent on clinician collection of pre-treatment outcome data. Emails included two file attachments: a tutorial created by Julie Taylor that included step-by-step guidance on how to access the PPH Pre/Post Assessment in MyEvolv, and a copy of the PowerPoint slides from the Assessment training.

Treatment Satisfaction

At the end of their treatment or the end of the study, participating clinicians were encouraged to ask their youth clients to complete the 8-item Client Satisfaction Questionnaire (CSQ; $\alpha = .91$). The CSQ was administered through a condition-specific Qualtrics survey, using the clinician's phone, iPad, or computer. This data was collected anonymously; the youth client did not provide their name or a client ID number, but did select the name of their clinician/provider. The survey was intended for the client to complete independently; however, clinicians were permitted to read aloud the questions and type the responses for a client if it was necessary due to readability challenges. Responses on the CSQ were time-stamped in Qualtrics. CSQ survey entries spanned from 2/28/23 through 6/13/23.

Study Conditions

After clinician recruitment closed for each cohort, the project statistician stratified the list of enrolled clinicians by geographic region of employment, then randomly assigned approximately half of the participants in each region to the treatment group (PPH training and use) and the other half to control group (services-as-usual [SAU]). For Cohort 1, the 66 enrolled clinicians were assigned to treatment ($n = 34$) or control ($n = 32$). For Cohort 2, the 23 enrolled clinicians were assigned to treatment ($n = 11$) or control ($n = 12$). The 45 clinicians assigned to PPH treatment were intended to complete professional development in that approach, and then use the PPH with approximately 3-10 youth clients each (the next 3-10 assigned to their case load) and gather baseline and outcome data on those clients. The 44 clinicians in the SAU control were intended to continue their current way of work, but gather baseline and outcome data on their next 3-10 clients served.

PPH treatment condition. The Positive Psychology through Happiness (PPH) Assessment and HAPPINESS Curriculum is a recently advanced positive psychology intervention for use by community mental health clinicians serving youth and adults, including youth in schools who present with mental health problems. During 2021-22, CHS commissioned a year-long pilot study with six clinicians to advance, refine, and verify the acceptability of this program (Suldo, Coolman, & Legra, 2023). The PPH Assessment and HAPPINESS Curriculum is detailed in an intervention manual (see Appendix A). It is in use by CHS clinicians, and in the future may be made available to the public (copywrite pending). The PPH is rooted in positive psychology theory, and focuses on strengths and positive subjective experiences through well-being, joy, and happiness (Seligman, 2002) instead of only attempting to fix what is wrong.

The PPH Assessment contains a weekly and monthly check-in. One or the other is to be utilized at the beginning of each session a clinician has with a client. At the initial assessment, clients complete 'The PPH Assessment – Monthly' to establish a baseline, and then again complete it once a month to assess changes. This assessment asks a Strength Question (i.e., List something positive about yourself or something you are good at) and Enjoyment Questions (i.e., On a scale of 1-10, with 10 being the highest, how happy are you?, Think of all the things you do in your daily life and complete this sentence: I am most happy when I am ____, How many hours last week did you spend enjoying (identified activity)?, What could you do to increase the amount of time you're able to dedicate to _____?) and then presents seven items (i.e., I feel satisfied with my life as a whole, I feel good about myself as a person, I feel good about my physical health, I feel good about my mental health, I feel good about my relationships with others, I feel good about my education, and I feel good about my job) that clients rate from 1=*strongly disagree* to 5=*strongly agree*. When clients meet with their clinician the weeks between the monthly sessions, they complete 'The PPH Assessment – Weekly' that only asks the Strength and Enjoyment Questions from the monthly assessment.

The HAPPINESS Curriculum consists of nine different sections, corresponding to each letter of HAPPINESS (i.e., H = Understanding Happiness, A = Assessing Where I Am Now, P = Producing Positive Thoughts and Actions, P = Practicing My Daily Habits, I = Investigating a New Way of Doing Things, N = Navigating the Bumps in the Road, E = Examining My Successes, S = Spreading My Strengths, S = Savoring My Success). The purpose of this intervention is to help each client understand their individual happiness (subjective well-being) and create goals and steps to work towards being happier, all under a positive psychology framework. The intervention is manualized and developed to be used in order of the HAPPINESS steps, allowing for some steps to have more time spent on them but moving through from H to the last S. For each letter, there are three different types of lesson tools (i.e., ACTS) that clinicians can choose to use during a session. ACTS stands for Activities (suggested exercises to do with client in session or to prescribe the client do outside of the session), Cognitive Copy (worksheets designed for clients to work on in session), Talking Points (questions used to guide discussion), and Simple Changes (brief worksheets to be done weekly around simple changes to reach happiness goal).

The HAPPINESS Curriculum is based in positive psychology using aspects of signature strengths (Gable & Haidt, 2005), developing optimism for the future, and savoring (van Agteren et al., 2021). Clinicians in the PPH treatment group were intended to participate fully in the initial training on how to use it, and be exposed to positive psychology as a clinical tool. Clinicians were instructed to then use the HAPPINESS Curriculum with their clients; actual reported use was variable across clinicians. Many enrolled clinicians work with students in

schools through their community partnership with schools. Previous research has shown increases in student outcomes and well-being when using a positive psychology intervention (Tejada-Gallardo et. al, 2020).

As specified in the initial training and the intervention manual, the PPH is designed to be integrated with other clinical practices (e.g., cognitive-behavioral therapy, motivational interviewing, trauma-informed care) pending the client's individual needs and treatment plan. Thus, clinicians have autonomy over the extent to which they choose to use the intervention in conjunction with their evidence-based practices and tools.

SAU control condition. At CHS, clinical counselors come from one of three fields of study: Mental Health Counseling, Social Work, or Marriage and Family Therapy. All three fields of study have a basis in counseling theories. Registered interns and Licensed Clinical Counselors follow the guidelines of the Florida Department of Health, which also require clinicians to utilize a foundational theory when planning treatment for clients. CHS is accredited by COA (Council on Accreditation), and follows all standards and guidelines from the Florida Department of Health, as well as SAMHSA, VOCA, and other funders' requirements. The 2018 Family First Prevention Services Act (FFPSA) requires the use of Evidenced-Based Practices or Theories in practice. In general, CHS follows multiple sets of guidelines in its clinical counseling programs. These guidelines increasingly require the use of Evidenced-Based Practices (EBP). Thus, at CHS, clinicians utilize a variety of EBP as outlined in CHS 7217: Clinical Practice Manual for Behavioral Health Programs (CHS Clinical Practice Manual), which contains a listing and description of multiple EBP; of most relevance to this program evaluation is Section 6.3 – Children (6-12) and Adolescents (13-18). In addition, various programs in regions have contracts that require use of a specific EBP or curriculum. Striving to stay on the cutting edge, CHS continues to add new EBPs as research continues to evolve.

Training in PPH among the Treatment Group

The purpose of the initial training (series of three 2-hour workshops) was for the CHS clinician to increase understanding of (a) positive psychology, (b) how to use the PPH Assessment monthly and weekly check-ins, (c) how to use the HAPPINESS Curriculum, and (d) the purpose of the pilot and subsequent evaluation study. The workshops were primarily facilitated by Julie Taylor of CHS, with some portions led by Shannon Suldo of USF. In order to be certified to deliver the PPH, participants were asked to (a) fully attend and participate in all three training sessions, and (b) obtain a passing score (80%) on a post-test knowledge quiz.

Two members of the evaluation team (graduate student research assistants) monitored participant attendance at each workshop, administered and scored the knowledge quizzes pre- and post-training, and evaluated the fidelity of implementation of the training as intended. Regarding fidelity of implementation of the training, the evaluation team recorded "yes" or "no" whether numerous critical elements of each workshop were present or absent using checklists created in the pilot year.

The 45 participants randomized to the treatment condition were immediately invited to attend a 3-part workshop series to learn the PPH. Only 32 (71.1%) began the training by attending the first workshop. Of the 13 who did not initiate training, 6 were identified by CHS leadership as ineligible to participate in the study because they had roles at CHS such as supervisor in which they would not have access to a caseload with new youth clients to assess or

treat with the PPH. Five other left the agency, 1 withdrew participation from the study, and 1 went on FMLA in the period between enrollment and initial training. Of the 32 who began the training, 30 completed it. The two who began but did not complete the training left the agency between the first and third workshops.

To determine the acceptability of the training and perception of the intervention, the evaluation team collected survey data throughout the training (end of each workshop) and immediately post-training. After each workshop, participants were asked to complete a Qualtrics survey that included 5 close-ended items and 4 open-ended items (see Appendix E). For the close-ended items, participants indicated their agreement using a 5-point response scale, ranging from S*trongly Disagree* (1) to *Strongly Agree* (5). The open-ended items included:

- What part of this workshop did you find most interesting or useful?
- What recommendation(s) this workshop do you have?
- What main ideas (takeaway points) did you learn from this workshop?
- What questions would you like the presenters to address during the next workshop?

Immediately post-training, the acceptability of the entire initial professional development was assessed to gather perceptions on the training as a whole. Participants were asked to complete a Qualtrics survey that included 17 close-ended items and 3 open-ended items (see Appendix E). For the close-ended items, participants indicated their agreement using a 5-point response scale, ranging from *Strongly Disagree* (1) to *Strongly Agree* (5). The 3 open-ended items included:

- What was the most useful part of this training?
- What was the least useful part of this training?
- What changes, if any, would you suggest?

After the initial training, weekly meetings were offered via Zoom for supervision of PPH application to client care. Specifically, CHS trainer Julie Taylor provided open "office hours" each week through Zoom for clinicians to use at their own discretion. Reports from Ms. Taylor were that these voluntary meetings were rarely utilized by the clinicians.

Fidelity of PPH Usage among the Treatment Group

The evaluation team received reports from CHS containing treatment clinicians' entries for the "Self-Report Fidelity of Use of PPH Intervention" form they were asked to complete after each session with a youth client with whom they worked with intent to provide the PPH. Although the evaluation team anticipated receiving this session data for about 67 clients (the number of clients served by clinicians in the treatment group, who had post-treatment data in the outcome file), session data were ultimately provided for only 44 youth clients. The total number of sessions reported for these clients ranged from 1 (min) to 15 (max). The mean number of sessions was 4.86 (*SD* = 3.54, sk = 0.93, ku = 0.12). In sum, for these 44 clients whose clinicians provided any information on fidelity of implementation, on average there were about 5 sessions of treatment after which the clinician completed the fidelity report.

From those sessions for which the fidelity tool was completed, the evaluation team scored responses to Question 3 "*Approximately how much of the session did you use the PPH assessment and happiness curriculum*" where none=0, some=.25, half=.5 most=.75, and nearly all=1.0. This permitted an examination of the total number of sessions that contained at least some PPH. The mean number of sessions in which at least some PPH was used was 4.23 (*SD* =3.49, *sk* = 1.16, *ku* = 0.86). Regarding the range, 2 clients had no reported exposure to PPH and 1 client had some exposure in 15 sessions. In sum, for these 44 clients whose clinicians provided

any implementation data, on average they participated in just over 4 sessions ($M = 4.23$) that included at least some PPH treatment. Of note, the most frequently provided responses to Question 4 *"What activities or interventions did you use in this session OTHER THAN the PPH?"* included references to: cognitive-behavioral therapy, motivational interviewing, client-centered therapy, solution-focused therapy, and/or play therapy. These responses suggest that clinicians tended to integrate the PPH intervention with existing clinical practices during their treatment of youth clients.

Last, the evaluation team created a number of PPH sessions variable, in which the score from Question 3 was summed across sessions. The number of PPH Sessions ranged from 0 (min) to 6.5 (max). The mean number of PPH sessions was 2.01 ($SD = 1.60$, $sk = 1.21$, $ku=0.98$), further illustrating that clinicians in the treatment group who completed the self-report of PPH usage tool tended to report some but not full use of PPH in sessions.

RESULTS

Intervention Training for the Treatment Group: Fidelity, Completion, and Acceptability

Fidelity. To assess fidelity of implementation (FOI) of the planned initial training, members of the evaluation team attended each workshop and recorded whether the important elements of training were present or absent using a pre-established fidelity form tailored to the content of each workshop (see Appendix E for an example completed FOI of training checklist). A total of 12 synchronous live workshops (3 workshops * 2 occurrences each * 2 cohorts) were held at specified times over Zoom. As displayed in Table 5, the maximum value of 100% of planned elements was observed to have occurred in 9 of 12 live workshops (range: 97.2 – 100% FOI for each workshop). Across the 12 workshops, the average FOI was 99.39%, indicating that execution of the initial training plan was quite high for both cohorts of clinicians trained.

Table 5. *Fidelity of Implementation of Initial Training in PPH*

Date	**Workshop**	**Cohort**	**FOI *percentage***
8/11/22	1	1	97.9
8/16/22	1 (Make-up)	1	100
9/1/22	2	1	97.2
9/8/22	2 (Make-up)	1	100
9/22/22	3	1	100
10/6/22	3 (Make-up)	1	100
12/13/22	1	2	100
12/19/22	1 (Make-up)	2	100
1/5/23	2	2	100
1/10/23	2 (Make-up)	2	100
1/19/23	3	2	100
1/23/23	3 (Make-up)	2	97.6

Completion: **Participant attendance.** To be certified to use the PPH intervention, participants were asked to fully attend all training sessions. Attendance was recorded at the sessions. For each workshop, a make-up session at a later date and time was offered to clinicians

who missed the initial offering. If they were unable to make the original workshop date or the make-up session, they were contacted by the agency and invited to a meeting in which they would view a recorded version of a previous live session. For Cohort 1, 23 clinicians began the training; 21 out of 23 clinicians completed all 3 workshops and an additional participant completed 2 of 3 workshops and was permitted by the agency to use the PPH. For Cohort 2, 11 clinicians began the training; 8 of 11 clinicians completed all 3 sessions. Table 6 summarizes the number of clinicians in Cohort 1 and 2 who attended each workshop.

Table 6. *Clinician Attendance at Initial Training in PPH*

Date	**Workshop**	**Cohort**	**Number of Clinicians Present**
8/11/22	1	1	17
8/29/22	1 (Make-up)	1	4
9/12/22	1 (recording played)		1
9/1/22	2	1	14
9/8/22	2 (Make-up)	1	4
9/19; 9/27	2 (recording played)	1	4
9/22/22	3	1	13
10/6/22	3 (Make-up)	1	6
10/3/22	3 (recording played)	1	2
12/13/22	1	2	1
12/19/22	1 (Make-up)	2	4
12/22; 1/6; 1/18	1 (recording played)	2	3
1/5/23	2	2	3
1/10/23	2 (Make-up)	2	2
1/12;1/18	2 (recording played)	2	3
1/19/23	3	2	3
1/23/23	3 (Make-up)	2	3
2/3/23	3 (recording played)	2	2

Completion: Knowledge assessment. Of the 30 clinicians with full (n = 29) or majority (n = 1) workshop attendance, 29 and 27 completed the knowledge measure at pre-test and post-test, respectively. Analysis of scores from the 26 clinicians who completed the knowledge quiz at both time points indicated improvement in scores over time. Specifically, of 100 possible points total, the average score on the knowledge quiz increased from 76.92 (SD = 11.50) at baseline/ pre-test to 91.35 (SD = 7.29) at post-training (Table 7 presents mean scores for each cohort).

A total of 26 of 30 clinicians achieved a passing score by post-test. Two more clinicians in Cohort 1 showed increases in knowledge from pre-test; their earned scores of 70% or 75% at post-test were deemed sufficient progress to proceed with remaining in the treatment group. A final 2 additional clinicians who completed the workshops in make-up sessions did not complete the post-test knowledge quiz for unknown reasons.

Table 7. *Clinician Scores on Knowledge Quiz of Positive Psychology and PPH Intervention*

Cohort	Pre- Score Average (*% items correct*)	Post- Score Average (*% items correct*)	Score ≥ 80% (*% passed quizzed*)
Cohort 1 (N = 20)	77.00	90.25	90% [a]
Cohort 2 (N = 6)	76.67	95.00	100%

Note. Score of 80% or higher is benchmark for sufficient knowledge in intervention framework and manual. [a]The two clinicians with post-test scores below this threshold showed marked increases in knowledge from pre-test; their earned scores of 70% or 75% at post-test were deemed sufficient progress to proceed with remaining in the treatment group.

In sum, 30 clinicians who completed the initial training workshops were permitted to proceed with use of the PPH as a result of their participation in the training series.

Acceptability. Average responses from acceptability surveys completed by participants in Cohorts 1 and 2 indicated high levels of satisfaction with each professional learning workshop. As shown in Table 8, mean scores for each item and the overall measure (average scores = 4.43, 4.42, and 4.20 for Workshops 1, 2, and 3 respectively) exceeded the rating corresponding to both a neutral (3.0) and positive (4.0) affective appraisal. In Appendix I, Table 9 presents qualitative responses to the open-ended items.

Table 8. *Clinician End of Workshop Acceptability Ratings*

Rating Scale Items	Workshop 1 M (SD) *n* = 28	Workshop 2 M (SD) *n* = 25	Workshop 3 M (SD) *n* = 30
1. The material in the workshop enhanced my knowledge of positive psychology interventions.	4.43 (0.82)	4.42 (0.49)	4.20 (1.17)
2. The material in the workshop was easy to understand.	4.36 (0.55)	4.46 (0.50)	4.33 (0.91)
3. The amount of material presented was appropriate for the time available for the session.	4.25 (0.74)	4.54 (0.50)	4.13 (1.02)
4. I am likely to use what I learned today with my students.	4.46 (0.57)	4.58 (0.49)	4.30 (0.97)
5. I am confident that I could use the positive psychology interventions discussed in this workshop.	4.18 (0.66)	4.25 (0.66)	4.27 (0.68)
AVERAGE SCORE	**4.34 (0.12)**	**4.45 (0.13)**	**4.36 (0.08)**

Note. Response metric was 1 = *Strongly Disagree* to 5 = *Strongly Agree*.

A total of 29 of 30 clinicians who completed the workshop series completed the overall training acceptability survey. Mean scores on the End of Initial Training Acceptability are shown in Table 10. Clinicians' ratings ranged from 4.07 to 4.76 with an average of 4.47 (*SD* = 0.19) on the items related to Satisfaction with Training, the highest possible rating being a 5.0 (see Table 10). Responses to the open-ended items provided useful feedback on the training and generally positive responses (see Appendix J, Table 11).

Table 10. *Clinician End of Initial Training Evaluation Ratings (Cohorts 1 and 2)*

Items	M (SD) (n = 29)
Satisfaction with Training	
1. The communication I received in advance of the workshops gave me the information I needed to prepare for the virtual training.	4.14 (0.90)
2. The logistics for the virtual training were well executed.	4.38 (0.55)
3. The goals and objectives of the virtual training were clearly stated.	4.59 (0.49)
4. Training facilitators were knowledgeable about the content.	4.76 (0.50)
5. Facilitators presented the material clearly.	4.69 (0.53)
6. Visuals in the PowerPoints were clear.	4.55 (0.50)
7. Facilitators maintained good pacing.	4.45 (0.56)
8. Transitions between sections were smooth.	4.41 (0.56)
9. Facilitators were enthusiastic.	4.69 (0.53)
10. The material was well-organized.	4.62 (0.49)
11. The material was easy to understand.	4.45 (0.50)
12. The amount of information presented was appropriate.	4.24 (0.62)
13. Facilitators were respectful in answering questions.	4.62 (0.49)
14. Facilitators provided adequate wait-time when questions were posed.	4.45 (0.50)
15. Facilitators monitored and managed time well.	4.48 (0.50)
16. Facilitators were personally connected to the participants.	4.45 (0.67)
17. I feel prepared to implement the intervention in my school setting.	4.07 (0.52)
Scale Composite (average)	**4.47 (0.19)**

In sum, data from the post-training acceptability survey indicated high levels of satisfaction with the entire professional development.

Client Mental Health Outcomes

At two time points—pre- and post-treatment—clinicians administered the outcomes assessment battery to their youth clients. At pre-treatment, 334 youth (123 treatment group, 211 control group) provided self-report ratings of mental health. Post-treatment data were gathered for 178 youth clients (67 intervention, 111 control). For the 12 clients who completed post-treatment assessments at multiple points after baseline, the last assessment was analyzed as the post-test. Analyses on changes in client mental health were restricted to outcomes for N = 178 clients served during 2022-23 by N = 42 clinicians enrolled in the program evaluation.

The data analytic strategy used to examine change in client outcomes accounted for clustering of clients in clinicians. The ICCs were 0 for all dependent variables, indicating that although the analyses took into account the nested data structure, there was little to no empirical evidence to support the clustering. In any event, only clinicians who provided complete client outcome data at pre and post for at least one youth client were included in this analysis of client outcomes. In the PPH treatment group, 20 clinicians had at least 1 client with pre/post data. The number of clients per clinician ranged from 1 to 9, with a mean of 3.35 and a median of 2.5, totaling 67 clients. In the SAU control group, 22 clinicians had at least 1 client with pre/post data. The number of clients per clinician ranged from 1 to 11, with a mean of 5.05 and a median of 4, totaling 111 clients. Of note, the number of *clinicians* in each group is similar, with the

small difference explainable by the difference in the number of eligible clinicians assigned to each condition. The project statistician was not concerned about differential attrition between the two conditions because the proportion of eligible treatment clinicians that had at least 1 client with pre/post data is very similar to the proportion of control clinicians that had at least 1 client with pre/post data. It is unclear why the median number of clients enrolled by condition was different and higher for the control group; for an unknown reason, more clinicians in the PPH treatment group (n = 7) contributed only 1 client to the dataset than clinicians in the SAU control group (n = 2) who contributed only 1 client. Regardless, for most client outcome variables, the sample available for analyses regarding the impact of the PPH on client mental health involved a maximum sample size of 178 youth clients. Of note, two clients in treatment and 2 in the control condition were missing values on some outcomes, so in some cases the analysis used data from 174 youth as opposed to 178.

For the sample of 174 to 178 clients, Table 12 presents the average scores within each condition (PPH treatment or SAU control) on each measure of mental health at baseline (pre) and after treatment (post). These descriptive statistics illustrate that in both groups, clients evidenced improvements in mental health over time. Within the PPH treatment and SAU groups, mean scores on each indicator of psychopathology symptoms (BPM) were lower at post than pre, and mean scores on each positive indicator of subjective well-being (SLSS, PANAS-Positive) were higher at pre than post.

Table 12. *Descriptive Statistics for Client Outcome Variables at Pre and Post, by Group (PPH Treatment, SAU Control)*

Outcome	**Means**				**SDs**			
	PPH Tx		SAU Control		PPH Tx		SAU Control	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
BPM- Total	13.97	12.05	16.30	10.97	6.33	5.29	6.53	6.94
BPM- Attention	5.58	5.27	6.15	4.56	2.73	2.53	2,78	2.72
BPM- Internalizing	4.10	3.16	5.56	3.07	2.97	2.64	2.87	2.77
BPM- Externalizing	4.28	3.69	4.62	3.34	2.74	2.48	2.90	3.04
SLSS	4.03	4.41	3.63	4.08	1.09	1.00	1.02	1.05
PANAS-Positive	3.00	3.39	2.96	3.29	1.07	0.94	1.01	0.92
PANAS-Negative	2.01	1.67	2.20	1.72	0.77	0.57	0.71	0.65

Note. BPM = Brief Problem Monitor. SLSS = Students Life Satisfaction Scale. PANAS = Positive and Negative Affect Scale for Children. At Pre, N=67 for treatment group and N = 111 for control group for most variables; For BPM-Attention and BPM- Total N=109 (control) at pre and N = 65 (treatment) at post. Reliability estimates (pre/post): BPM-Total (α=.83/.85), BPM-Attention (α=.71/.74), BPM-Internalizing (α=.80/.79), BPM-Externalizing (α=.74/.79), SLSS (α=.81/.84), PANAS-Positive (α=.88/.87), and PANAS-Negative (α=.67/.68).

To estimate the raw score treatment effects, a multilevel model was estimated via restricted maximum likelihood for each outcome (e.g., a separate model for BPM, SLSS, PANAS-Positive affect, and PANAS-Negative affect). The general form of the model is shown in Equation 1, where the raw score treatment effect (i.e., $\hat{\gamma}_{01}$) is the difference in post-assessment means after adjusting for the pre-assessment and taking into account the clustering of clients within clinicians. Positive values for $\hat{\gamma}_{01}$ indicate higher adjusted mean values for the treatment group (i.e., Tx was coded 1 for the treatment group and 0 for the control group), thus a positive

intervention effect would lead to positive values of $\hat{\gamma}_{01}$ SLSS and PANAS-Positive, and a negative value of $\hat{\gamma}_{01}$ for BPM and PANAS-Negative.

$$\begin{aligned} Y_{ij} &= \beta_{0j} + \beta_{1j} PreY_{ij} + e_{ij} \qquad e_{ij} \sim N(0, \sigma_e^2) \\ \beta_{0j} &= \gamma_{00} + \gamma_{01} Tx_j + r_{0j} \qquad r_{0j} \sim N(0, \sigma_r^2) \\ \beta_{1j} &= \gamma_{10} \end{aligned} \tag{1}$$

To estimate the standardized effect the raw score treatment effect estimate (i.e., $\hat{\gamma}_{01}$) was divided by a standard deviation estimate obtained from the variance components from a model that did not contain the $PreY_{ij}$, such that we obtained a cleaner estimate in the variation between participants in the treatment and control conditions. This reduced model used to estimate the variances is shown in Equation 2 and the standardized effect estimator is shown in Equation 3.

$$\begin{aligned} Y_{ij} &= \mu_{0j} + v_{ij} \qquad v_{ij} \sim N(0, \sigma_v^2) \\ \mu_{0j} &= \theta_{00} + \theta_{01} Tx_j + w_{0j} \qquad w_{0j} \sim N(0, \sigma_w^2) \end{aligned} \tag{2}$$

$$d = \frac{\hat{\gamma}_{01}}{\sqrt{\sigma_v^2 + \sigma_w^2}} \tag{3}$$

Table 13. *Effect Estimates*

Outcome	Effect Estimate	SE	p-value	Standardized Effect (d)	Within Variance	Between Variance
BPM- Total	1.77	0.96	.07	.28	40.73	0
BPM- Attention	0.93	0.38	.014	.35	7.01	0
BPM- Internalizing	0.59	0.40	.14	.22	7.41	0
BPM- Externalizing	0.47	0.41	.25	.17	8.10	0
SLSS	0.14	0.14	.31	.14	1.07	0
PANAS-Positive	0.08	0.12	.71	.09	0.86	0
PANAS-Negative	0.003	0.09	.97	.00	0.38	0

Note. BPM = Brief Problem Monitor. SLSS = Students Life Satisfaction Scale. PANAS = Positive and Negative Affect Scale for Children. *N* = 167 for BPM-Attention and BPM-Total; and *N* = 171 for BPM- Internalizing, BPM- Externalizing, SLSS, PANAS-Positive affect, and PANAS-Negative affect.

A review of the effect estimates and associated p-values displayed in Table 13 indicates the SAU group had more favorable Attention outcomes than the PPH group ($d = .35$, $p = .014$). Among the other variables, there were no significant differences between the two treatment groups. To interpret effect sizes, Cohen's guidelines were used, in which $d = .20$ is considered small, $d = .50$ is considered medium, and $d = .80$ is considered large. Although the estimated effects in the sample favored the PPH group for SLSS ($d = .14$) and PANAS-Positive ($d = .08$) and favored the SAU group for BPM-Total ($d = .28$), Internalizing ($d = .22$), and Externalizing ($d = .17$), all of these estimates were small and none were statistically significant. In sum, non-significant trends in the data suggest that the PPH treatment group may be more effective in increasing youth clients' global life satisfaction and positive affect (mental *wellness*), whereas

SAU may be more effective in reducing psychopathology symptoms (mental *illness*), particularly symptoms of attention problems.

Treatment Acceptability

The purpose of the CSQ was for the youth clients to rate their satisfaction with their counseling experiences. Both groups reported high satisfaction with treatment on the CSQ. For the PPH treatment group, $M = 3.26$ ($SD = .73$), and $Mdn = 3.44$ across the 20 clients served by 11 clinicians. For clients in the SAU control group, $M = 3.78$ ($SD = .31$), and $Mdn = 3.88$ for the 32 clients served by 11 clinicians. Considering the 1 (*quite dissatisfied*) to 4 (*very satisfied*) response metric, it is notable that the average and mid-point scores for both conditions exceed the response point corresponding to "mostly satisfied."

Average between-group CSQ scores were examined using a multilevel model to account for the clustering of clients into clinicians (e.g., some clinicians had data for 4 clients, other clinicians had data for only 1 client). The cluster adjusted mean on the CSQ score for the PPH intervention group was .30 lower than for the SAU control group, which is not statistically significant, $t(1, 19) = -1.36$, $p = .189$. In sum, clients in both groups reported high acceptability scores (max value is 4.0). When the fact that the clients are nested in clinicians is controlled for statistically, the trend for somewhat higher scores among the SAU control group relative to the PPH intervention group is not statistically significant. Thus, mean levels of acceptability with counseling services are comparable between the groups. Responses to the final three items that followed the 8-item CSQ are provided in Table 14. Similar comments voiced across clients are denoted with an "x" followed by the number of different clients who expressed the idea.

Table 14. *Client Responses to Open-Ended Questions that Followed the CSQ*

Condition	**What did you like best about the services you received?**	**What did you like least about the services you received?**	**Any additional thoughts, feedback, or information?**
Treatment	• Activities done in session (games, drawings, etc.) (x4) • Talking to the counselor (x2) • Likeability of the counselor (x3) • Outlet of someone to talk to (x2) • Provided solutions to problems (x2) • The counselor asked about the child's day • Helped understand their emotions • Child felt understood • Everything	• Nothing (x15) • Having to talk (x2) • "The thinking process" • Counselor leaving • The counselor was not nice • Do not see the counselor as much as they would like • Better communication is needed	• Counselor was helpful • Therapist was likeable • Everything went well • Unsure/no/no response (x12)
Control	• Likeability of the counselor (x5) • Feeling heard (x3) • Everything went well (x3) • Convenience of the therapy occurring at school (x3)	• Nothing/Unsure (x19) • Schedule or timing of sessions (x2)	• Counselor was helpful and listened (x2) • Very satisfied with services (x4)

	• Good communication (x3) • Breathing and positive thinking • Learning something new • Helped with understanding emotions • Sessions held in the home • Enjoyed therapy overall • Unsure (x2)	• Location of sessions (x2) • Better communication is needed • Want to meet with their counselor more (x3)	• Sessions should be more than once per week • Clinician has helped calm client down, and the client enjoys the sessions • Unsure/ no/ no response (x20)

Clinician Mental Health

At the start and end of the study, clinicians completed five measures of personal mental health. Three measures assess indicators of positive mental health (i.e., life satisfaction, flourishing, and positive affect) and two measures assessed indicators of negative emotional experiences (i.e., negative affect, and perceived stress). At baseline, 84 of 89 clinicians who consented to take part in the study completed pre-study measures of mental health (44 treatment, 40 control). At post-study, 44 of these clinicians completed these measures of mental health again (19 treatment, 25 control).

An attrition analysis was conducted to explore if there was a significant difference in baseline/pre-study mental health scores between those clinicians who completed the study and those who did not. A series of independent t-tests was used to compare the baseline scores of the 44 clinicians with pre and post data (i.e., "study group") to the baseline scores of those 40 who did not provide post data but did have baseline data (i.e., "attrition group"). Of the 89 clinicians who consented for the study, 84 filled out the baseline measures. Of the 40 participants without post data, 19 left the agency during the study period (13 intervention, 6 control), 4 remained clinicians at the agency but withdrew from study participation (2 intervention, 2 control), 13 transitioned to a different position at the agency such as supervisor or intake coordinator (9 intervention, 4 control), and 4 remained clinicians at the agency but were unresponsive to requests to complete post-test measures for unknown reasons (1 intervention, 3 control). There was not a significant difference between the study group and the attrition group on the measures of life satisfaction (SWLS), flourishing (FS), and negative affect (NA). There was a significant difference for stress (PSS). As shown in Table 15, the 44 who completed the study started with a lower stress score (M = 26.95, SD = 4.57) than those who were lost to attrition for various reasons (M = 29.88, SD = 6.97), $t(82) = 2.27$, $p < .05$. There was also a significant difference in positive affect (PA); the 44 who stayed in the study had higher baseline positive affect (M = 35.77, SD = 6.75) compared to the attrition group (M = 31.15, SD = 7.68), $t(82) = -2.94$, $p < .05$. In sum, clinicians who did not fill out post measures for any reason started the study reporting higher perceived stress and lower frequency of positive affect, but levels of flourishing, life satisfaction, and negative affect that were similar to those of clinicians who remained in the study throughout the year.

Table 15. *Clinician Scores on Baseline Measures of Mental Health*

				Study Group (n = 44)		Attrition Group (n = 40)	
Variable	*t*	df	*p*	*M*	*SD*	*M*	*SD*
SWLS	-1.94	82	.056	24.68	6.08	21.93	6.96
FS	-0.53	82	.60	41.32	4.30	40.75	5.48
PA	-2.94	82	.004*	35.77	6.74	31.15	7.68
NA	1.33	82	.19	19.05	4.40	20.93	8.19
PSS	2.27	82	.026*	26.95	4.57	29.88	6.97

Note. *$p < .05$

To examine change over time in clinician mental health, analyses were restricted to data from the study group, specifically the 45 participants with complete data at pre and post. Table 16 displays the descriptive statistics for the various mental health outcomes, assessed at Pre and Post. The pre/baseline time point was before any participant was randomly assigned to condition and before the treatment group had any exposure to positive psychology for both the treatment group and the control group. The descriptive statistics for the post time point were after clinicians in the treatment group participated in the PPH training and used the intervention as much or little as they saw professionally fit with their clients.

Table 16. *Descriptive Statistics for Clinician Mental Health Outcome Variables at Pre and Post, by Group (PPH Treatment, SAU Control)*

Outcome	**Means**				**SDs**			
	PPH Tx (n = 19)		SAU Control (n = 25)		PPH Tx (n = 19)		SAU Control (n = 25)	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post
SWLS	24.95	27.11	24.48	25.96	5.90	4.40	6.33	6.77
FS	47.47	48.26	47.64	47.52	5.22	6.31	2.61	5.99
PA	36.05	34.58	35.56	36.44	7.95	7.66	2.77	6.37
NA	18.63	17.32	19.36	16.12	3.95	5.23	2.86	4.62
PSS	25.63	25.16	28.00	24.92	4.36	4.48	1.01	5.77

Note. SWLS = Satisfaction with Life Scale. FS = Flourishing Scale. PA = Positive Affect scale of the PANAS. NA = Negative Affect scale of the PANAS. PSS = Perceived Stress Scale.

First, change in mental health among clinicians in the PPH treatment group was examined through a series of repeated measures ANOVA analyses (one per dependent variable) using data from only the 19 clinicians in the PPH treatment group. For all scales, pre scores were subtracted from post scores to see the gains between the two time points. Results are shown in Table 17, including p-values and effect sizes (Cohen's *d*). Effect sizes were calculated using the gain/difference score (subtracting pre from post) and divided by the standard deviation from the scores at pre-test. As indicated in Table 17, there was a significant change in the PPH clinicians' complete mental health on three of the five scales: SWLS, NA, and PSS. The SWLS showed a 2.16 raw score increase (p = .005, d = 0.37) with a small effect size, indicating an overall increase in life satisfaction. The NA scale of the PANAS showed a 1.32 raw score decrease over time (p = .008, d = 0.25) with a small effect size, indicating a decline in negative affect over time. The PSS showed a 0.47 decrease (p = .04, d = 0.19) with a small effect size, indicating

reductions in perceived stress throughout the study period. Changes in positive affect and flourishing were not statistically significant.

Table 17. *Changes in PPH Treatment Clinicians' Complete Mental Health (N = 19)*

	Group Differences from Pre- to Post-Study for PPH Clinicians		
Outcome	Gain Scores	*p*	*d*
SWLS	2.158	.005*	0.37
FS	0.789	.53	0.15
PA	-1.473	.76	0.11
NA	-1.316	.008*	0.25
PSS	-0.474	.04*	0.19

Note. *p< .05. SWLS = Satisfaction with Life Scale. FS = Flourishing Scale. PA = Positive Affect scale of PANAS. NA = Negative Affect scale of PANAS. PSS = Perceived Stress Scale.

Next, to determine if the aforementioned changes in clinician mental health were unique to the treatment group, a second set of analyses focused on time by treatment group interactions to determine if there were any significantly different changes in mental health between the PPH treatment group and the SAU control group. A series of mixed model ANOVAs was conducted, with findings reported in Table 18.

Table 18. *All Clinicians Mental Health Across Time, Tests of Within- and Between-Subjects Effects (N = 44)*

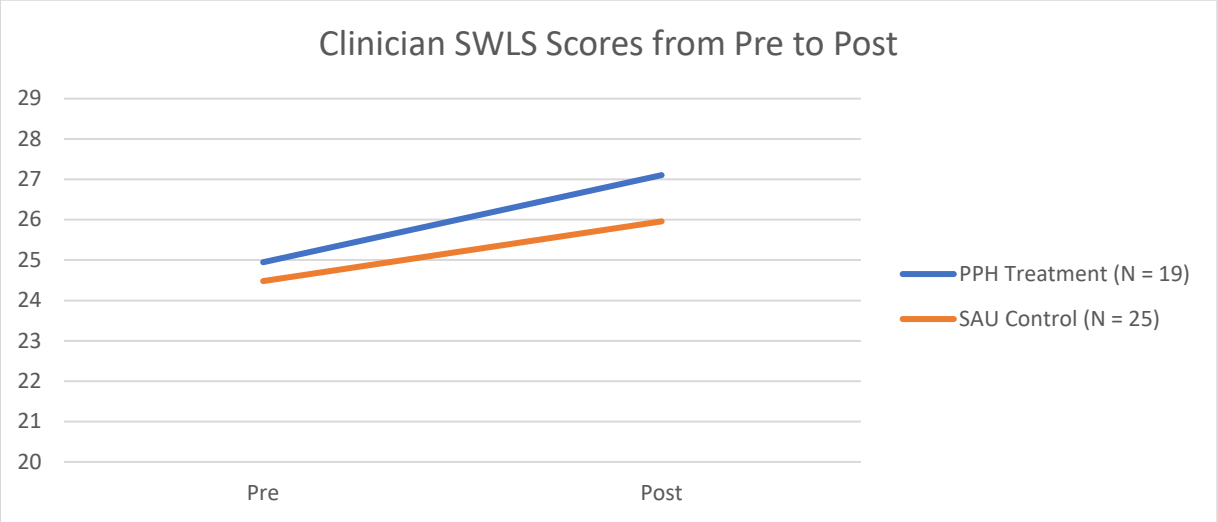
Variable	*F*	*p*
Life Satisfaction		
Time	8.69	.005*
Clinician Group	0.22	.64
Time x Clinician Group	0.31	.58
Flourishing		
Time	0.22	.64
Clinician Group	0.04	.85
Time x Clinician Group	0.40	.53
Positive Affect		
Time	0.09	.76
Clinician Group	0.14	.71
Time x Clinician Group	1.47	.23
Negative Affect		
Time	7.68	.008*
Clinician Group	0.04	.84
Time x Clinician Group	1.37	.25
Perceived Stress		
Time	4.28	.04*
Clinician Group	0.80	.38
Time x Clinician Group	2.24	.14

Note. *p < .05

For these analyses that include data from all 44 clinicians in both groups, a main effect of time was statistically significant (p < .05) for life satisfaction, negative affect, and perceived stress. The direction of the effect was the same as reported for just the PPH treatment group:

from pre- to post-test; specifically, clinician life satisfaction increased while negative affect and stress decreased. There were no main effects of clinician group and no significant time by group interactions, suggesting that clinicians across both groups tended to begin and change in mental health (increase in life satisfaction, decrease in negative affect and stress) similarly over time, rather than improvements in mental health being particularly unique to the PPH treatment group. Such similarity in change between groups is depicted in Figure 1, which shows mean pre to post SWLS scores for each condition.

Figure 1. *Change in Clinicians' Life Satisfaction During Study, by Condition*



Taken together, this set of analyses indicated that there were no significantly different end-of-year changes in personal mental health among clinicians who used the PPH treatment as compared to those clinicians who continued with services as usual during this same time period.

Exploratory analyses. Given the variability in clinician reported use of the PPH within the treatment group, additional analyses were conducted to explore if changes in clinician mental health varied in relation to how much or little they used the PPH in their clinical practice. For each outcome, difference scores (pre-treatment subtracted from post-treatment scores) were correlated with total exposure to PPH in practice. The total exposure to PPH during client care variable considers (1) *amount*, defined as the number of times a clinician completed a PPH fidelity measure after a session with a client in the study [amount], and (2) *usage*, defined as the average percentage of each session that contained PPH content as reported on the PPH fidelity measure, with response options ranging from: none (0% = 0), some (up to 25% of session content = .25), about half (about 50% of session content = .50), most (about 75% of session content = .75), and nearly all (close to 100% of session content = 1.0). For the 19 clinicians in the PPH treatment group, Table 19 presents their usage, amount, and total exposure values.

A total exposure score of 0 represents a clinician in the treatment group who completed the initial training needed to use the PPH, but either chose not to use it with their clients *or* did not report the fidelity of usage. Table 19 also presents the number of youth clients each clinician enrolled (i.e., collected baseline data for at the start of treatment), and the number of clients the

clinician completed (i.e., collected post data for by the conclusion of the study). For clinicians with multiple enrolled clients, it is unknown why failure to complete the fidelity measure occurred given regular reminders from the evaluation team staff and the agency to report fidelity of use with enrolled clients. However, for two clinician participants (numbers 4 and 16) who collected pre- and post-treatment data from numerous youth clients, no fidelity measures were completed; their fidelity data is conceptualized as missing rather than a "0" score because they completed treatment with several youth clients. Due to missing fidelity data, these two were omitted from correlational analysis of clinician outcomes and total exposure.

Table 19. *Total Exposure Variable and Number of Youth Clients for Clinicians in PPH Group*

Clinician ID	Amount	Usage	Total Exposure	Youth Clients Enrolled in RCT	Youth Clients Completed in RCT
1	12	0.73	8.75	6	4
2	18	0.43	7.25	5	3
3	2	0	0	3	1
4	.	.	.	10	10
5	6	0.21	1.25	9	1
6	0	0	0	1	0
7	12	0.50	6.00	6	2
8	2	0.50	1.00	1	1
9	2	0.25	0.50	4	4
10	1	0.25	0.25	8	3
11	76	0.28	21.50	12	7
12	36	0.49	17.75	9	6
13	49	0.46	22.50	10	7
14	0	0	0	0	0
15	0	0	0	0	0
16	.	.	.	7	6
17	40	0.28	11.50	6	5
18	0	0	0	2	0
19	0	0	0	0	0

Note. "." = missing data. Amount = number of sessions a clinician completed the PPH fidelity of use measure. Usage = average percentage reported in fidelity measure (sum of all use percentage values, divided by the number of entries). Total exposure = product of usage and amount.

Table 20 presents the correlations between difference/gain scores on each of the five mental health outcomes and total exposure to the PPH intervention during the program evaluation year. With regard to associations between total exposure to PPH and clinician mental health, there were no statistically significant correlations ($p < .05$) between improvements in any of the five outcomes (SWLS, FS, PA, NA, PSS) and total exposure to the PPH in practice. Because there were no statistically significant correlations, any interpretations of magnitude from these exploratory analyses may be non-generalizable. To fully explore trends in the data within this underpowered portion of study, Cohen's (1992) guidelines were used to understand the strength/magnitude of correlations as small ($r = .10$), medium ($r = .30$), and large ($r = .50$) for this specific sample. Three associations reached the threshold for medium in magnitude. Specifically, the correlation between clinicians' total exposure to PPH and change in personal

levels of perceived stress was negative, with a medium magnitude and non-significant p-value (r = 0.370, p = .144). This suggests that as exposure to the PPH in clinical practice increased, levels of perceived stress reported by clinicians tended to decrease for this sample. It was also found that as total exposure to PPH in clinical care increased, personal flourishing and positive affect also tended to increase with a medium magnitude correlation but a non-significant p-value (r = 0.316, p = .216 for flourishing; r = 0.316, p = .217 for positive affect). In sum, there were no statistically significant findings between total exposure to PPH in clinical practice and any indicator of clinician mental health, in part due to lack of power associated with a small sample size (N = 17). Trends in the data include medium-sized associations between greater total use of PPH in client care and improvements in three indicators of mental health (perceived stress, positive affect, and flourishing).

Table 20. *Correlations between Exposure to PPH and Mental Health Gain Scores of Clinicians in Treatment Group with Pre and Post Outcome Data (N = 17)*

Variable	*N*	*M*	*SD*	Total Exposure
Total Exposure to PPH	17	5.78	7.97	1.000
Usage	17	0.26	0.23	0.556
Amount	17	15.06	22.19	0.945*
Clients Enrolled in RCT	19	5.21	3.85	0.770*
Clients Completed in RCT	19	3.16	3.00	0.905*
Difference Pre to Post SWLS	19	2.16	4.48	-0.280
Difference Pre to Post FS	19	1.65	3.94	0.316
Difference Pre to Post PA	19	-1.47	7.87	0.316
Difference Pre to Post NA	19	-1.32	5.88	0.094
Difference Pre to Post PSS	19	-0.47	4.03	-0.370

Note. *p < .05; Total Exposure = (Amount x Usage).

SUMMARY AND NEXT STEPS

This program evaluation examined differences in client and clinician mental health outcomes associated with clinician use of a new manualized positive psychology intervention—the PPH Assessment and HAPPINESS Curriculum—in treatment vs. services as usual (SAU) conditions. Across two cohorts, 89 clinicians enrolled in the program evaluation and were randomly assigned to the PPH treatment group ($N = 45$) or SAU control group ($N = 44$). These clinicians completed training on how to measure client mental health using a comprehensive battery of indicators of wellness and illness at two time points- pre-treatment and post-treatment. Attrition of clinicians during the study period was high, driven by changes in employment. Ultimately, about half of enrolled clinicians ($N = 42$; 47.2% of the initial sample) recorded pre- and post-treatment data for a total of 178 youth clients (67 treatment group, served by 20 PPH clinicians; 111 control group, served by 22 SAU clinicians). For the examination of clinician mental health, 84 of 89 enrolled clinicians completed pre-study measures of personal mental health (44 treatment group, 40 control), and 44 of them completed the measures again at the end of the study period (52.4% of the initial sample; 19 treatment, 25 control).

We had hypothesized that clients served by clinicians in the PPH treatment condition would show *more favorable* mental health outcomes than those assigned to SAU control. These hypotheses were not supported by any statistically significant findings from data analyses; relative to the clients served by SAU clinicians, clients served by clinicians in the PPH treatment condition did not evidence significantly higher subjective well-being, fewer mental health problems, or greater satisfaction with clinical services. Instead, at post-treatment, average scores for clients in each condition (PPH treatment and SAU control) indicated increases in subjective well-being (SLSS and PANAS-Positive affect scores) and reductions in mental health problems (BPM-Total scores) from pre-treatment levels, and clients in both groups reported high satisfaction with services. These findings suggest that clinical care that includes the PPH is as efficacious and well-received as clinical care in the SAU condition. This level of support for the PPH is promising given that the SAU condition features clinician use of multiple evidence-based practices per agency policy and accreditation guidelines. However, the PPH treatment was not supported as superior to SAU. The estimated effects favored the PPH treatment group on client outcomes involving indicators of subjective well-being ($d = .14$ for life satisfaction and $d = .08$ for positive affect), and favored the SAU group on indicators of psychopathology ($d = .28$ for total emotional and behavioral problems, more specifically $d = .22$ for internalizing problems and $d = .17$ for externalizing problems), but these estimates were small and none were statistically significant. Given the direction of these non-significant trends in the data, future studies with larger sample sizes may find the PPH treatment group to be more effective in increasing youth clients' global life satisfaction and positive affect (mental *wellness*), whereas the SAU control may be more effective in reducing psychopathology symptoms (mental *illness*). An unanticipated finding in the current study was that the SAU group had a significantly more favorable outcome on one of the three narrower types of psychopathology examined—attention problems—than the PPH group at post-treatment. It is possible that the inclusion of clinical content intended to upregulate positive emotional experiences associated with mental wellness may detract clinical attention from fully addressing various symptoms of mental illness, especially inattention.

We had hypothesized that clinicians in the PPH treatment condition would report *more favorable* mental health outcomes than clinicians assigned to SAU control, specifically higher

levels of life satisfaction, flourishing, and positive affect, and lower levels of stress and negative affect. Instead, at the end of the study period, average scores for clinicians who remained in each condition (PPH treatment and SAU control) indicated increases in life satisfaction (SWLS scores) and reductions in perceived stress and negative affect (PSS and PANAS-Negative affect) from levels reported at the beginning of the study period. These average improvements in clinician mental health were not unique to either treatment condition. Follow-up correlational analyses were conducted with the sample of 19 clinicians in the PPH treatment group who provided personal mental health data at pre- and post-study, to explore if change in any mental health outcome was associated with the clinician's level of exposure to the PPH intervention during their clinical practice with the youth clients whose outcomes were assessed pre- and post-treatment. Results indicated no statistically significant correlations between improvements in any of the five outcomes (SWLS, FS, PA, NA, and PSS scores) and total exposure to the PPH in practice. Trends in the data include medium-sized associations between greater total use of PPH and improvements in three indicators of mental health—perceived stress, positive affect, and flourishing. More research with larger samples of clinicians is warranted to further determine the reliability of these trends.

Study Limitations and Directions for Future Research

Attrition of clinicians during the study period was high (47.6% - 52.8%), which contributed to smaller sample sizes than desired in the datasets available for the analysis of client and clinician outcomes. Of note, other studies with clinicians in community mental health agencies have also encountered high rates of attrition; for instance, Adams and colleagues (2019) reported a turnover rate of 39% during their 1-year study of 247 therapists from 28 community mental health agencies. Our data analyses found that clinicians who left this study for any reason reported higher stress and less frequent positive affect at the start of the study, as compared to their colleagues who stayed in their clinical role at CHS and participated in the study throughout the year. Future research with clinicians from community agencies might plan to oversample at the start of the study in anticipation of substantial attrition, and/or monitor staff mental health (stress, positive affect) throughout their employment to identify, support, and retain staff who may report signs of diminished well-being.

Another limitation in the current study involves some differences in demographic features of clients in the two conditions. In particular, the average age of clients in the PPH treatment group was 10.87 years old, whereas the average age of clients in the SAU group was 12.34 years old. This study used random assignment of therapist to condition; it is unknown why the sample of clients served by clinicians in the PPH treatment group was significantly younger—by about 1.5 years, on average, than the sample of clients served by clinicians in the SAU group. This difference may be relevant to the current evaluation, though, as findings from the first pilot study with the PPH indicated that clinicians suspected the intervention may be more effective with older youth. Specifically, a theme that emerged across exit interviews with clinicians who reported their impression of the PPH when used with multiple clients was: "Better to use with older clients, as paradigm change for younger clients was difficult when thinking through positive lens, making this program fit better with certain clients" (Suldo, Coolman, & Legra, 2023, p. 32). Future studies of the PPH might consider equivalence of client age across conditions, and/or restrict use of the PPH with youth above a minimum age (e.g., 8 years old; the current study included youth ages 5+ in each condition). Of note, the client sample in the current

study was also somewhat unbalanced across conditions with regard to proportion identified as Hispanic or Latino (10% in PPH treatment group, 23% in SAU group), which may have affected the findings in an unknown way; however, no qualitative data in the pilot suggested the PPH may be more or less effective on the basis of client race or ethnicity.

Among the clinicians assigned to the PPH treatment group, reported use of the intervention with youth clients was variable across clinician as well as within a given session. Some clinicians reported their fidelity of use of the PPH after a high number of sessions (e.g., 36, 40, 49, and 76 sessions), some reported fidelity of use on a moderate number of instances (e.g., after 6 – 18 sessions), and multiple others completed 0 reports of fidelity of use. Of the clinicians who completed the self-report fidelity of use survey as requested, the average amount of the session in which they used the PPH ranged from *some* to *most* of the session content. Such variability within the treatment condition poses challenges with isolating the effect of any novel intervention that is being integrated with use of other evidence-based interventions. Future studies of the PPH may consider: (a) utilizing more objective indicators of PPH usage (e.g., coding of intervention content during direct observation of sessions or review of audiofiles from recorded sessions), (b) routine monitoring of fidelity of implementation after the initial training to identify and support clinicians with no to low use, and (c) planning to examine PPH dosage within statistical analyses of intervention effectiveness on various client and clinician outcomes.

Conclusions

The Positive Psychology through Happiness (PPH) Assessment and HAPPINESS Curriculum is a novel manualized intervention intended to direct attention to client strengths and positive subjective experiences. The intervention is rooted in positive psychology theory, and an extensive evidence base supports the effectiveness of positive psychology interventions on improving client mental health outcomes across aspects of wellness, distress, and quality of life (Carr et al., 2024). The PPH aims to foster emotional well-being and positive mental health during clinical care. Clinicians are encouraged to use the PPH alongside their existing evidence-based practices that address symptoms of mental health problems, resulting in a balanced approach to counseling that maximizes potential to increase client wellness and decrease illness. The results of this randomized controlled trial of the PPH among a final sample of 42-44 clinicians during the 2022-23 school year establish that it is at least equivalent to use of traditional evidence-based practices with respect to improving multiple aspects of client and clinician mental health, and that clients of clinicians trained in it report high levels of treatment satisfaction. Trends in the data that were not statistically significant suggest that the PPH may be more effective in increasing youth clients' global life satisfaction and positive affect (mental *wellness*), whereas services as usual may be more effective in reducing psychopathology symptoms (mental *illness*); further, non-significant but medium-sized correlations suggest that more frequent use of PPH in client care may be associated with greater improvements in clinician mental health (less stress, more positive affect and flourishing). Future research is needed to determine if these trends replicate and are associated with statistically significant effects in larger samples. The manualized intervention evaluated in this study is ready for use in such future research and practice, and findings detailed in this report support the acceptability of the initial training procedures created to prepare clinicians to use the PPH within their clinical care for youth in individual psychotherapy.

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Appendix A: PPH Intervention Manual (select pages)

Positive Psychology through Happiness

Positive Psychology through Happiness (PPH) Assessment and Curriculum Version 2.0

MANUAL

First edition, December 2021

Version 2.0 August 2022

Children's Home Society of Florida

Positive Psychology through Happiness

Positive Psychology through Happiness (PPH) Assessment and Curriculum

Children's Home Society of Florida

Positive Psychology through Happiness

Appendix C – HAPPINESS Curriculum

Introduction -

The HAPPINESS protocol curriculum is designed to help the CHS professional take definitive steps with CHS clients to guide and teach steps toward defining, planning, and achieving self-defined happiness in their lives. While there is no time limit on how long a client stays at each step, the steps are introduced and worked on in order. The curriculum presents an overview of each letter of the HAPPINESS acronym (listed below) to provide both the CHS professional and the CHS client with the basics of the step.

During interactions with the client, the CHS professional will introduce the topic in the age/developmental level of the client. Then the CHS professional will review the ACTS acronym for each step. ACTS refers to the type of learning opportunities in each section: Activities, Cognitive Copy (worksheets), Talking Points, and Simple Changes. By the time the client works through the HAPPINESS curriculum the client will have gained an understanding of what it takes to make their own happiness, learned how to plan and set goals, and learned how to go through the process until they reach success. Helping clients learn to build their own success is a key part of our CHS mission of "We Do Good."

The HAPPINESS curriculum follows a step-by-step process, using the HAPPPINESS acronym:

H - Understanding Happiness

A - Assessing Where I Am Now

P - Producing Positive Thoughts and Actions

P - Practicing My Daily Habits

I - Investigating a New Way of Doing Things

N - Navigating the Bumps in the Road

E - Examining My Successes

S - Spreading My Strengths

S - Savoring My Success

The steps are designed to walk the client through the key concepts and lessons that they will need to be able to define, take action, and achieve their own personal happiness goal.

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For each step above the curriculum includes an overview of each topic and the lessons you can use to work with your clients. The lessons are tools we call ACTS. ACTS stands for:

A – Activities to do with your client to emphasize the step

C – Cognitive Copy, worksheets designed to have your client work on to learn the step. Many of the Cognitive Copy worksheets are designed for children, but do also work for adults.

T- Talking Points, questions that you can use to guide the discussion with the client. These tend to work well with teens and adults.

S- Simple Changes, a brief worksheet to be done each week that asks the client what one simple change they can make the next week toward their goal. It is expected for this worksheet to evolve, and for the happiness goal to evolve, as the client learns and grows. This is designed for use with children through adults.

The ACTS tools for each of the steps in the HAPPINESS curriculum have many options. As the counselor you have the option to choose which of the ACTS works best with your client. Some clients respond well to activities, some clients respond well to structured worksheets, other clients do best with talking points. The only required piece is the S – Simple Changes. Doing this each session is a key component.

In the spring 2022 pilot of the HAPPINESS Curriculum, CHS counselors reported a variety of ACTS done for each HAPPINESS step. The counselors in the pilot reported that they used different ACTS with different clients. The key is to find the way that best connects with your client and use it. If you have a client who is not getting the point of the lesson, stay on that step of HAPPINESS another week and try a different activity.

Using the Curriculum

The HAPPINESS curriculum is designed to done in order. In the pilot it took counselors between 10 to 12 weeks to complete all of the HAPPINESS steps with their clients. If you do not have a set time to end services with a client or a natural stop (such as end of school year), there is no limit on how long you can spend on each HAPPINESS step. However, there are times when a counselor cannot work with a client for a full 12 weeks, so below is a scope and sequence for various time frames to use the curriculum:

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II. **10 Week Scope and Sequence-**

A 10-week scope and sequence allows the client to focus on the key paradigm shifting steps while moving along through the HAPPINESS curriculum:

Week #1: **H - Understanding Happiness**

Week #2: **A - Assessing Where I Am Now**

Week #3: **P - Producing Positive Thoughts and Actions** *(This topic is key to the program and is where the paradigm shift happens)*
***Focus on Thoughts**

Week #4: **P - Producing Positive Thoughts and Actions** *(This topic is key to the program and is where the paradigm shift happens)*
***Focus on Actions**

Week #5: **P - Practicing My Daily Habits**

Week #6: **I - Investigating a New Way of Doing Things**

Week #7: **N -Navigating the Bumps in the Road**

Week #8: **E- Examining My Successes**

Week #9: **S- Spreading My Strengths**

Week #10: **S- Savoring My Success**

III. **8 Week Scope and Sequence**

The 8-week scope and sequence still allows for a focus on the first P, which is a key component of the curriculum, while touching each of the topics.

Week #1: **H - Understanding Happiness and A - Assessing Where I Am Now**

Week #2: **P - Producing Positive Thoughts and Actions**

Week #3: **P - Practicing My Daily Habits**

Week #4: **I - Investigating a New Way of Doing Things**

Week #5: **N-Navigating the Bumps in the Road**

Week #6: **E-Examining My Successes**

Week #7: **S-Spreading My Strengths**

Week #8: **S-Savoring My Success**

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Appendix B: Client Mental Health Outcome Measures

PPH Pre/Post-Assessment

1. Client biological gender is: Male Female Other (*specify*): _____

2. Actual date survey administered:

PANAS-C-10

This scale consists of a number of words that describe different feelings and emotions. Indicate to what extent you have felt this way in the past few weeks.

Feeling or emotion:	Very slightly or not at all	A little	Moderately	Quite a bit	Extremely
1. Sad	1	2	3	4	5
2. Happy	1	2	3	4	5
3. Scared	1	2	3	4	5
4. Miserable	1	2	3	4	5
5. Cheerful	1	2	3	4	5
6. Proud	1	2	3	4	5
7. Afraid	1	2	3	4	5
8. Joyful	1	2	3	4	5
9. Mad	1	2	3	4	5
10. Lively	1	2	3	4	5

SLSS

We would like to know what thoughts about life you've had *during the past several weeks*. Think about how you spend each day and night, and then think about how your life has been during most of this time. Here are some questions that ask you to indicate your satisfaction with life. In answering each statement, circle a number from (1) to (6), where (1) indicates you *strongly disagree* with the statement and (6) indicates you *strongly agree* with the statement.

	Strongly Disagree	Moderately Disagree	Mildly Disagree	Mildly Agree	Moderately Agree	Strongly Agree
1. My life is going well	1	2	3	4	5	6
2. My life is just right	1	2	3	4	5	6
3. I would like to change many things in my life	1	2	3	4	5	6
4. I wish I had a different kind of life	1	2	3	4	5	6
5. I have a good life	1	2	3	4	5	6
6. I have what I want in life	1	2	3	4	5	6
7. My life is better than most kids'	1	2	3	4	5	6

ASEBA BPM-Y

[items not presented due to copyright restriction]

Appendix C: Client Treatment Satisfaction

CSQ-8 English

CLIENT SATISFACTION QUESTIONNAIRE
CSQ-8

Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. *Please answer all of the questions.* We also welcome your comments and suggestions. Thank you very much. We appreciate your help.

CIRCLE YOUR ANSWERS

1. How would you rate the quality of service you received?

4 *Excellent*	3 *Good*	2 *Fair*	1 *Poor*

2. Did you get the kind of service you wanted?

1 *No, definitely not*	2 *No, not really*	3 *Yes, generally*	4 *Yes, definitely*

3. To what extent has our program met your needs?

4 *Almost all of my needs have been met*	3 *Most of my needs have been met*	2 *Only a few of my needs have been met*	1 *None of my needs have been met*

4. If a friend were in need of similar help, would you recommend our program to him or her?

1 *No, definitely not*	2 *No, I don't think so*	3 *Yes, I think so*	4 *Yes, definitely*

5. How satisfied are you with the amount of help you received?

1 *Quite dissatisfied*	2 *Indifferent or mildly dissatisfied*	3 *Mostly satisfied*	4 *Very satisfied*

6. Have the services you received helped you to deal more effectively with your problems?

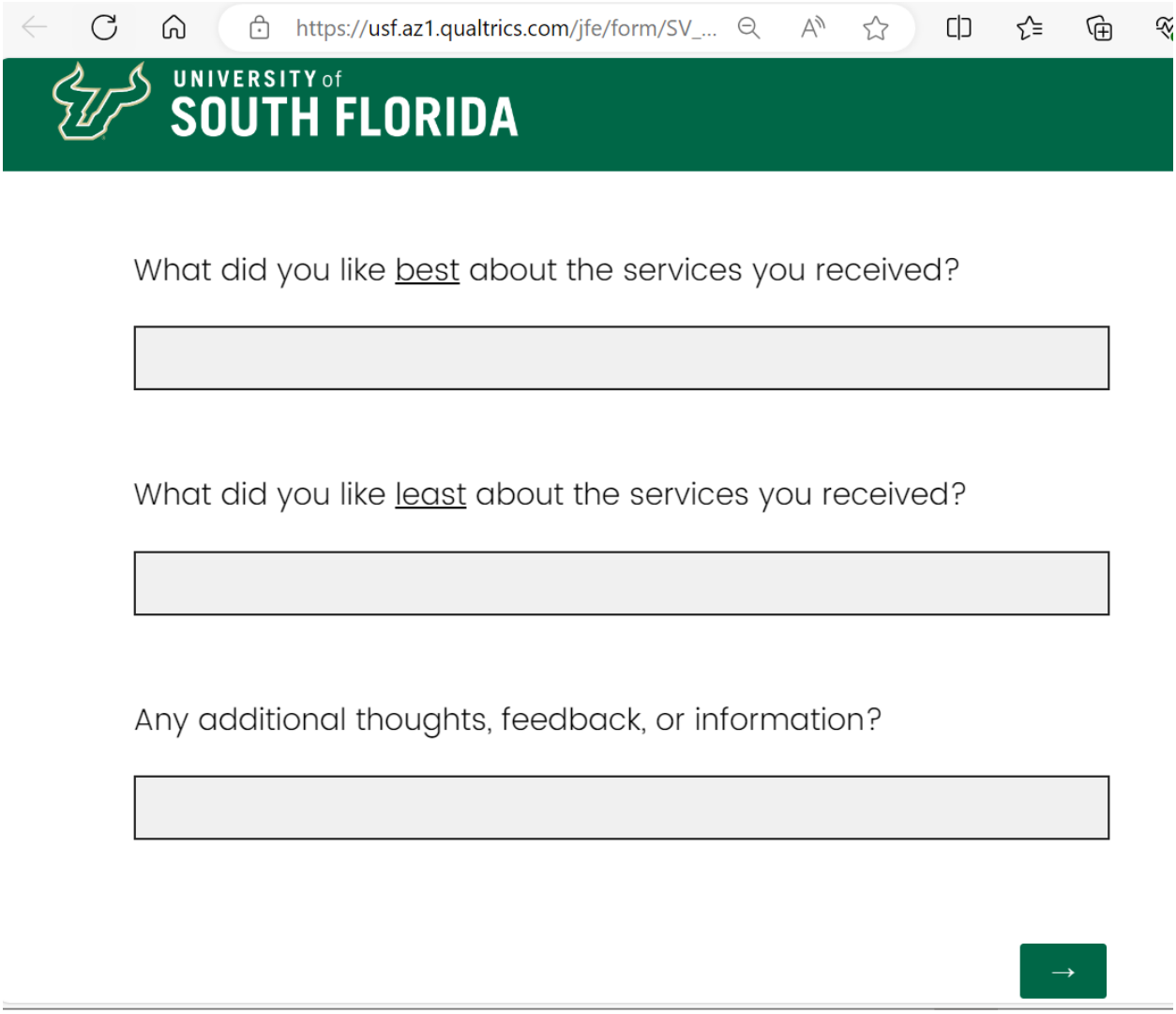
4 *Yes, they helped a great deal*	3 *Yes, they helped somewhat*	2 *No, they really didn't help*	1 *No, they seemed to make things worse*

7. In an overall, general sense, how satisfied are you with the service you received?

4 *Very satisfied*	3 *Mostly satisfied*	2 *Indifferent or mildly dissatisfied*	1 *Quite dissatisfied*

8. If you were to seek help again, would you come back to our program?

1 *No, definitely not*	2 *No, I don't think so*	3 *Yes, I think so*	4 *Yes, definitely*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What did you like best about the services you received?
What did you like least about the services you received?
Any additional thoughts, feedback, or information?
→

Appendix D: Clinician Mental Health Outcome Measures

SATISFACTION WITH LIFE SCALE (SWLS)

This survey assesses your feelings about life. Below are 13 statements with which you may agree or disagree. Using the 1 - 7 scale, indicate your agreement with each item by selecting that response for each statement. Please be open and honest in your responding.

	Strongly Disagree	Disagree	Slightly Disagree	Neither Agree nor Disagree	Slightly Agree	Agree	Strongly Agree
1. In most ways my life is close to my ideal.	1	2	3	4	5	6	7
2. The conditions of my life are excellent.	1	2	3	4	5	6	7
3. I am satisfied with my life.	1	2	3	4	5	6	7
4. So far I have gotten the important things I want in life.	1	2	3	4	5	6	7
5. If I could live my life over, I would change almost nothing.	1	2	3	4	5	6	7

FLOURISHING SCALE

This survey assesses your feelings about life. Below are 8 statements with which you may agree or disagree. Using the 1 - 7 scale, indicate your agreement with each item by selecting that response for each statement. Please be open and honest in your responding.

1. I lead a purposeful and meaningful life.	1	2	3	4	5	6	7
2. My social relationships are supportive and rewarding.	1	2	3	4	5	6	7
3. I am engaged and interested in my daily activities.	1	2	3	4	5	6	7
4. I actively contribute to the happiness and well-being of others.	1	2	3	4	5	6	7
5. I am competent and capable in the activities that are important to me.	1	2	3	4	5	6	7
6. I am a good person and live a good life.	1	2	3	4	5	6	7
7. I am optimistic about my future.	1	2	3	4	5	6	7
8. People respect me.	1	2	3	4	5	6	7

POSITIVE AND NEGATIVE AFFECT (PANAS)

This scale consists of a number of words that describe different feelings and emotions. Read each item and then circle the appropriate answer next to that word. Indicate to what extent you have felt this way during the past few weeks.

	Feeling or emotion:	**Very slightly or not at all**	**A little**	**Moderately**	**Quite a bit**	**Extremely**
1.	Interested	1	2	3	4	5
2.	Distressed	1	2	3	4	5
3.	Excited	1	2	3	4	5
4.	Upset	1	2	3	4	5
5.	Strong	1	2	3	4	5
6.	Guilty	1	2	3	4	5
7.	Scared	1	2	3	4	5
8.	Hostile	1	2	3	4	5
9.	Enthusiastic	1	2	3	4	5
10.	Proud	1	2	3	4	5
11.	Irritable	1	2	3	4	5
12.	Alert	1	2	3	4	5
13.	Ashamed	1	2	3	4	5
14.	Inspired	1	2	3	4	5
15.	Nervous	1	2	3	4	5
16.	Determined	1	2	3	4	5
17.	Attentive	1	2	3	4	5
18.	Jittery	1	2	3	4	5
19.	Active	1	2	3	4	5
20.	Afraid	1	2	3	4	5

PERCEIVED STRESS SCALE (PSS)

Instructions: The questions in this scale ask you about your feelings and thoughts **during the last month**. In each case, indicate *how often* you have felt or thought a certain way.

In the last month…	**Never**	**Almost Never**	**Some-times**	**Fairly Often**	**Very Often**
1. How often have you been upset because of something that happened unexpectedly?	0	1	2	3	4
2. How often have you felt that you were unable to control the important things in your life?	0	1	2	3	4
3. How often have you felt nervous and "stressed"?	0	1	2	3	4
4. How often have you felt confident about your ability to handle your personal problems?	0	1	2	3	4
5. How often have you felt that things were going your way?	0	1	2	3	4
6. How often have you found that you could not cope with all the things that you had to do?	0	1	2	3	4
7. How often have you been able to control irritations in your life?	0	1	2	3	4
8. How often have you felt that you were on top of things?	0	1	2	3	4
9. How often have you been angered because of things that were outside your control?	0	1	2	3	4
10. How often have you felt difficulties were piling up so high that you could not overcome them?	0	1	2	3	4

Appendix E: Training in PPH Among the Treatment Group

Acceptability of PPH Professional Development

(questions that clinicians answered after completing each workshop)

Think about the professional development you just completed on Zoom, and answer the 5 items with your opinion about the virtual workshop and level of agreement with the following:

	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
The material in the workshop enhanced my knowledge of positive psychology interventions.	○	○	○	○	○
The material in the workshop was easy to understand.	○	○	○	○	○
The amount of material presented was appropriate for the time available for the session.	○	○	○	○	○
I am likely to use what I learned today with my clients.	○	○	○	○	○
I am confident that I could use the assessment and interventions tools discussed in this workshop.	○	○	○	○	○

What part of this workshop did you find the most interesting or useful?

What recommendation(s) for change to this workshop do you have?

What main ideas (takeaway points) did you learn from this workshop?

What questions would you like the presenters to address during the next workshop?

(questions that clinicians answered after the full initial training)

PART I: Please complete this 20-item survey to evaluate the quality of the initial training you just completed in Positive Psychology through Happiness (PPH).

1. The communication I received in advance of the workshops gave me the information I needed to prepare for the virtual training.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Neither Agree nor Disagree
- ◯ Agree
- ◯ Strongly Agree

5. Facilitators presented the material clearly.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Neither Agree nor Disagree
- ◯ Agree
- ◯ Strongly Agree

16. Facilitators were personally connected to the participants.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Neither Agree nor Disagree
- ◯ Agree
- ◯ Strongly Agree

17. I feel prepared to implement the intervention in my setting.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Neither Agree nor Disagree
- ◯ Agree
- ◯ Strongly Agree

10. The material was well-organized.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Neither Agree nor Disagree
- ◯ Agree
- ◯ Strongly Agree

Fidelity Checklist- Interventionist Initial Training in the PPH V1.1 (9/1/22)

Date: __9/1/2022__ **Participants:** (complete attendance log), *N* = __14____
Study Staff- Facilitator(s): _____Shannon Suldo/Julie Taylor_____ **FOI Recorder:** _____Camryn Legra _____

Workshop 2			
A. Online Workshop Preparation (Est. Time – 10 min).			**Start Time: _9:52__End Time: _10:07**
1. Platform with desired characteristics secured (e.g., Zoom).	No	Yes	
2. Ensured that presenter Wi-Fi, video, and audio worked.	No	Yes	
3. Open the platform 5 -10 minutes before start time to allow participants to join early and trouble shoot technology issues.	No	Yes	
4. Ensured that chat box, audio, and video is enabled for all participants.	No	Yes	
5. Desired facilitator to participant ratio obtained (at least: 1 per 4 participants)	No	Yes	3:14
B. Refresher of Workshop 1 (Est. Time – 30 mins). Start Time: 10:07_End Time: __10:42_.			
6. Greet participants upon arrival for workshop 2	No	Yes	
7. Workshop materials reviewed (manual, PowerPoint, etc.).	No	Yes	
8. Overview of professional learning workshop series reviewed.	No	Yes	
9. Workshop agenda (objectives and activities) reviewed.	No	Yes	
10. Benefits of subjective well-being reviewed.	No	Yes	
11. Outcomes of school-based positive psychology interventions reviewed.	No	Yes	
12. Learning from clinicians – discussion of clinicians' experiences with PPH to date.	No	Yes	
13. Instructions for using Evoly for assessments	No	Yes	Some questions about Pre-Test on evolve
14. HAPPINESS Curriculum acronym reviewed.	No	Yes	
15. ACTS Curriculum acronym reviewed.	No	Yes	
C. Using the HAPPINESS Curriculum: P- P- I (Est. Time – 30 mins).			**Start Time: 10:43__; End Time: _11:45__**
16. Producing Positive Thoughts and Actions Overview.	No	Yes	
17. Producing Positive Thoughts and Actions, Theory of change introduced.	No	Yes	
18. Producing Positive Thoughts and Actions, discussion of clinicians' personal experiences with change goals.	No	Yes	Went over pilot clinicians experiences
19. Producing Positive Thoughts and Actions Cognitive copy worksheets introduced.	No	Yes	
20. Producing Positive Thoughts and Actions Talking Points reviewed.	No	Yes	
21. Producing Positive Thoughts and Actions Simple changes or Set a goal reviewed.	No	Yes	
22. Discussion time activity for Producing Positive Thoughts and Actions	No	Yes	
23. Break provided	No	Yes	11: 28-11: 35
24. Practicing My Daily Habits Overview	No	Yes	
25. Practicing My Daily Habits Activities introduced	No	Yes	
26. Practicing My Daily Habits Cognitive copy worksheets introduced.	No	Yes	
27. Practicing My Daily Habits Talking points reviewed.	No	Yes	
28. Practicing My Daily Habits Simple changes or Set a goal reviewed.	No	Yes	
29. Investigate a New Way of Doing Things Overview.	No	Yes	Start @ 11:45
30. Investigate a New Way of Doing Things Activities introduced	No	Yes	
31. Investigate a New Way of Doing Things Cognitive copy worksheets introduced.	No	Yes	
32. Investigate a New Way of Doing Things practice with Cognitive copy worksheet.	No	Yes	
33. Investigate a New Way of Doing Things Talking Points reviewed.	No	Yes	
34. Investigate a New Way of Doing Things Simple changes or Set a goal reviewed.	No	Yes	
35. Learning from clinicians – discussion of clinicians' reactions and questions	No	Yes	Time was set aside, but there were no questions
36. Participants asked to complete professional development (workshop 2) anonymous feedback survey.	No	Yes	_10__ of 14___ Participants completed
Workshop 2, Fidelity to Training Protocol Score: A. # of session elements completed (circled "Yes"): 35 B. # of session elements possible (36 – N/A items): 36 % of elements completed (Line A / Line B): 97.2%			

Appendix F: Fidelity of PPH Usage among the Treatment Group

SELF-REPORT OF FIDELITY OF USE OF PPH ASSESSMENT AND HAPPINESS CURRICULUM

The new items for myEvolv to add immediately after the PPH questions (e.g., after "*I feel satisfied with my life as a whole*"), new items for myEvolv:

Q1. Which step(s) in the HAPPINESS curriculum did you access in today's session? (*check all that apply)*

- H – Understanding Happiness
- A – Assessing Where I Am Now
- P – Producing Positive Thoughts and Actions
- P – Practicing My Daily Habits
- I – Investigating a New Way of Doing Things
- N – Navigating the Bumps in the Road
- E – Examining My Successes
- S – Spreading My Strengths
- S – Savoring My Success
- None, I did not use the HAPPINESS curriculum in today's session

Q2. Within the HAPPINESS step(s) accessed today, which of the ACTS learning opportunities did you use in the session? *(check all that apply)*

- Activities
- Cognitive Copy
- Talking Points
- Simple Changes
- None of the ACTS; (briefly describe why not or what else was used in the session: _____

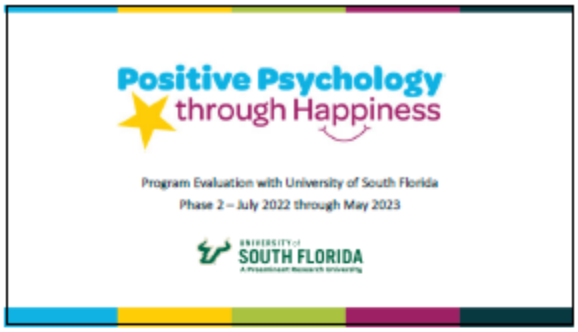
Q3. Approximately how much of this session did you use the PPH Assessment and HAPPINESS Curriculum?

- Nearly all (close to 100% of session content)
- Most (about 75% of session content)
- About half (about 50% of session content)
- Some (up to 25% of session content)
- None (0%)

Q4. What activities or interventions did you use in this session OTHER THAN the PPH?

- NONE; I only used the PPH Assessment and HAPPINESS Curriculum in this session
- I used... (briefly describe the activities or intervention that you used in this session that are not in the PPH manual)_____

Appendix G: Slides from Presentation during Assessment Training



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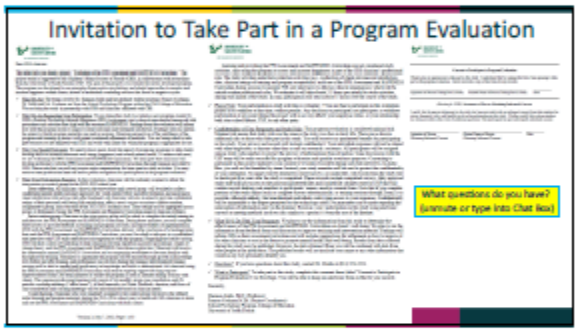

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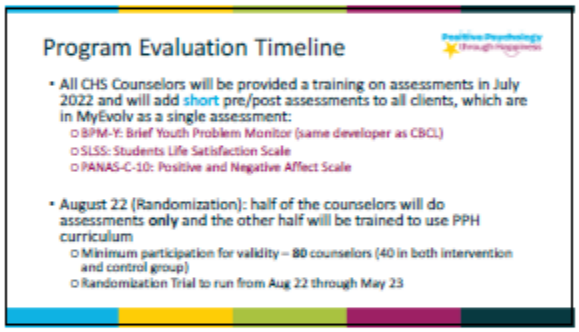

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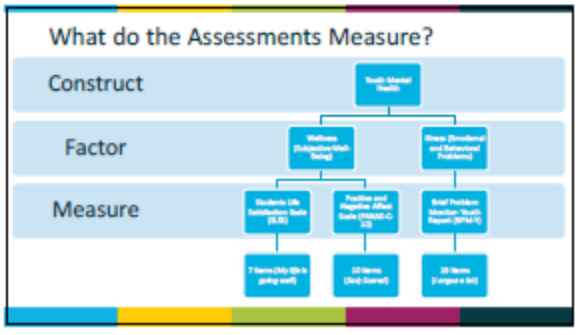

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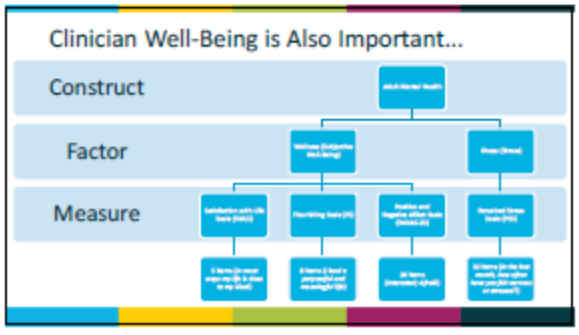

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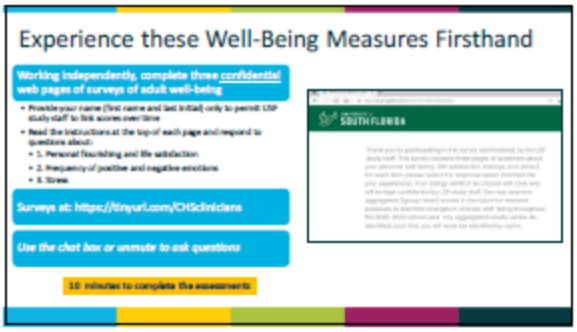
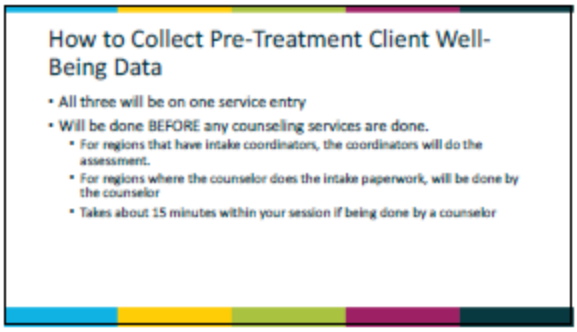
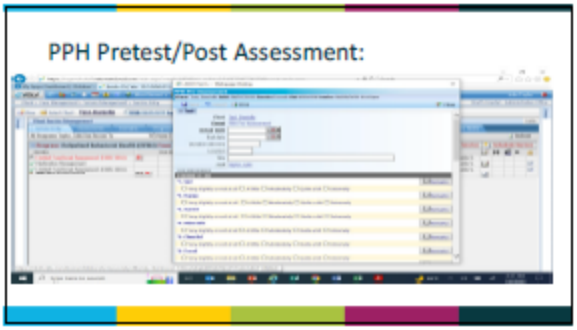

Experience these Well-Being Measures Firsthand
Working independently, complete three confidential web pages of surveys of adult well-being
Provide your name (first name and last initial) only to permit USF study staff to link scores over time
Read the instructions at the top of each page and respond to questions about:
1. Personal flourishing and life satisfaction
2. Frequency of positive and negative emotions
3. Stress
Surveys at: https://tinyurl.com/CHSclinicians
Use the chat box or unmute to ask questions
10 minutes to complete the assessments

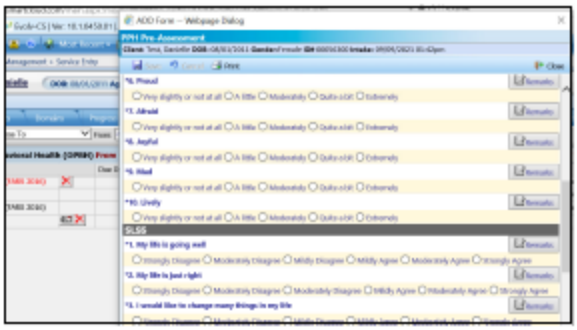
7


How to Collect Pre-Treatment Client Well-Being Data
All three will be on one service entry
Will be done BEFORE any counseling services are done.
For regions that have intake coordinators, the coordinators will do the assessment.
For regions where the counselor does the intake paperwork, will be done by the counselor
Takes about 15 minutes within your session if being done by a counselor

8


PPH Pretest/Post Assessment:

9



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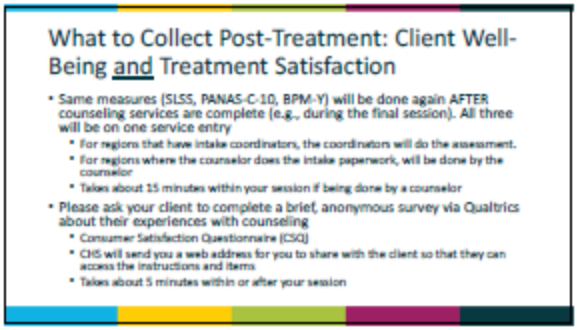
What to Collect Post-Treatment: Client Well-Being and Treatment Satisfaction
Same measures (SLSS, PANAS-C-10, BPM-Y) will be done again AFTER counseling services are complete (e.g., during the final session). All three will be on one service entry
For regions that have intake coordinators, the coordinators will do the assessment.
For regions where the counselor does the intake paperwork, will be done by the counselor
Takes about 15 minutes within your session if being done by a counselor
Please ask your client to complete a brief, anonymous survey via Qualtrics about their experiences with counseling
Consumer Satisfaction Questionnaire (CSQ)
CHS will send you a web address for you to share with the client so that they can access the instructions and items
Takes about 5 minutes within or after your session

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Appendix H: Clinician Consent Form

Dear CHS clinician:

This letter tells you about a project, "Evaluation of the PPH Assessment and HAPPINESS Curriculum." The project/study is supported by the Children's Home Society of Florida (CHS), in collaboration with researchers from the University of South Florida (USF). The goal of the project is to evaluate the newly developed program. The program was developed to use principles from positive psychology and related approaches to monitor and increase happiness within clients, instead of traditional counseling services that focus on negative cycles.

- ✓ Who We Are: The team is led by Dr. Shannon Suldo and her graduate student assistant, Frances Coolman. Dr. Suldo and Ms. Coolman are from the School Psychology Program within the USF College of Education. We are doing the study in partnership with CHS and clinicians affiliated with CHS.
- ✓ Why We Are Requesting Your Participation: We are doing this study to evaluate a new program created by CHS—Positive Psychology through Happiness (PPH) Assessment, and a clinical intervention framework with procedures and activities that align with the acronym HAPPINESS. Findings from the evaluation will inform how well the program works to improve client outcomes and treatment satisfaction. Findings will also inform the extent to which program materials are used in sessions. Clinician perspectives of the usefulness of the program and trainings to learn it will permit continued refinement of materials. You are being asked to take part because you are affiliated with CHS and work with clients for whom the program is appropriate for use.
- ✓ Why You Should Participate: We need to know more about the impact of promising programs to help clients develop skills to increase emotional well-being (happiness) and overall mental health. To address this need, we are evaluating the PPH Assessment and HAPPINESS Curriculum. We anticipate that clinicians will develop proficiency with the PPH Assessment and HAPPINESS Curriculum through trainings provided by CHS. Please note that you will not receive extra compensation for time spent in study activities. You may receive some professional time off and/or public recognition for participation in the program evaluation.
- ✓ What Your Participation Requires: In this evaluation, clinicians will be randomly assigned to either the *intervention* or *control* group for the 2022-2023 school year.

  Data collection. All clinicians- those in the *intervention* and *control* group- will be asked to collect confidential mental health outcomes measures for youth clients before and after treatment, and anonymous client satisfaction with services data after treatment. All clinicians will also be asked to provide confidential ratings of their personal well-being (life satisfaction, affect, stress) on two occasions—before random assignment to group, and at the end of the 2022-2023 academic year. These ratings will be aggregated across groups to determine if using the PPH Assessment and Happiness Curriculum impacts clinician wellness.

  Intervention group. Clinicians in the *intervention* group will be asked to complete the initial training in, and then use, the PPH Assessment and HAPPINESS Curriculum. During these activities, you will complete brief surveys to provide feedback on training and program activities, and report fidelity of implementation (FOI) with the PPH Assessment and HAPPINESS Curriculum delivery. After conclusion of a treatment plan that used the PPH Assessment and HAPPINESS Curriculum, you may be asked to take part in a confidential exit interview with USF study staff about your experiences with the program. Regarding the ***initial training,*** CHS will host a series of workshops to help clinicians develop expertise in positive psychology, stages of change theory, and the PPH Assessment and HAPPINESS Curriculum in particular. Clinicians will receive the intervention manual *HAPPINESS Curriculum* and accompanying worksheets to become familiar with throughout the training. Readiness to implement the program will be ensured through growth on knowledge tests before and after training, and performance on activities during the training. Individualized training sessions will be held as needed until proficiency in knowledge and skills is demonstrated. All clinicians using the PPH Assessment and HAPPINESS Curriculum will receive ***ongoing support during program implementation*** from CHS team members to ensure the program is used as intended during sessions with clients. This ongoing professional learning will consist of (a) monthly group case consultation, and (b) periodic coaching meetings ("office hours"), all held remotely via Zoom. Feedback, duration, and focus of case consultation and coaching meetings will be individualized based on clinician needs.

  Control group. Clinicians who were randomly assigned to the control group will receive the refined initial training and program materials during the 2023-2024 school year, to enable all CHS clinicians to learn and use the PPH Assessment and HAPPINESS Curriculum with their clients.

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Learning and providing the PPH Assessment and HAPPINESS Curriculum are not considered study activities, since using the program to assess and increase happiness is part of the CHS clinician's professional role. The study activities entail data collection activities (e.g., collection of client outcome and satisfaction data; clinician ratings of training and program acceptability, and use of the PPH Assessment and HAPPINESS Curriculum during sessions to monitor FOI; exit interviews to discuss clinical experiences), which will be outside routine professional roles. We estimate it will take about 2-3 hours per month for study activities, during each month of the study. In sum, participation will total about 15 hours over the course of the study.

- ✓ Please Note: Your participation in study activities is voluntary. You are free to participate in this evaluation project or to withdraw at any time, without penalty. Any decision to participate, not participate, or withdraw participation at any point during the project will in no way affect your employee status, or your relationship with your school/district, USF, or any other party.

- ✓ Confidentiality of Your Responses and Study Risks: This program evaluation is considered minimal risk. Minimal risk means that study risks are the same as the risks you face in daily life. There are no known additional risks to those who take part in this study. You will receive no guaranteed benefits by participating in this study. Your privacy and records will be kept confidential. Your individual responses will not be shared with other employees, or anyone other than us and our research assistants. All participants will be assigned unique study code numbers to protect the privacy of information from all parties. Some discussions with the USF team will be audio recorded for program evaluation and quality assurance purposes. Consenting to participate in this project indicates your consent to be audio recorded during such exit interviews. In audio files, you will not be identified by name. Instead, your study number will be used to protect the confidentiality of your statements. No names will be attached to stored surveys or audio files. All records from the study will be destroyed five years after the study is completed. These records include completed surveys. Only approved study staff will have access to the password-protected files and locked file cabinets stored at USF that will contain records linking code numbers to participants' names, and/or consent forms. Note that if you complete portions of the study online (such as complete surveys electronically, or training sessions through Zoom), it is possible, although unlikely, that unauthorized individuals could gain access to your responses. Confidentiality will be maintained to the degree permitted by the technology used. No guarantees can be made regarding the interception of information sent via the Internet. However, your participation in this study using electronic surveys or meeting methods involves risks similar to a person's everyday use of the Internet.

- ✓ What We'll Do With Your Responses: We plan to use the information from this study to determine the effectiveness of the PPH Assessment and HAPPINESS Curriculum on clients' well-being. We plan to use the information from feedback forms and discussion to improve training and intervention materials. Findings will inform CHS on their assessment/curriculum and will include suggestions for refinement on how to improve it for other clinicians to use in the future to promote mental health and well-being. Results from data collected during this study may be published. However, the data obtained from you will be combined with data from other people in the publication. The published results will not include your name or any other information that would in any way personally identify you.

- ✓ Questions? If you have questions about this study, contact Dr. Suldo at (813) 974-2223.

- ✓ Want to Participate? To take part in this study, complete this consent form (titled "Consent to Participate in Program Evaluation") via DocuSign. You will be able to keep an electronic form on file for your records.

Sincerely,

Shannon Suldo, Ph.D. (Professor)
Frances Coolman M.Ed. (Project Coordinator)
School Psychology Program, College of Education
University of South Florida

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USF RESEARCH & INNOVATION

Consent to Participate in Program Evaluation

I freely give my permission to take part in this study. I understand that by signing this form I am agreeing to take part in the program evaluation. I have received a copy of this form for my records.

Signature of Person Taking Part in Study	Printed Name of Person Taking Part in Study	Date

(Portion for USF): **Statement of Person Obtaining Informed Consent**

I certify that the person taking part in the study has been provided with an informed consent form that explains the nature, demands, risks, and benefits involved in participating in this study. I further certify that a phone number has been provided in the event of additional questions. This participant has provided legally informed consent.

Signature of Person Obtaining Informed Consent	Printed Name of Person Obtaining Informed Consent	Date

Appendix I: Qualitative Data from End-of-Workshop Surveys

Table 9. *Clinician Qualitative Responses to Acceptability Survey After Each Workshop (Combined Cohorts 1 and 2)*

	Questions Posed to Clinicians			
	What part of this workshop did you find the most interesting or useful?	**What recommendation(s) for this workshop do you have?**	**What main ideas (takeaway points) did you learn from this workshop?**	**What questions would you like presenters to address during the next workshop?**
Responses for Workshop 1	The cake baking activities The information regarding Happiness defined in the very beginning Ranking time spent in happiness The theory/modalities based off the curriculum Assessing my happiness Empowering clients to feel happier Tools (worksheets, talking points, activities) I enjoyed being able to apply some of the workshop to myself and assess my own level of happiness The actual curriculum How positive psychology does not begin by focusing on the client's negative behaviors The entire concept of PPH Practical examples The pillars slide, discussion Top 3 happiness items The actual importance of assessing your level of happiness and how it related to mental health. As well as behavioral actions, academics, etc. Overall learning about the program Visuals The assessment Having the client give feedback	Maybe make it shorter and more to the point Extensive training to practice Involving audience more, and discuss more realistic cases Spend more time on the different activities More interactions with the audience Continue working with trauma narrative More application examples There should be more interaction so participants do not get bored or feel tired from just sitting in a seat looking at the screen More activities Make a drop box with information so we can get it on our own Include more background on cultural competency of development for clients impacted by systems that negatively effect happiness	Do the work for the best outcome We are going to work on this Assisting clients to find their own goals To look through a different professional lens when practicing in the fiels The idea that when focusing on the happiness from the onset of the session with a client can change the trajectory of the session and bring more quality conversations and interactions with the child Life satisfaction can be measured in 4 categories The Significance of induvial happiness and what that means What PPH is (more in depth) and how to use it Having a focus on positive psychology can affect all aspects of your life This seems easy to implement	When discussing their happiness in what they can control- how do you balance cognitive reframing without moving towards toxic positivity? Time to practice prior to implementation with clients Go over the rest of the letters Knowing which client is best for PPH Experiences with clients Entering into MyEvolv Clients with trauma history and experiencing trauma

	Showing images of the assessments and tools The purpose behind the study and wanting to invoke and incrase hapiness within our clients and ultimately our community Everything Learning about the ACTs activities to do with clients The information was great, I just wish I had a copy of the PPT before the training so I could make my notes in it Interventions		Better emotional development for kids We can find something positive in every situation. Happiness is a choice This resonates with me because I tent to ask: what is good? Rather than what is wrong Top 3 happiness items Simply how differently happiness is interpreted Ways to ask questions about happiness or describe happiness How to help children learn valuable skills to bring happiness in their world Cognitive reframing Warning clients to be happy with what they have and where they are Learned about myself What is SWB and how it affects us all Cognitive Reframing The structure	
Responses for Workshop 2	The examples helped to put in perspective and see client progress in each step. I was also able to establish a routine to prepare me for session Talking points that can be utilized to facilitate client engagement	Hands on learning More worksheets on how to do activities with the clients Having clinicians fill our the worksheets on themselves or a client and share	Theories of change and the elimination of the relapse piece and how we can help to facilitate progress even if there is a bump Steps of change	What if a client becomes resistant during series? Are there daily tracks for the positive psychology practice? Talk more about workbooks

	All Technically how to use it with the materials, ideas, and tips Examples to use with the children The activities Going over worksheets Making option plans of options The discussion Worksheets Work sheets to use in sessions Learning to focus on positive aspects of people over their negative thoughts The practice section Being able to apply the stages of change to my own life/behaviors Cognitive Copy of Happiness Goals Everything, I am very excited to implement PPH with my upcoming clients The incorporation of PPH with traditional approaches How to implement with the family In the piece about investigating new ways of doing things and how coming up with additional plans is beneficial to achieve the goal Encouraging small steps Techniques for practical use There is nothing specific that stuck out Wealth of information The visual helped me alot	More explanation on how to incorporate this with therapy sessions More activities during the workshop Addressing systemic challenges to happiness Can we get a copy of the slides before the workshop? The slides move too fast for note taking Use more group interaction	Positive Psychology is something we need to continuously practice To be creative with the kids Ways to help clients start thinking more positively Curriculum Know clients readiness PPH when done correctly greatly enhances the client The change steps How happiness make the sessions go better The execution of the PPI letters That there is not just one way to help change and focus on your happiness That failing with the first option of a goal does not mean that the goal itself is unreachable. This is something personal for me with my own happiness goals Affirmed held beliefs How to prepare to help the clients That it is common to use PPH with other modalities Empowering clients to define success I like the small steps and not calling things a failure if it did not work	Putting the information in MyEvolv, worksheets, etc Incorporating with therapeutic techniques

			There is nothing specific that stuck out Challenging myself to make a positive change I learn a lot about having 3 options	
Responses for Workshop 3	I enjoyed the concepts overall, I like the structure of the process and the assigned activities to help to guide the process Character strengths I really enjoyed taking the strengths quiz to identify my top strengths I believe the ACTS are very useful within sessions Strategies and worksheets The "H" through "I" Everything Celebrating Success! I love the intervention shared by Julie. Powerful. Explanation of the N-E-S-S Part 2 Strength oriented goals Engaging the clients in the sessions with the new curriculum Celebrate Savoring my success Tools (worksheets, activities, etc) Perspective on happiness Everything It was all interesting Examine my success- I think the success journal is a brilliant idea Applicable interventions ACTS	Practice more during trainings Give the workshop material before the corresponding session More interactive Finding a way to approach this practice as a way for clinician to use skills and not just as an entire program. I did not agree with multiple parts of this theory but I did enjoy some interventions that were discussed so possibly finding ways to discuss the intervention pieces without it being tied to the theory, if that makes sense or is possible. Practical examples through video of actual sessions Continuing to evaluating the role of systemic issues that affect client's outlook More group interaction More practical application More examples Perhaps videos applying these techniques with clients that we can preview	The influence of taking the positive approach to addressing needs of a client Savoring Success I learned how to work with the client in the action stage and also support the client if relapses occur Continuing the conversation with client about next steps happiness requires time and dedication This could help with setting goals on treatment plans Happiness Keep it fun Happiness is a journey not a destination The importance of allowing children and adolescents to understand the importance of their happiness That you can use your clients strengths to help guide and empower them through this process Listen to the client as they work for their happiness The discussion of ages	More examples Working with the sheets/handouts Talk about engaging young kids To see videos of these steps being used with clients- children and adults

	Creative elements to add to the work The survey Finishing with modality and strengths The e.n.s Intervention about success in life Examples I prefer to hear the stories of people who have used this with their client successfully and their stories Explanation of topics Creative ways to reinforce this technique with children and adults	The family can be involved in the process even though we focus on the child Cultivating success for clients How to better engage clients The "spreading my strengths" as I find so many of my young clients simply unaware of their personal strengths I love the story that truly told about her client being able to realize her success with the help of the visual aid of crepe paper Helping the clients to savor their success at the end of treatment How to utilize clients skills into treatment Navigation Empowerment Bumps in the road Success work How to use the letters and their curriculum Goals and interventions Steps to change How to use the curriculum How to reframe thinking and empower clients

Note. Responses such as "Not Applicable," "None at the moment," or similar are excluded from this table. Responses are largely verbatim although some have been edited for grammatical clarity.

Appendix J: Qualitative Data from End-of-Training Survey

Table 11. *Clinician Responses to Open-Ended Items on End-of-Training Acceptability Survey*

	Questions Posed to Clinicians		
	18. What was the most useful part of this training?	**19. What was the least useful part of this training?**	**20. What changes, if any, would you suggest?**
Responses	• The organization of the curriculum and how it flows making it easy to follow with a client • A new method of providing services which focuses on the positive • Being able to offer various ways to deliver skill techniques to clients (worksheets, activities, or discussions) • The ACTS, examples from other clinicians • The Worksheets provided • All of it. Training was exciting. The information shared was greatly appreciated • The examples given and the explanations regarding the training and goals • Understanding Happiness for myself (counselor know thy self) then using it forward! The facilitators were great • Activities to introduce to the clients • Trainers were very knowledgeable • Getting to practice some interventions on myself • The easy acronym • Going through the manual • The paradigm shift • Finding ways to be happy • The breakdown of different steps • The break down in different steps	• Talking too long on presentations sometimes • Doing the surveys • Time management was off at times and breaks do not happen when they are scheduled. • Pacing was too fast • No group interaction • It went too quickly in the third part. Too much time in-between trainings	• None (x24) • Printing the hardcopy of the manual at the start (x4) • Inclusion of section on addressing systemic influences on PPH outcomes • Greater Income Potential • Integration with other disciplines • To continue to include the client in the aspects that pertain to them. • Some of us have been so trauma focused and driven that we also neglect happiness and its importance. • More active • Know the population

	• Learning a new way to help my future clients manage difficult feelings and emotions that often lead to negative behaviors • Learning a new perspective on how to support clients in perceiving themselves and their lives on more positive terms • Ease of using the trainings with kids • The knowledge of how to use PPH with our clients and families • Ability to ask questions openly and honestly without judgment • Examples of how to use the material • Having access to the manual while going through the client

Note. Responses such as "None," "Not Available," or similar are excluded from this table. Responses are largely verbatim although some have been edited for grammatical clarity.