School-Based Mental Health: Program Evaluation Results, 2012-2013

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Executive Summary: 2012-2013 Doing Evaluation Program

Child and Family Centre: School-Based Mental Health Program Evaluation
Linda Dugas, Director of Clinical Services
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The School-Based Mental Health program (SBMH) is an extension of the Child & Family Intervention Program (CFI), a core clinical program at the agency which was implemented in its actual setting in August 2011. The program is offered in collaboration between CFC and its four local School Boards. The overall goal of the program is to facilitate access and provide time-limited intervention to youths 12 -18 years of age who are struggling with mental health problems in their school milieu.

The Purpose

- To determine the effectiveness of the program with respect to the delivery of its services based on evidence informed practices and client outcomes.
- To evaluate stakeholder satisfaction (client, school representative and clinician), average number of sessions per client, target population, number of eligible and excluded referrals and the most prevalent presenting problem treated.
- To measure whether the program has served to improve behavioural, emotional and academic functioning, as well as problem solving skills for the youth.

The Program

The School-Based Mental Health Program serves youths, male and female, between the ages of 12 to 18 years who are referred by the representatives of the four school boards out of concern for the youth’s mental health problems. Most often, presenting concerns include depression, anxiety, substance use, and family and peer conflicts.

All services are provided in a confidential setting in the school milieu. Interventions are time-limited (up to 12 sessions) and the treatment approaches utilized include Motivational Interviewing, Cognitive Behavioural Therapy and Solution-Focused Therapy. The program’s capacity is targeted at 150 clients served per year.

The Child and Family Centre is building an infrastructure that allows for program evaluation across the Agency, particularly for new initiatives such as the School-Based Mental Health Program. The evaluation of this program will inform clinical practice and will allow shifting in order to better meet the client needs.

The Plan

The referral form is the chosen tool to collect demographic data, target population, number of eligible and excluded referrals and the most prevalent presenting problems. Two surveys were designed to
measure the Client’s and School’s satisfaction with services. We also conducted interviews with Clinicians and a Youth Focus Group to measure overall satisfaction with services. In order to measure outcomes, we utilized The Children’s Hope Scale (relating to problem-solving skills) and the Child and Adolescent Functional Assessment Scale (CAFAS), relating to the client’s behavioural, emotional and school functioning. Finally, we measured the average number of sessions and outcome at closure with the Agency’s File Disposition Form.

Data was collected on the Agency’s “Dashboard” which is a Central Data System. Statistical analysis was conducted utilizing SPSS and Microsoft Excel computer software. The Agency collected data for this evaluation throughout the school year (September 2012 to June 2013). The total referral sample was 126 students.

The Product

During the evaluation period, 126 students were referred to the SBMH program. Results indicate overall Stakeholder (client, school representatives and clinicians) satisfaction with School-Based Mental Health services. 93.7% of clients who completed the client feedback questionnaire agreed or strongly agreed to being satisfied with services. Common themes emerged from the clinician interviews, Youth Focus Group and comments from the satisfaction questionnaires: The desire for increased capacity and increased awareness of Mental Health services in schools and the community.

The average number of sessions required to attain treatment goals is mean=5.3 sessions which respects the time-limited design of the program, however results indicate that the length of time (number of days) required to complete treatment is an average of 7 months. These results validate the importance of addressing treatment progress barriers identified, such as students’ attendance/truancy issues and “school life” barriers.

Students who completed the SBMH service were more likely to have lower CAFAS scores at time T14 upon exiting the program, which indicates an increase in overall functioning. Unfortunately, the small sample size of CAFAS scores limited what one can infer about the effectiveness of the program on the various CAFAS subscale scores. These results serve to guide the Agency to redefine the standard for CAFAS completion of clients being served within a time-limited program. Results also reflect the fact that many clients who were referred during this evaluation period (September 2012-June 2013) were still receiving treatment at the time of this report and had yet to complete the CAFAS at T14. As we continue the evaluation of this program and increase our sample size, we hope to gain further insight as to the effectiveness of the program in regard to increasing behavioural, social, emotional, and academic functioning. Finally, results indicate that the School-Based Mental Health program serves to increase the youth’s perceived problem-solving skills (89%) as measured by the Children’s Hope Scale.

The Child and Family Centre has acquired knowledge from the SBMH program evaluation process and has developed an infrastructure and evaluation model for future program evaluations. The Agency extends this knowledge to community partners and future program evaluation stakeholders. As CFC shares this knowledge, the Agency Staff, Community Partners and stakeholders will develop greater confidence, awareness and enthusiasm towards future program evaluation initiatives.

Final report received: October 31, 2013
Region: Sudbury, ON, Northeast Region
Introduction and Literature Review

Using qualitative and quantitative methods, a program evaluation was undertaken to investigate the effectiveness of the School-Based Mental Health Program and processes. Specifically, the evaluation explored client characteristics, client outcomes, and stakeholder satisfaction in order to facilitate program development.

Program Overview

Research has shown that the schools are an ideal venue for providing mental health services to youth because youth spend a great deal of time at school (Anglin, 2003; Wei & Kutcher, 2011). Furthermore, school may be the first and only place where mental health services are received (Burns et al., 1995) and the consequences of not receiving timely treatment may have serious implications for academic functioning (Owens & Murphy, 2004; Wei & Kutcher, 2011; Weist, Goldstein, Morris, & Bryant, 2003). In contrast, providing access to school based mental health services may improve behavioural and emotional functioning, coping skills, attendance, and disciplinary referrals (Weist et al., 2003). A large body of literature suggests that school based mental health services are effective for presenting issues such as depression, anxiety, and substance abuse (Armbruster & Lichtman, 1999; Shirk, Kaplinski, & Gudmunsen, 2009; Weist, Paskewitz, Warner, & Flaherty, 1996).

The School-Based Mental Health Program (SBMH) was developed with the overarching goal of increasing access to time-limited intervention in the school setting for adolescents struggling with mental health difficulties. SBMH is an extension of the Child and Family Intervention Program (CFI) and was first implemented in August, 2011. The SBMH is a collaboration between the Child and Family Centre (CFC) and four local School Boards (English/French Separate and Public). In order to facilitate access to services, the Child and Family Centre has dedicated two Clinicians to the program and the
School Boards provide the space and equipment required for confidential clinical work to be conducted in the school setting.

The major objective of the SBMH Program is to increase and facilitate access to a time-limited intervention for students who are struggling with mental health problems in the school setting. The SBMH program seeks to increase social, emotional, and academic functioning among adolescents between the ages of 12 and 18 who live in Sudbury and the surrounding area. During this evaluation period (September, 2012 – June, 2013), the SBMH program served 126 youth with primary presenting concerns including depression, anxiety, substance use, and family and peer conflicts.

Students are referred to the Child and Family Centre Program Manager by referral agents who complete a referral package that includes the Referral Form (Appendix A) and the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA; Gowers et al., 1999). Referral agents may include guidance counsellors, teachers, principals or social workers. When eligibility is determined through the referral package, students are assigned to a Clinician who engages the adolescent in orientation to services. If the student decides to continue with services, the Clinician completes a comprehensive time-limited assessment. At that time, the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 2000) and the Children’s Hope Scale (Snyder et al., 1997) are completed as pre-outcome measures.

A time-limited treatment plan is then developed by the Clinician based on the student’s identified strengths and needs. Treatment may last a maximum of 12 sessions and may include Cognitive Behavioral Therapy, Solution-Focused Therapy, and motivational interviewing approaches. Clinicians have received training in all of these treatment modalities and continue to receive on-going support through further training, supervision, and participation in Communities of Practice.
A literature review revealed that these therapeutic approaches are supported as treatments for issues commonly faced by adolescents. Cognitive Behavioral Therapy has been demonstrated to be effective in treating adolescent depression (Chu & Harrison, 2001; Michael & Crowley, 2002; Shirk et al., 2009; Spielmans, Paske, & McFall, 2007) and anxiety (Cartwright-Hatton, Roberts, Chitsabesan, Forthegill, & Harrington, 2004; Chu & Harrison, 2001; Ishikawa, Okajima, & Sankano, 2007; Prins & Ollendick, 2003). The literature suggests that Solution-Focused Therapy is effective in treating adolescent depression, anxiety, and substance abuse (Cepukiene & Pakrosnis, 2011; Wheeler, 2001) and is associated with outcomes including increased self-esteem and coping, social skills, help reaching goals, and reduced problem behaviour (Cepukiene & Pakrosnis, 2011; Gostautas, Cepukiene, Palrosnis, & Fleming, 2005; Hopson & Kim, 2004). Similarly, Motivational Interviewing has demonstrated efficacy in treating adolescent substance use (Bailer, Barker, Webster & Lewin, 2004; Breslin, Li, Sdao-Jarvie, Tupker, & Ittig-Deland, 2002; Grella, Hser, Joski, & Rounds-Bryant, 2001; Jensen et al., 2011; Mason & Posner, 2009; McCambridge et al., 2011; Wagner, Brown, Monti, Myers, & Waldron, 1999).

When treatment is concluded, the student is again asked to complete a post-Children’s Hope Scale (Snyder et al., 1997) and a Client Feedback Questionnaire (Appendix C). The Clinician completes a post-CAFAS (Hodges, 2000) and a File Disposition Form (Appendix D). The referral agent then completes a School Feedback Survey (Appendix E).

**Evaluation Goals**

The SBMH program evaluation was undertaken to determine the effectiveness of the program. Specifically, program processes, stakeholder satisfaction, and client outcomes were examined. A Program Logic Model (Figure 1) was created to outline the program components and evaluation targets. Please see Appendix F for the completed Process Evaluation Matrix and Appendix G for the Outcome Evaluation Matrix. The specific questions addressed by this evaluation are listed below.
Process Evaluation Questions:

1. Are stakeholders (1. Clients; 2. Schools; 3. Clinicians) satisfied with SBMH services?
2. What is the average number of sessions per client required to attain treatment goals?
3. How many clients did not pursue SBMH services and why?
4. How many clients in the SBMH program are referred to adult mental health services?

Outcome Evaluation Questions:

1. Has SBMH served to improve behavioural and emotional functioning for clients?
2. Has SBMH services served to increase clients’ problem-solving skills?
3. Do SBMH services help to improve students’ overall functioning at school?
NEED IN THE COMMUNITY: SERVICES WHICH ARE EASILY ACCESSIBLE TO YOUTH WHO HAVE MENTAL HEALTH PROBLEMS WHICH IMPACT ON THEIR ACADEMIC SUCCESS.

PROGRAM GOAL: FACILITATE ACCESS AND PROVIDE TIME-LIMITED INTERVENTION TO YOUTH WHO ARE STRUGGLING WITH MENTAL HEALTH PROBLEMS IN THEIR SCHOOL.

RATIONALE(S): RESEARCH SHOWS THAT ADOLESCENTS CAN BE EASILY REACHED AND SCHOOL IS THE MOST COMMON AND EFFECTIVE PORTAL TO ACCESS MENTAL HEALTH SERVICES.

PROGRAM

ACTIVITIES

- Referral from a school representative (Referral form and screening tool)
- Client orientation with Clinician
- Assignment to Clinician
- Children’s Community Network complete intake review

Target population: Age: 12-18 years
Students with mental health problems

Required resources: Confidential office space for clinicians in each participating schools

SHORT-TERM OUTCOMES

Improve Behavioural Functioning:
- ↑ knowledge of coping skills
- ↓ frequency and severity of risk behaviours (substance use, self-harm, sexualized and/or aggressive behaviours)

Improve Social Functioning:
- ↑ problem-solving skills
- ↑ awareness of community resources

Improve Emotional Functioning:
- ↓ severity and frequency of symptoms of depression, anxiety and/or suicidal ideation

IMPROVE ACADEMIC FUNCTIONING:
- ↑ school attendance
- ↑ motivation

MEDIUM-TERM OUTCOMES

- ↓ conduct and oppositional behaviours
- ↑ positive and healthy coping skills
- ↓ conflicts with peers

- ↓ parent-teen conflict
- ↑ self-esteem, self-confidence
- ↑ mindfulness and resiliency

LONG-TERM OUTCOMES

- ↑ adolescent’s overall well-being (emotional, behavioural, social)
- ↑ adolescents receiving and accessing services

ASSUMPTIONS: SCHOOL REPRESENTATIVES ARE COMMITTED TO THE PROGRAM AND WILL DEDICATE THE NECESSARY TIME.
Methodology

The approach to data analysis in this evaluation was mixed methods. Both quantitative (e.g. Child and Adolescent Functional Assessment Scale and Children’s Hope Scale) and qualitative (e.g. open ended Client Satisfaction Survey questions, Clinician Interviews, Focus Group) methods were employed with the goal of obtaining a greater understanding of the program and process; general information regarding participants’ academic, medical, social and behavioural characteristics; stakeholder satisfaction; and participant outcomes.

Participant Characteristics

General demographic characteristics: The total referral sample for this evaluation period was 126 students. On average, females outnumbered males (71% vs. 29%, respectively); there were no significant differences between the genders on age, where the mean age for females was 14.97 (SD=1.19) and males was 15.22 (SD=1.34).

General health: A total of 4 variables gave some insight regarding the general health conditions of the students referred to the SBMH program. In total, 19% of students were identified as being on some type of medication; slightly over 1 in 6 students were identified as having a diagnosed mental health disorder (16%); and 16% of students were identified as having either a physical, developmental or intellectual disability (Table 1).

Table 1. Percentage of Student Referrals by General Health

<table>
<thead>
<tr>
<th>Percentage of students on medication</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students with a diagnosed mental health disorder</td>
<td>20</td>
<td>16</td>
</tr>
<tr>
<td>Students with a physical disability</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Students with a developmental or intellectual disability</td>
<td>13</td>
<td>10</td>
</tr>
</tbody>
</table>
**Culture:** A total of 48% of students referred to the SBMH program were identified as English; 25% were identified as Francophone; while 6% of students were identified as First Nation (Table 2). The English language was the main language spoken within the referred student population (66%); while 27% of students referred identified French as being their language of choice (Table 3).

Table 2  
*Percentage of Student Referrals by Culture*  

| English | N 60 | % 48 |
| Francophone | N 32 | % 25 |
| First Nation | N 8 | % 6 |
| Other | N 4 | % 3 |

Table 3  
*Percentage of Student Referrals by Main Language*  

| English | N 83 | % 66 |
| French | N 34 | % 27 |
| Other | N 1 | % 1 |

**School Descriptive Characteristics:** The 2012-2013 SBMH program sample’s school related variables examined many aspects that reflected the student’s academic experience, including: grade, performance, educational needs, and attendance. Although many students referred to the program came from secondary schools, 9% of students referred to the program were identified as being in Grade 8. Almost half of the remaining students referred came from Grades 9 and 10, where almost 1 out of 3 students referred were currently in Grade 9 (31%), and 1 out of 4 were identified coming from Grade 10 (25%). The remaining 31% of students referred came from Grades 11 and 12, where 1 out of 5 students referred to the program came from Grade 11 (21%; see Table 4), while 1 out of 10 students referred were identified as coming from Grade 12 classrooms.

Table 4  
*Percentage of Student Referrals by School Grade*  

| Grade 8 | N 11 | % 9 |
| Grade 9 | N 39 | % 31 |
| Grade 10 | N 32 | % 25 |
| Grade 11 | N 26 | % 21 |
| Grade 12 | N 13 | % 10 |
Of the students referred to the program, 12% were identified as failing academically; while 1 out of 3 students were reported to be performing within the 70-89% range (Table 5). It is important to note that 21% of the data for this variable was missing, limiting the insight that can be gained for this variable.

Table 5
*Percentage of Students Referred by Grade Average Range*

<table>
<thead>
<tr>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missing</td>
<td>26</td>
</tr>
<tr>
<td>50-59%</td>
<td>10</td>
</tr>
<tr>
<td>60-69%</td>
<td>32</td>
</tr>
<tr>
<td>70-79%</td>
<td>29</td>
</tr>
<tr>
<td>80-89%</td>
<td>13</td>
</tr>
<tr>
<td>90-100%</td>
<td>1</td>
</tr>
<tr>
<td>Failing</td>
<td>15</td>
</tr>
</tbody>
</table>

Regarding the educational needs of students referred to the program, slightly over 1 out of 4 students were identified as possessing an IEP (Table 6), while 41% of students referred were identified as being academically-at-risk.

The association between absenteeism and school problems has been described within educational and psychological literatures, where chronic absenteeism from school has been shown to have detrimental effects one’s overall academic experience by causing missed learning opportunities, gaps in learning, decreased socialization opportunities, and lack of routine and continuity (Baker & Jansen, 2000; Alexander, Entwisle & Horsey, 1997). Within the 2012-2013 SBMH referral population, there appears to be an even distribution with the percentage of student across absenteeism categories (Table 6).

Table 6
*Percentage of Students Referred by Academic and Attendance Characteristics*

<table>
<thead>
<tr>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students who have an IEP</td>
<td>33</td>
</tr>
<tr>
<td>Students who have failed or repeated a course</td>
<td>34</td>
</tr>
<tr>
<td>Students who have failed a grade</td>
<td>8</td>
</tr>
<tr>
<td>Student that require Resource Support</td>
<td>18</td>
</tr>
<tr>
<td>Identified as academically at risk</td>
<td>52</td>
</tr>
</tbody>
</table>
Social Developmental and Behavioral Characteristics: Some of the higher percentages of identified social developmental issues seemed to reflect conduct associated with internalizing behavior where 33% (N=42) of students referred were identified as preferring to be alone; 25% (N=32) were identified as being excessively shy or timid; and 25% (N=32) were described as having tendencies of withdrawing from social settings (Table 7). Other social characteristics that were flagged by referral agents included difficulty making friends (35%; N=44), not sought out for friendship by peers (24%; N=30), teased by other students (27%; N=34), and tends to gravitate towards negative peers (31%; N=39; Table 7).

Table 7
Percentage of Students by Social Developmental Characteristics

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prefers to be alone</td>
<td>42</td>
<td>33</td>
</tr>
<tr>
<td>Difficulty making friends</td>
<td>44</td>
<td>35</td>
</tr>
<tr>
<td>Not sought out for friendship by peers</td>
<td>30</td>
<td>24</td>
</tr>
<tr>
<td>Overly trusting of others</td>
<td>21</td>
<td>17</td>
</tr>
<tr>
<td>Has difficulty with turn-taking</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Engages in attention seeking behavior</td>
<td>32</td>
<td>25</td>
</tr>
<tr>
<td>Excessively shy or timid</td>
<td>32</td>
<td>25</td>
</tr>
<tr>
<td>Teased by other students</td>
<td>34</td>
<td>27</td>
</tr>
<tr>
<td>Difficulty seeing another person's point of view</td>
<td>24</td>
<td>19</td>
</tr>
<tr>
<td>Doesn't appreciate humor</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Has difficulty with physical boundaries</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>More interested in objects than people</td>
<td>13</td>
<td>10</td>
</tr>
<tr>
<td>Bullies other students</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>Doesn't empathize with others</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Tends to gravitate towards negative peers</td>
<td>39</td>
<td>31</td>
</tr>
<tr>
<td>Withdraws from social settings</td>
<td>32</td>
<td>25</td>
</tr>
<tr>
<td>Approaches and Discloses information to people indiscriminately</td>
<td>11</td>
<td>9</td>
</tr>
</tbody>
</table>
Some of the more frequent behavioral characteristics identified by referral agents within the SBMH referral population also seemed to reflect behavior characteristics associated with an internalizing behavioral profile. For example, around 1 out of 2 students were identified as being: depressed (56%); excessively worried or anxious (51%), unmotivated (47%), irritable, angry or resentful (45%). Other behaviors identified by the referees that seemed to be associated with internalizing behavioral profiles were: cries frequently (37%); and purposely harms or injures self (22%; Table 8). In addition to these behavioral characteristics, 21% of students were identified as having threatened to commit, or as having attempted to commit suicide.

Table 8
Percentage of Students by Social Developmental Characteristics

<table>
<thead>
<tr>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stubborn</td>
<td>60</td>
</tr>
<tr>
<td>Strikes out at others</td>
<td>28</td>
</tr>
<tr>
<td>Stealing</td>
<td>11</td>
</tr>
<tr>
<td>Risk Taking Behaviour</td>
<td>32</td>
</tr>
<tr>
<td>Impulsivity Control Issues</td>
<td>43</td>
</tr>
<tr>
<td>Dangerous to self or others</td>
<td>20</td>
</tr>
<tr>
<td>Seems depressed</td>
<td>71</td>
</tr>
<tr>
<td>Overly Preoccupied with details</td>
<td>26</td>
</tr>
<tr>
<td>Drug use</td>
<td>29</td>
</tr>
<tr>
<td>Motivation issues</td>
<td>59</td>
</tr>
<tr>
<td>Irritable, angry or resentful</td>
<td>57</td>
</tr>
<tr>
<td>Throws or destroy things</td>
<td>13</td>
</tr>
<tr>
<td>Argumentative with adults</td>
<td>43</td>
</tr>
<tr>
<td>Runs away</td>
<td>15</td>
</tr>
<tr>
<td>Poor sense of danger</td>
<td>21</td>
</tr>
<tr>
<td>Purposely Harms or injures self</td>
<td>28</td>
</tr>
<tr>
<td>Cries frequently</td>
<td>47</td>
</tr>
<tr>
<td>Not affected by negative consequences</td>
<td>21</td>
</tr>
<tr>
<td>Alcohol use</td>
<td>32</td>
</tr>
<tr>
<td>Doesn't complete work or tasks</td>
<td>43</td>
</tr>
<tr>
<td>Frequent angry outbursts</td>
<td>30</td>
</tr>
<tr>
<td>Lying</td>
<td>37</td>
</tr>
<tr>
<td>Low frustration threshold</td>
<td>44</td>
</tr>
<tr>
<td>Needs a lot of supervision</td>
<td>15</td>
</tr>
<tr>
<td>Skips school</td>
<td>34</td>
</tr>
<tr>
<td>Unusual fears, habits, mannerisms</td>
<td>20</td>
</tr>
<tr>
<td>Excessively worried or anxious</td>
<td>64</td>
</tr>
<tr>
<td>Overly attached to certain objects</td>
<td>18</td>
</tr>
<tr>
<td>Sexually active</td>
<td>29</td>
</tr>
<tr>
<td>Doesn't like to engage in new activities</td>
<td>18</td>
</tr>
</tbody>
</table>
Data Collection

The data collection period occurred between September, 2012 and June, 2013. The sources of data utilized to address Process Evaluation Questions were the Client Satisfaction Survey, School Feedback Questionnaire, the Youth Focus Group, the Clinician Interview, CIMS, and the File Disposition Form. The major sources of data utilized to address Outcome Evaluation Questions were the Child and Adolescent Functional Assessment Scale and the Children’s Hope Scale. These measures are described in below.

Measures

The Children’s Hope Scale: The Children’s Hope Scale (Appendix B) is a six-item self-report measure assesses the child’s perceived capacity to find pathways to desired goals and the motivation to use those pathways (Snyder, Rand, & Sigmon, 2002). The measure attempts to quantify two general constructs: pathways and agency thinking. Pathways thinking can be characterized as a person’s ability to see themselves as capable of thinking of ways to achieve personal goals in the face of obstacles (Dumoulin & Flynn, 2006). The authors reported internal consistency reliabilities (alphas) 0.72 to 0.86, and test-retest reliabilities of 0.71 - 0.73. Further studies have reported alphas of 0.51 - 0.84, and a test-retest reliability of 0.51 (Snyder et al., 1997).

Child and Adolescent Functional Assessment Scale: The measure is used to assess the degree of functional impairment in children and adolescents with emotional, behavioral, or substance use problems. The scale is composed of 8 domains: School performance, home role performance, community role performance, behavior towards others, moods/emotions, self-harmful behavior, substance use, and thinking (Hodges, 2000).

Stakeholder Satisfaction: The Client Feedback Questionnaire (Appendix C) and School Feedback Survey (Appendix E) were designed to elicit feedback about the program from both clients and school
referral agents. These forms contain both open-ended questions and questions regarding satisfaction rated on a Likert scale.

**Clinician Interview:** The Clinician Interview Guide (Appendix H) was developed to parallel the Process Question and Outcome Questions and facilitate Clinician feedback on the program process, stakeholder feedback and client outcomes.

**Focus Group Questionnaire:** The Youth Focus Group Survey (Appendix I) was designed to elicit stakeholder feedback. In particular, it was designed to investigate students’ views of mental health, why they may not access services, and the visibility of the SBMH program. The Youth Focus Group was developed using focus group toolkits (Health Communication Unit, 2002; Omni, n.d.).

**Data Analysis Plan**

An evaluation analysis plan was developed to address data analysis (Appendix J). Members of the program evaluation team were responsible for different portions of data collection and analysis. Please see Appendix J for details. The mixed method approach provides numerous opportunities for data collection and analysis including collection of participant characteristics, stakeholder feedback, and client outcomes. Statistical analyses conducted to answer the Process Evaluation Questions included Kaplan-Meir survival curve analyses, dependent t-tests, and descriptive statistics. The qualitative data collected provides extra in-depth information which is not readily available through any other method. Clinician interviews were conducted as semi-structured interviews, transcribed and recorded verbatim. Transcripts were analyzed according to the procedure outlined by Merriam (2009). Please refer to Appendix J and Results section for more detailed information regarding data analysis.

**Evaluation Limitations**

One challenge experienced during evaluation was in regard to collecting and recording data. On occasion, technological difficulties precluded referral agents from completing the referral form accurately, or using the most current version of the referral Form. Furthermore, a limited number (50%) of T14
CAFAS scores were collected due to treatment completion prior to the T14 administration date. Data entry also proved to be an obstacle at times. Although Dashboard is an effective tool that anyone can use, the challenge exists in entering data in a consistent manner by multiple people.

**Ethical Considerations**

Informed consent was obtained from all participants through the development of consent forms. Please see Appendix K for the Clinician Consent Form and Appendix L for the Youth Focus Group Consent Form. Confidentiality of the participants was protected by the removal of identifying data (e.g. names/places). Clients are informed that program evaluation is an intrinsic part of the program, and this information has been integrated into the Statement of Personal Health Information Practices form (Appendix M).

**Results and Interpretation**

**Process and Outcome Evaluation Questions:**

The following sections are related to answering the process and outcome evaluation questions that were outlined in the Evaluation Analysis Plan (Appendix J).

**Are stakeholders satisfied with SBMH services?**

**Stakeholder Satisfaction:**

**Client satisfaction:** A total of 48 clients completed and submitted the Client Feedback Questionnaire (Appendix C). 26 of these clients were female (70.3%) and 11 were male (29.7%). Eleven clients did not indicate their gender.

Overall, results indicated that the majority of clients either strongly agreed or agreed with the statements relating to their level of satisfaction with services, as indicated in Table 9 below. Three
clients (6.3%) indicated that the services did not improve their coping abilities or their school/work performance and 2 clients (6.5%) strongly disagreed with the statements.

Table 9
*Client Satisfaction Questionnaire Results*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, I am satisfied with the services I received</td>
<td>60.4%</td>
<td>33.3%</td>
<td>4.2%</td>
<td>2.1%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>I helped to choose my services and treatment goals</td>
<td>39.6%</td>
<td>45.8%</td>
<td>12.5%</td>
<td>2.1%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>I felt I had someone to talk to when I was troubled</td>
<td>62.5%</td>
<td>20.8%</td>
<td>10.4%</td>
<td>4.2%</td>
<td>2.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>I participated in my own treatment</td>
<td>47.9%</td>
<td>39.6%</td>
<td>8.3%</td>
<td>0.0%</td>
<td>2.1%</td>
<td>2.1%</td>
</tr>
<tr>
<td>The clinician treated me with respect</td>
<td>81.3%</td>
<td>14.6%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>4.2%</td>
<td>0.0%</td>
</tr>
<tr>
<td>As a result of the services I received, I am better able to cope when things go wrong</td>
<td>45.8%</td>
<td>39.6%</td>
<td>4.2%</td>
<td>2.1%</td>
<td>6.3%</td>
<td>2.1%</td>
</tr>
<tr>
<td>As a result of the services I received, I get along better with friends</td>
<td>35.4%</td>
<td>33.3%</td>
<td>18.8%</td>
<td>4.2%</td>
<td>2.1%</td>
<td>6.3%</td>
</tr>
<tr>
<td>As a result of the services I received, I get along better with family</td>
<td>29.2%</td>
<td>41.7%</td>
<td>16.7%</td>
<td>2.1%</td>
<td>2.1%</td>
<td>8.3%</td>
</tr>
<tr>
<td>As a result of the services I received, I get along better with other people</td>
<td>33.3%</td>
<td>43.8%</td>
<td>16.7%</td>
<td>2.1%</td>
<td>0.0%</td>
<td>4.2%</td>
</tr>
<tr>
<td>As a result of the services received, I am doing better in school and/or work</td>
<td>37.5%</td>
<td>31.3%</td>
<td>22.9%</td>
<td>6.3%</td>
<td>0.0%</td>
<td>2.1%</td>
</tr>
</tbody>
</table>

Three items on the Client Satisfaction Questionnaire were qualitative. These results also indicate that the majority of clients were satisfied with services received.

35 clients answered the question: “*What has been the most helpful part about the services received*”. Twelve client’s responses related to “having someone to talk to”. Three of the respondents stated “Everything”, and four respondents indicated feeling of trust and being respected by the clinician (i.e. “The most helpful service I have received was the ability to not only trust my clinician but be respected by her as well. She changed my future and I am thankful for that.”). Other responses (N=7) related to learning problem-solving and coping skills (i.e. I learned how to keep myself occupied and
think positive when things go wrong.”). Finally, other client statements related to increase in self-esteem, work with family and being referred to other community services.

25 clients answered the open question: “What would improve services here?” and 23 clients did not comment. The majority of client responses (N=12) indicated that they would not improve anything (i.e. “actually nothing because it’s already perfect”). Six clients suggested having more frequent visits and/or for the clinician to be in their school more frequently. Four students stated “not sure” or “don’t know”. Others indicated that we should have services in other secondary schools too and have a shorter wait list. Only one student’s answer indicated dissatisfaction with services, as he or she stated “For them to try and listen better”.

Finally, clients were asked if they had any additional comments. Eleven (23%) clients made comments. All comments related to how helpful the services had been for them (i.e. “I feel I was right coming here and got what it is I needed.”) and the clients thanking the clinicians (i.e. “Thank you for all the help!”).

School referral agent satisfaction: School referral agents were asked to complete a School Feedback Questionnaire (Appendix E). A total of 9 School referral agents completed the form. 38% of respondents were teachers, 25% were Principals and 38% were Guidance Counselors. Overall, respondents indicated complete satisfaction with the School-Based Mental Health Program (see Table 10 below).

<table>
<thead>
<tr>
<th>Questions</th>
<th>Yes (%)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the referral process clear?</td>
<td>88</td>
<td>13</td>
</tr>
<tr>
<td>Were the program’s mental health clinicians available for questions about the program?</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>In your opinion, was the School-Based Mental Health Program helpful for the student?</td>
<td>100</td>
<td>0</td>
</tr>
<tr>
<td>Since participating in the program, has it become easier for the student to seek or ask for mental health services within the school setting?</td>
<td>88</td>
<td>13</td>
</tr>
<tr>
<td>Overall, were you satisfied with the program?</td>
<td>100</td>
<td>0</td>
</tr>
</tbody>
</table>
For each question, respondents also had the opportunity to comment. Many did provide very useful comments/ideas on how we can better the services. For example regarding the referral process, a few respondents indicated that the Referral Form and Honosca (screening Tool) were at times difficult to complete.

With respect to the communication with the clinician, three respondents indicated that they would like more meetings and updates regarding the clients, however a few others indicated that such occurred and that they understand the issue of privacy.

Some respondents also commented on how helpful the services were to students (i.e. “Students have provided very positive feedback about the help they have received to deal with various issues. This makes me feel more confident that I am successfully able to support students in need by referring to the appropriate professionals. Having such professional support right in our school is great for our students in need. I hope it continues indefinitely!”).

Finally, respondents commented that overall they are satisfied with services, but wish they had more. For example, some indicated that they would like for the clinician to be in their school more often, or that there be more available clinicians to work within the school setting.

During semi-structured interviews with School-Based Mental Health Clinicians, three themes related to satisfaction emerged. These themes include overall satisfaction, increased demand for services, and the unique relationships formed with clients.

The first theme was overall satisfaction. Subthemes indicated that the clients, schools and communities were satisfied overall with the program and how it works. For example, one of the clinicians commented, “As far as the kids are concerned... we’re getting really good positive results from it.” Both Clinicians also rated their satisfaction with the program as 8 out of 10, citing factors such as flexibility and the relationship with students as definite benefits of the program.
The second theme that emerged from the interviews was capacity, specifically an increased demand for services. The Clinicians agreed that schools and clientele alike want to see more of the available services. One Clinician stated, “As far as the schools are concerned… they would like to see more of the service in their own school…” With respect to the clients, one clinician stated: “I know when they are filling out the satisfaction questionnaires at the end, a lot of them have said that, ‘I wished I could have seen you more.”

During the interviews, a third theme also emerged. Both Clinicians talked about the relationship they have built with clients based on validation, support and understanding. One Clinician said:

“… the kids are feeling that there is someone that they can talk to in the school who isn’t going to give them a hard time… but who can see the positives and have a different kind of relationship with them. I think that’s what I like best about the program.”

The Clinicians also discussed how students are beginning to look for their services in the school and that many clients return to chat or say hello. Furthermore, previous clientele appear to be introducing other students to the Clinicians. For example, one Clinician said: “We’re seeing that the kids want us there. They’re seeking us out. They’re asking – They’re bringing friends when they do come to introduce us and show that we’re safe in the school.”

In sum, clients, school representatives and Clinicians all appear to agree on three emerging themes: overall satisfaction with the SBMH program, the need for increased capacity and increased awareness of the services. The youth focus group results also validate these themes. These outcomes shall serve to facilitate the Agency’s decision-making with regards to our Service Delivery Model and allow us to further lobby for increase capacity in the Agency. Results regarding the need for increased awareness of services for students have guided our decision to create a flyer for students to be distributed in participating schools which is discussed in the Knowledge Exchange section below. The
Agency has also revamped our website to include a section regarding SBMH services and program evaluation, as well as connect to Facebook. Finally, the Agency has developed a Youth Engagement Group, who has set Mental Health Awareness as its goal in the next year. Our plan is to continue to offer peer-to-peer focus groups to create awareness of mental health and services in the community.

**What is the average number of sessions per client required to attain treatment goals?**

This sample consisted of the twenty (20) students who received the complete SBMH service. To gain some insight regarding the average number of sessions completed per client to attain treatment goals, several statistical methods will be considered, including calculating the mean and standard deviation for the group, frequency distribution (Figure 1), and, Kaplan-Meir survival curve analyses. In addition to the number of sessions, the following analyses will also include an examination of the average number of days an active file stays open prior to its end under the service closure type “Services Completed”. Together, these analyses which may shed some light on the typical SBMH program “dosage”.

According to frequency analyses, 20% of students who completed the full service received 4 sessions, 30% of students received between 4-5 sessions, while one student received as many as 14 sessions (Figure 1). The mean number of sessions for this cohort was 5.30 (SD=3.13).

In sum, we can conclude the School-Based Mental Health Program does respect the time-limited criteria it has set out to be (up to 12 sessions). There will be times however when exceptions are made.
(i.e. the student who received up to 14 sessions) due to the fact that the client may experience a crisis during the treatment period and we deem that it would be unwise to transfer the file to another clinician at the time (i.e. importance of maintaining the therapeutic alliance that may have been very difficult to develop).

The next analyses employed the Kaplan-Meier survival analytic approach, which allows a program evaluator to estimate the percentage of client files that remain open for a particular point in “time”, where time can be defined as either the number of sessions or the number of days a client’s file stays open.

For this particular SBMH program student cohort who received the complete service, 50% of these students received at least 5 sessions (Figure 2, circle 1), while 80% of students received at least 7 sessions (Figure 2, circle 2). The slope of the survival curve may also provide some qualitative insight regarding the rate of file closure over an ascribed period; for the analysis below, it appears that the file closure remains constant until session 8, where the rate after session 8 appears to plateau ending at session 14.

A Kaplan-Meier survival analytic approach was also used to estimate the number of days a student file stays open for the cohort who receives the complete service of the SBMH program (Figure 3). On average, 50% of student files are closed around the 6 months mark or day 180 (Figure 3, circle 1); while 80% of files for this cohort are closed around the early to mid 7 month mark, or approximately day 220 (Figure 3, circle 2).
These results do appear alarming, as we can deduct that although services are designed to be time-limited (12 sessions), it takes a long time (average of 7 months to have the average 5-6 sessions) to complete treatment. These results do validate once more the fact that there is a need for increased capacity. Clinicians serve 3-4 schools and are generally only at the school once per week to see the 6-8 students that they may be assigned in that school. Clinicians have often discussed how “school life” (ex. student must complete a test/exam that day, attend an assembly or school activity) can become a barrier to treatment progress. Also, many of the students referred have attendance issues (Refer to Table 6: Absenteeism and Truancy) and so it can be difficult for the clinician to reach the student. With client consent, the clinician may at times seek support from the school’s attendance counselors to reach the referred student.
In examining the slope of the survival curve or the rate of student file closure over time (number of days), there appears to be a slight delay in file closure between Day 0 and Day 45, where 100% of files remain open up until Day 45, which then leads to a slight downward trend in student file openings, then leads to what seems to be a more pronounced downward trend beginning by Day 120 and ending around Day 220, a slope that appears to mirror the overall trend in the previous Kaplan-Meier analysis. This finding may suggest that it may take time to set up the first session with the student, perhaps as many as 45 days according to these analyses. Considering the information from both Kaplan-Meier Analyses, we can estimate that 50% of the students who received the complete SBMH service received on average 5 sessions over the course of 180 days, for an estimated dosage of 1 session every 36 days.

Similar results were found for the estimation of dosage for 80% of this cohort, where it is estimated that 80% of students who complete the program receive 7 sessions over the span of 220 days for an estimated dosage of 1 session per 31 days. Together, these results suggest that students who completed the SBMH program for the 2012-2013 period received approximately 1 session per month. There are inherent limitations to Kaplan-Meier analyses, mainly that time delays (in days) in setting up
the sessions, and delays in closing the files may “skew” the findings presented here, however, these results may also suggest room for improvements in program efficiencies related to scheduling sessions and closing student files to make room for new clients.

How many clients did not pursue SBMH services and why?

Over the course of the program evaluation, 43 students who were referred did not receive services and 19 (15%) individuals were non-admissions. It may be that the non-admitted individuals did not meet program criteria, they were already assigned to a CFC program, or they were referred to crisis or private services for treatment of complex needs which could not be met by time-limited SBMH. One (3%) individual did not receive services because they were over 18, 4 individuals moved out of the serviced area, and 19 (15%) declined services.

Referral agent respondents commented in School Feedback Questionnaire (Appendix E) regarding the improved access to services within the school. Some noted that the stigma and lack of awareness regarding services continues to be a barrier (i.e. “There is still a huge stigma attached to this that students are afraid to come forward in many cases”), however others commented that students are becoming more aware of services now and asking for them (i.e. “… the word is getting around that there is additional layer of support for students with mental health issues. This means that students who would not formerly have spoken up have a greater tendency to do so.”).

Similarly, over half of the surveyed youth (54.5%) in the Focus Group indicated that they do not know how to access mental health services in their school or community. For example, one youth responded:

“In all honesty, don’t really know. I mean, I guess you could go to guidance and see what you can do. It is such a touchy subject that no one wants to bring up, it’s harder to find help for the problem.”
Although these students reported they weren’t sure how to access mental health services, many options were presented during the discussion including counseling services, guidance, hospital services, and Child and Family Centre. Furthermore, when asked about what they could do if they were struggling with a mental health issue, many students indicated that talking to someone was the best course of action. Other strategies were also mentioned, including education about mental illness, engaging in hobbies, sleeping, or writing about it.

Students were also asked about the best way to inform youth about mental health services in school. During the discussion, there was a consensus that the best way to convey information was through small groups, specifically focus groups and support groups. Students mentioned that it was easier to talk to peers than to strangers. Other information sharing activities suggested include posters and use of multimedia. The majority of youth (91%) indicated that if given the opportunity to share ideas/thoughts/views about mental health services they would be willing to do so.

**How many clients in the SBMH program are referred to adult mental health services?**

Over the course of the program evaluation, 55 files were closed. Of these 55, only one (2%) was referred to adult mental health services. 21 clients (38%) had completed service, six clients (11%) were referred to a different CFC program that would better serve their needs, five clients (9%) withdrew from treatment, four clients (7%) moved over the course of treatment, one client (2%) was not eligible for short-term treatment, one client non-materialized, and one (2%) client’s reason for closure was documented as “other”. The reason for closure was not available for 15 clients (27%).

**Do referred students demonstrate significantly better behavioral and emotional functioning upon receiving the complete SBMH service?**

Currently, the program administers two main outcome instruments, mainly the CAFAS and the Children’s Hope Scale (CHS; Snyder, 1997). The sample for the following analyses will consist of only those clients who received the complete service (N = 20). Despite having a sample size of 20, only half of
this cohort (n=10) received the complete CAFAS T1 and T14 series, limiting what one can infer about the effectiveness of the program on the various CAFAS subscale scores due to the small sample size.

Regarding the CHS, the pre CHS grouping consisted of 19 clients, while the post CHS group consisted of 18 total clients. Please refer to Appendix N which provides the SBMH program’s descriptive statistics for both the CAFAS (T1 and T14) and CHS (pre and post) outcome measures.

To examine the evaluation question about whether the SBMH program improved the behavioral and emotional functioning for the youth, comparisons between the Pre and Post CAFAS T1-T14 scores of students who received the complete SBMH service were conducted using the repeated measures T statistic. The small sample size precluded this author to conduct comparisons using the CAFAS subscales and excluded from this analysis. Only Total CAFAS scores for T1 and T14 were used for the following analysis, as the Total CAFAS scale demonstrated good reliability (Cronbach’s alpha = .73).

The results of the dependent t-test revealed that CAFAS T14 mean scores (M=34.00, SD=29.52) were significantly lower than the CAFAS T1 mean scores (M=8.00, SD=13.17), \(t(9)=3.122, p = .012\), Cohen’s D = .99. Calculating the Common Language effect size (McGraw and Wong, 1992) indicated that after controlling for individual differences, the likelihood that a person scores lower on CAFAS T14 after receiving the complete service is 84%.

In summary, of those students who completed the SBMH service were more likely to have lower T14 CAFAS scores upon exiting the program. Future analyses comprising of more substantial sample sizes may offer more robust support for this finding. These results corroborate Clinician’s comments regarding the usefulness of the CAFAS as outcome measure for this population and program. The Agency standards at time are that a T1 CAFAS be completed by the 4th session with a client and the common practice for clinicians is to do so once they have completed their assessment. However, when considering the fact that 20% completes treatment by the 4th session and 30% of clients complete treatment by 4-5th session, we can assume that the clinicians never completed a T1 CAFAS at all. These
results may lead the Agency to redefine the standard for CAFAS completion of clients being served within a time-limited program. Finally, these results also reflect the fact that many clients that were referred during this evaluation period (September 2012-June 2013) were still receiving treatment and so a T14 was yet to be completed.

**Do referred students have a significantly better perception regarding their ability to problem solve upon receiving the complete SBMH service?**

The measure used to assess the perception of one’s ability to problem solve was the CHS. Reliability analyses to evaluate the reliability of the Hope construct for both pre and post conditions revealed that the scale demonstrated very good reliability (Cronbach’s alpha = .85 and .85, respectively). A total sample size of 17 clients was used for the dependent T-Test to determine whether clients who received the complete SBMH service experienced significant improvements regarding their perceived ability to problem solve.

The results of the dependent t-test revealed that post-CHS mean scores (M=29.71, SD=4.34) were significantly higher than the pre-CHS mean scores (M=22.12, SD=6.13), t(16)= -4.95, p < .001, Cohen’s D = 1.20. Calculating the Common Language effect size (McGraw and Wong, 1992) indicated that after controlling for individual differences, the likelihood that a person scores higher on CHS after receiving the complete service is 89%.

In summary, clients who completed the SBMH service were more likely to have higher CHS scores upon exiting the program. As with the CAFAS analysis, future analyses comprising of more substantial sample sizes may offer more robust support for this finding.

**Do SBMH services help to improve the students’ overall functioning at school?**

Due to the small sample size and the inability to investigate the reliability of the School CAFAS subscale, this particular question cannot be answered with confidence at this time. Although there appears to be a difference in the mean scores for the School CAFAS subscale between T1 and T14 time
periods (Appendix N), there is currently no statistical difference between the T1 and T14 means for students who received the complete SBMH service.

**Stakeholder involvement and knowledge exchange**

The core evaluation team included key Agency staff members such as the Program Manager, Director of Clinical Services, Clinicians of the program, IT and Clerical Staff. The team included a Consultant who assisted in the creation and implementation of the Dashboard and the analysis of results. The team also included a lead Board representative from each of the 4 participating School Boards. Two Laurentian University students were also instrumental members of the team as they were part of each step of the evaluation and they assisted in the creation, implementation and analysis of the Youth Focus Group and Clinician Interviews. Throughout this evaluation period, the core team had three formal meetings to plan, implement and review steps and progress of the evaluation. The Program Manager also held bi-monthly meetings with each participating schools, School Board Leads and Clinicians to review the program, evaluation and client progress. Feedback was sought from all stakeholders (Client, school representatives and Clinicians) throughout the evaluation as this was an important process evaluation question.

Outcomes of the program evaluation and this final report will be shared through various knowledge exchange activities delivered between the months of September and December 2013. Firstly, a reporting cube was created to highlight the important results of this evaluation which was presented on tables at the Annual General Meeting in September 2013. Several knowledge exchange materials will be created, such as an Information graph, memory keys containing this final report and a flyer regarding the program to create awareness.

The Program Manager plans to welcome the core team and all school stakeholders to a presentation regarding the results of the program evaluation. The core team and school stakeholders will also be given a memory key containing the final report and Information graph. Other presentations
are planned for all staff at the Centre and the Local Service System Management Table (LSSMT). These presentations will foster the on-going collaboration between the Agency and its community partners to ensure that mental services are delivered to children and youth effectively. The Child and Family Centre has now created an infrastructure within to maintain on-going program evaluation. Although this evaluation period is at an end, it is really only the beginning for the Child and Family Centre to evaluate its programs effectiveness, which will continue to guide future decisions about our services and programs based on evidence. It is our goal to continue to engage our community partners in this growth and development.

Conclusions and Recommendations

Although this program evaluation had some limitations in regard to data collection, important insights about the SBMH program have been gained. The first is that stakeholders are largely satisfied with the SBMH program and feedback converges in increased demand for service. Clients, school referral agents and Clinicians all indicated a desire for increased SBMH capacity. Furthermore, the majority of clients complete treatment within the time-limited criteria set out by the SBMH Program (up to 12 sessions). The length of treatment speaks to the unique challenges faced by Clinicians working within the school system, namely making contact with clients.

Another important finding was the percentage of individuals who were referred to SBMH but did not receive services. The majority of these individuals did not meet criteria for service or declined services. At this time it is unclear why students declined services, and this may be an interesting investigation in the future. Results from the Focus Group indicate that the main reason students may decline services is related to fears about stigma and confidentiality. These results align with current research. In a recent study by Soleimanpour, Gelerstanger, Kaller, McCarter, and Brindle (2010), high school focus group results suggested that confidentiality was important to youth in accessing a school-
based mental health center. Furthermore, similar to the program evaluation results, students indicated that they may not have used the service because they didn’t know about it or they were worried about what others would think if they saw them going (Soleimanpour et al., 2010). Concern about stigma and confidentiality may be addressed in future program evaluations as a possible reason students decline services.

Results also indicate that clients who complete the SBMH Program are more likely to demonstrate better behavioral and emotional functioning upon receiving the complete SBMH service. Furthermore, these clients are also more likely to have a significantly better perception regarding their ability to problem solve. Although changes in academic functioning could not be determined, a following program evaluation may have the ability to evaluate this question in the future.

These results are similar to those shown in school-based mental health research. For example, Soleimanpour et al. (2010) found that use of a school-based health center experienced significant improvements in anxiety, depression, eating disorders, grief, behaviour management, self-injury, substance abuse, expressing emotions productively, expressing hope, and involvement in activities.

Based on the results, we can conclude that it is necessary to review the Agency’s resources and attributed capacity to this program. The results from satisfaction questionnaires and interviews indicate that Clients, school referral agents, and Clinicians are satisfied with this service and that all stakeholders desire increased capacity. This finding is also in line with existing research. For example, in a study evaluating a school counselling service in Scotland, researchers found that students, referrers, and counselors were satisfied with the service (McKenzie, Murray, Prior, & Stark, 2011). Referrers reported that counselling had helped the students in terms of coping at school, expressing themselves in an appropriate manner, and increasing their level of openness and confidence.
Secondly, further consideration must be given to the timing of CAFAS administration in regard to this program. As a time-limited program, clients may have completed service before the CAFAS is administered at T1. The timing of CAFAS administration limited the analyses that could be conducted in regard to these outcome variables and, therefore, the conclusions that can be drawn.

Finally recommendations emerging from the current program evaluation are related to data collection and entry. Technological difficulties may hinder school referral agents from completing forms in the manner required for data analysis. Furthermore, attention should be drawn to consistent data entry. These issues may be partially due to the evolving nature of the program which is a relatively new endeavour. Although the current methods of data collection and entry are working, it is imperative for data analysis that the correct forms are utilized, forms are returned completed (no missing data), and data is entered in a consistent manner.
References


Appendix A: School-Based Mental Health Referral Form

General Information:

<table>
<thead>
<tr>
<th>Referral Source (School): School</th>
<th>Date: DOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral Completed by: Completed By</td>
<td></td>
</tr>
<tr>
<td>Referral Source Telephone Number: Telephone</td>
<td>Ext: Ext</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Student’s Name: Name</th>
<th>Home #: Home #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Student Address: Address</td>
<td>Cell #: Cell #</td>
</tr>
<tr>
<td>Best way to reach student: Contact</td>
<td></td>
</tr>
<tr>
<td>Gender: Gender</td>
<td>Date of Birth: DOB</td>
</tr>
<tr>
<td>Age: Age</td>
<td>Primary Language: Language</td>
</tr>
<tr>
<td>Cultural Identity: Culture</td>
<td>Student’s Grade: Grade</td>
</tr>
</tbody>
</table>

Medical History:

<table>
<thead>
<tr>
<th>M1. Is the student on medication?: On Medication</th>
<th>M1a. If on medication, what type of medication? : Types of Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>M2. Has the student been diagnosed with a mental health disorder?: Disorders</td>
<td>M2a. If diagnosed with a mental health disorder, what was the diagnosis (please identify all mental health disorders if more than one is present)?</td>
</tr>
<tr>
<td>M3. Does the student have a physical disability?: Physical</td>
<td>M3a. If yes, what kind?: Disability</td>
</tr>
<tr>
<td>M4. Does the student have a Developmental or Intellectual disability?: Developmental</td>
<td>M4a. If yes, what is the disability?: Developmental</td>
</tr>
</tbody>
</table>

Educational Profile: Please check all that apply

<table>
<thead>
<tr>
<th>E1. Number of courses completed: Courses</th>
<th>Absenteeism:</th>
</tr>
</thead>
<tbody>
<tr>
<td>E2. What is the student’s academic program: Program</td>
<td>E10. Within the last 12 months, on average, how often does the student miss school?: Average missed</td>
</tr>
<tr>
<td>E3. Overall, what is the student’s average mark this year: Grades</td>
<td>E11. Student has left school without permission Suspensions and Truancy</td>
</tr>
<tr>
<td>☐ E4. Student has IEP</td>
<td>E12. Student has been suspended within the last 12 months;</td>
</tr>
<tr>
<td>☐ E5. Student has failed or repeated a course</td>
<td>E13. If E12 box is checked, please indicate how many Incidences? Suspension Count</td>
</tr>
<tr>
<td>☐ E6. Student has failed a grade</td>
<td>E14. And how many days missed? Days Missed</td>
</tr>
<tr>
<td>☐ E7. Student has been held back a grade</td>
<td>☐ E15. Student has been Expelled</td>
</tr>
<tr>
<td>☐ E8. Student requires Resource Support</td>
<td>☐ E16. Student has a history of truancy issues</td>
</tr>
<tr>
<td>☑ E9. Student’s academic success is at risk</td>
<td>Support type</td>
</tr>
</tbody>
</table>

Referral Process:

Referral Agent e-mails the Referral Form and completed HONOSCA screening tool to the Child and Family Centre Program Manager: Mrs. Chantal Lafleur, E-MAIL: clafleur@childandfamilycentre.on.ca
### Behaviour Profile:

#### Social Development:

- ☐ S1. Prefers to be alone
- ☐ S2. Difficulty making friends
- ☐ S3. Not sought out for friendship by peers
- ☐ S4. Overly trusting of others
- ☐ S5. Has difficulty with turn-taking
- ☐ S6. Engages in attention seeking behavior
- ☐ S7. Excessively shy or timid
- ☐ S8. Teased by other students
- ☐ S9. Difficulty seeing another person’s point of view
- ☐ S10. Doesn’t appreciate humor
- ☐ S11. Has difficulty with physical boundaries
- ☐ S12. More interested in objects than people
- ☐ S13. Bullies other students
- ☐ S14. Doesn’t empathize with others
- ☐ S15. Tends to gravitate towards negative peers
- ☐ S16. withdraws from social settings
- ☐ S17. Approaches and discloses information to people indiscriminately

#### Behaviour:

- ☐ B1. Stubborn
- ☐ B2. Strikes out at others
- ☐ B3. Stealing
- ☐ B4. Risk taking behaviour
- ☐ B5. Impulsivity control issues
- ☐ B6. Dangerous to self or others
- ☐ B7. Seems depressed
- ☐ B8. Overly preoccupied with details
- ☐ B9. Drug use
- ☐ B10. Motivation issues
- ☐ B11. Irritable, angry or resentful
- ☐ B12. Throws or destroy things
- ☐ B13. Argumentative with adults
- ☐ B14. Runs away
- ☐ B15. Poor sense of danger
- ☐ B16. Purposely harms or injures self.
- ☐ B17. Cries frequently
- ☐ B18. Not affected by negative consequences
- ☐ B19. Alcohol use
- ☐ B20. Doesn’t complete work or tasks
- ☐ B21. Frequent angry outbursts
- ☐ B22. Lying
- ☐ B23. Low frustration threshold
- ☐ B24. Needs a lot of supervision
- ☐ B25. Skips school
- ☐ B26. Unusual fears, habits, mannerisms
- ☐ B27. Excessively worried or anxious
- ☐ B28. Overly attached to certain objects
- ☐ B29. Sexually active
- ☐ B30. Doesn’t like to engage in new activities

### ST1. STRESSORS:

Have there been any recent stressors that may be contributing to the student’s difficulties (e.g. illness, deaths, operations, accidents, changed schools, other issues?)

### PR1. PRIMARY CONCERNS:

What is the referral source’s primary concern re: student? Has the student ever threatened to commit, or has attempted to commit suicide?

### Support Services, special education programs or specialized assessments

- ☐ SS1. Services from a Social Worker or/and Attendance Counselor – SS1a
- ☐ SS2. Psychological Assessment: date of last evaluation – SS2b
- ☐ SS3. Does student have access to an EAP? SS3
- ☐ SS4. Is the student receiving services elsewhere (other community agencies involved)? SS4
- ☐ SS4a. If yes, then please specify

### AI1. ADDITIONAL INFORMATION:

(includes risk rating, risk level, risk factors, health and/or medical concerns, behavioral concerns, brief treatment history)

- ☐ R1. Received authorization from parent/guardian
- ☐ R2. Received authorization from student
- ☐ R3. Received approval from school Principal

### Referral Process:

Referral Agent e-mails the Referral Form and completed HONOSCA screening tool to the Child and Family Centre Program Manager: Mrs. Chantal Lafleur, E-MAIL: clafleur@childandfamilycentre.on.ca
Appendix B: Children’s Hope Scale

The six sentences below describe how children and youth think about themselves and how they do things in general. Read each sentence carefully. For each sentence, please think about how you are in most situations. Place a check inside the square that describes YOU the best. For example, place a check (✓) in the (☐) above “None of the time,” if this describes you. Or, if you are this way “All the time,” check this square. Please answer every question by putting a check in one of the circles. There are no right or wrong answers.

<table>
<thead>
<tr>
<th></th>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>A lot of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I think I am doing pretty well.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. I can think of many ways to get the things in life that are most important to me.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>3. I am doing just as well as other kids my age.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4. When I have a problem, I can come up with lots of ways to solve it.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5. I think the things I have done in the past will help me in the future.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. Even when others want to quit, I know that I can find ways to solve them.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Developed by Snyder, C.R. et al. (1997)
Appendix C: SBMH Client Feedback Questionnaire

Your name (optional): _________________________     I am (optional) ☐ Female ☐ Male

Select the area that best describes where you live.

☐ In Greater Sudbury, which includes Onaping Falls, Nickel Centre, Rayside-Balfour, Valley East, Walden

☐ Outside of Greater Sudbury, which includes Alban, Burwash, Chapleau, Espanola, Estaire, Gogama, Hagar, communities on Manitoulin Island, Markstay, Massey, Noëlville, Warren, Whitefish Falls.

Please help us improve by answering questions about our services you have received. Your answers are confidential and will not influence the services you receive.

Please choose the option that reflects how you feel about the services you received.

<table>
<thead>
<tr>
<th></th>
<th>Overall, I am satisfied with the services I received.</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I helped to choose my services and my treatment goals.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2.</td>
<td>I felt I had someone to talk to when I was troubled.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>4.</td>
<td>The clinician treated me with respect</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>5.</td>
<td>As a result of the services received, I am better able to cope when things go wrong</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6.</td>
<td>As a result of the services I received, I get along better with friends.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>7.</td>
<td>As a result of the services received, I get along better with family.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>8.</td>
<td>As a result of the services received, I get along better with other people.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>9.</td>
<td>As a result of the services received, I am doing better in school and/or work.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
1. What has been the most helpful part about the services you received?
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

2. What would improve services here?
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

3. ADDITIONAL COMMENTS:
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
Appendix D: SBMH School Feedback Survey Questionnaire

Please help us evaluate our services by answering questions about the SBMH services you have received. You are not obligated to complete this school feedback questionnaire; your participation is completely voluntary. You are not obligated to indicate your name on the form, this is optional; your identifying information will not be collected or mentioned for the purpose of the program evaluation and your anonymity will be protected.

The purpose of this school Feedback questionnaire is to better understand the SBMH stakeholder's perceptions/views and opinions regarding the effectiveness of this program. The data will be collected and analyzed for the purpose of the SBMH program evaluation. The final document will be shared with all stakeholders and used to inform other practices.

Your name (optional):             I am (optional)     Select

I am a:  Select

Please choose the option that reflects how you feel about the services you received.

1. Was the referral process clear?   Select

   1.a What would you improve about the referral process?

2. Were the program’s mental health clinicians available for questions about the program?

   Select

   2.a What would you recommend to improve communication between the school and the School-Based Mental Health Program?

3. In your opinion, was the School-Based Mental Health Program helpful for the referred students?

   Select
3.a If ‘Yes’ please describe how the program was helpful; If ‘No’, please include a brief description about why the program was not helpful for the students.

4. Since participating to the program, has it become easier for students to seek or ask for mental health services within the school setting?

Select

4.a What would you recommend to improve the way students seek or ask for mental health services within the school setting?

5. Overall, were you satisfied with the program?

Select

5.a Overall, what would you improve about the School-Based Mental Health Program?

6. ADDITIONAL COMMENTS:

This project has been supported by the Ontario Centre of Excellence for Children and Youth Mental Health.

Please return this Form to the Child and Family Centre, by email to: clafleur@childandfamilycentre.on.ca

By fax or mail:
FAX: (705) 521-7390
Or
MAIL TO: Child and Family Centre
319 Lasalle Blvd., Unit 4
Sudbury, ON
P3A 1W7

Should you wish to further elaborate or discuss your answers to these questions, please contact Chantal Lafleur at the above email address.

THANK YOU!
Appendix E: File Disposition Form For Transfer or Closure

Client Name: __________________________ D.O.B.: __________________________
Assigned Staff: ______________________ Service: __________________________

1. TRANSFER

To which service: ___________________________________________________________
To be assigned to: (staff name) ______________________________________________
Signature: ______________________ AND ______________________
Transferring Program Manager Transferring Clinician

2. CLOSURE

Full File Closure □ Program Closure □ Program Name: __________________________
Reason for Closure

- [ ] Moved [ ] Refused/declined services/Non-materialized **
- [ ] Moved while on wait list ** [ ] Service Agreement not upheld by client
- [ ] Does not qualify/does not meet criteria [ ] Service not appropriate at this time
- [ ] Other [ ] Service complete
- [ ] Passed away [ ] Withdrew (had service)
- [ ] Referred elsewhere [ ] Internal transfer
- [ ] Referred to adult mental health services

** ONLY IN THESE INSTANCES IS A CLIENT SURVEY NOT OFFERED

# of sessions______ # of cancellations (clinician)______ # of cancellations (client)______
# of No shows (client)______

Client Feedback Survey

- [ ] Survey completed on site [ ] The client to complete survey off site
- [ ] Please mail the survey to: ______________________________________________
- [ ] If a survey is not sent please explain: ____________________________________

3. ADDITIONAL SERVICE

Service to be added: _________________________________________________________

Assigned to: _____________________________ (i.e. Wait List or Clinician)
(Enter staff name or N/A)

FOR CLERICAL USE ONLY

Date Information Updated: __________________ Secretary: ___________________
### Appendix F: Process Evaluation Matrix:
School-Based Mental Health Services, Child and Family Centre

<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Inputs/Activities</th>
<th>Indicator(s)</th>
<th>Source of Data (Measures)</th>
<th>How data will be collected (e.g. survey)</th>
<th>Person responsible for data collection</th>
<th>Dates of data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are stakeholders satisfied with SBMH services (1.clients, 2. schools, 3.clinicians)?</td>
<td>1. Termination of services/closure 2. Bi-monthly Operational review meetings with Schools 3. Yearly structured interviews with Clinicians</td>
<td>1.a Client’s self-reported score of satisfaction 1.b. Student’s response in survey and during focus group discussions 2. Referral agent’s reported score of satisfaction • Reported satisfaction or concerns during meeting 3. Clinician’s responses to structured interview questions</td>
<td>1. a.CFC Client Satisfaction Survey 1.b. Survey for Youth Focus Group, Note-taking of discussion 2. SBMH School Feedback Questionnaire 3. Clinician Interview questions (qualitative)</td>
<td>1.a. Clinician gives to client during closure session 1.b. Survey Monkey and note-taking of discussion 2. School representatives are asked to complete on a tri-yearly basis. • Program Manager takes notes/minutes of meeting 3. Notetaking and recording of clinicians’ responses during interview</td>
<td>1.a. Executive Secretary 1.b. SBMH team and Students 2. Program Manager and I.T. 3. Students</td>
<td>1.a. Quarterly 1.b. March 2013 2. On-going 3. Interviews conducted March 2013. Data analyzed by June 2013</td>
</tr>
<tr>
<td>What is the average number of sessions per client required to attain treatment goals?</td>
<td>Time-limited intervention</td>
<td>-actual length of service (number of sessions)</td>
<td>-CAFAS closing episode -File Disposition Form</td>
<td>-Clinician indicate success of treatment in CAFAS closing and the number of sessions on File Disposition Form</td>
<td>I.T.</td>
<td>On-going</td>
</tr>
<tr>
<td>How many eligible youths were referred to SBMH and pursued services?</td>
<td>-Target population: Youths aged 12-18 years, referred with mental health problems -Presenting concerns and Student behavioural and social profile -Prevalence of CAFAS scales</td>
<td>-# of clients who (1) were referred and (2) who completed treatment</td>
<td>-Referral Form -Running list of Clients referred -CAFAS closing episode -Characteristics of client in Referral Form -CAFAS results</td>
<td>-Client demographics and characteristics on Referral Form -Referrals in Dashboard -Clinician complete closing CAFAS</td>
<td>I. T.</td>
<td>On-going</td>
</tr>
<tr>
<td>How many clients did not pursue SBMH services and why?</td>
<td>Number of referrals who are:</td>
<td>-Referral Form</td>
<td>-Referral does not meet admission criteria</td>
<td>-P. Manager reviews admission</td>
<td>On-going</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>-------------------------------</td>
<td>-----------------</td>
<td>-------------------------------------------</td>
<td>-------------------------------</td>
<td>----------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-non-admissions</td>
<td>-Referral status on Dashboard</td>
<td>-Client declines services during orientation</td>
<td>secretarial clerk updates status</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-declined services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-moved</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>-aged out</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>How many youth in the SBMH program are referred to Adult Mental Health Services?</td>
<td>Number of youth who are “aging out” of service.</td>
<td>Reason for File closure</td>
<td>File Disposition Form</td>
<td>Clinician to complete SBMH File Disposition Form</td>
<td>I.T.</td>
<td>On-going</td>
</tr>
</tbody>
</table>
## Appendix G: Outcome Evaluation Matrix
School-Based Mental Health Services, Child and Family Centre

<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Short-Term Outcomes</th>
<th>Indicator(s)</th>
<th>Source of Data (Measures)</th>
<th>How data will be collected (e.g. survey)</th>
<th>Person responsible for data collection</th>
<th>Dates of data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has SBMH served to improve behavioural and emotional functioning for the youth?</td>
<td>-Emotional functioning (symptoms of anxiety and depression, self-harm or suicide ideation) -behavioural functioning (substance use, conduct/oppositional/aggressive behaviours)</td>
<td>-Decreased severity levels (0, 10, 20 or 30) of 5 CAFAS scales (behavior towards others, moods/emotions, self-harmful behav., substance use, thinking)</td>
<td>CAFAS</td>
<td>-Clinicians complete CAFAS at assessment and at closure</td>
<td>I.T.</td>
<td>Sept 2012 to June 2013</td>
</tr>
<tr>
<td>Has SBMH services served to increase youth’s problem-solving skills?</td>
<td>-problem-solving skills -positive social interactions</td>
<td>Increased scores on the Post CHS</td>
<td>Children’s Hope Scale</td>
<td>-Clinicians administer CHS at assessment and at closing</td>
<td>I.T.</td>
<td>Sept 2012 to June 2013</td>
</tr>
<tr>
<td>Do SBMH services help to improve the youth’s overall functioning at school?</td>
<td>-Improved Academic functioning</td>
<td>-Reduced score on the CAFAS, school domain scale.</td>
<td>CAFAS, School Domain</td>
<td>Clinicians completes Pre/Post CAFAS</td>
<td>I.T.</td>
<td>September 2012 to June 2013</td>
</tr>
</tbody>
</table>
Appendix H: Clinician Interview Guide

Script: “For the purpose of Program Evaluation, we are interested in the Clinician perspectives in regard to the School-Based Mental Health program (SBMH). This is strictly voluntary so if there are any questions you do not feel comfortable answering, please do not hesitate to let me know. This interview should take about an hour and the information you provide will be utilized to improve the program.”

Introductory Questions (Ice breaker questions)
1) How long have you been working in the SBMH program?
2) What schools do you generally serve?

Interview Questions
3) From your point of view, what is the level of satisfaction you see with the SBMH?
   a. Of clientele
   b. Of schools
   c. Of the community
4) What are your views on the referral process?
   a. Internal referral process
      i. What are the strengths?
      ii. What are the limitations?
   b. External referral process
      i. What are the strengths?
      ii. What are the limitations?
5) In your opinion, how are the measures chosen for the DOING evaluation (CAFAS, Hope scale, referral form) serving the SBMH program?
   *HONOSCA not included in DOING evaluation but is part of referral process
   a. What are the strengths?
   b. What are the limitations?
6) What are your views of the treatment process?
   a. What are the strengths?
   b. What are the limitations?
7) What are your views of the closure and transition process?
   a. What are the strengths?
   b. What are the limitations?
8) Is there anything else you would like me to know concerning your experience with the SBMH program?

Concluding Script
“Thank you so much for your participation. I appreciate your willingness to discuss your experiences with the SBMH program.”
Appendix I: Youth Focus Group Survey
School-Based Mental Health Services

This survey is designed to help us better understand Youth’s perceptions regarding mental health services and needs. The answers to this survey will guide further discussion as a group, so that we hear everyone’s important opinions and ideas. Your name or any identifying information will not be revealed, so your answers will remain anonymous.

1. What is mental health for you?

2. What do you think are some of the most common mental health issues teens face?

3. What are the things that you could do if you are struggling with a mental health issue?

4. Do you know how to access mental health services in your school or community?

5. If there were mental health services in your school, do you think that you or your friend would use them if needed?

   5.B. Why?

6. What would be the best way to inform students about mental health services in your school?

7. If you were given an opportunity to share your ideas/thoughts/views about mental health services, would you be willing?

   7.B. Why?

THANK YOU FOR YOUR PARTICIPATION!!!
Appendix J: Evaluation Analysis Plan: SBMH PROGRAM EVALUATION 2012-2013

- Data Collection will terminate on May 27th, 2013.
- Data analysis to begin on July 15th, 2013.
- Deadline: August 12, 2013

<table>
<thead>
<tr>
<th>Process Evaluation Question</th>
<th>Measures</th>
<th>Plan for Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are stakeholders satisfied with SBMH services (1. clients, 2. schools, 3. clinicians)?</td>
<td>1. CFC Client Satisfaction Survey</td>
<td>Statistical analysis:</td>
</tr>
<tr>
<td></td>
<td>1.b. Survey for Youth Focus Group, Note-taking of discussion</td>
<td>1. Survey monkey descriptive statistics</td>
</tr>
<tr>
<td></td>
<td>2. SBMH School Feedback Questionnaire</td>
<td>1B. Basic Interpretive analysis of Youth Focus Group, to include in Discussion re: needs for services and next steps in the final report.</td>
</tr>
<tr>
<td></td>
<td>3. Clinician Interview questions (qualitative</td>
<td>2. Descriptive statistics from Dashboard</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Merriam’s Basic Interpretive Analysis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• To use Wordle for report and presentation</td>
</tr>
<tr>
<td>What is the average number of sessions per client required to attain treatment goals?</td>
<td>File Disposition Form:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- number of sessions for cases where treatment was successful</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- average days from date of referral and date of assignment</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cox Regression analysis and descriptives</td>
</tr>
<tr>
<td>How many clients did not pursue SBMH services and why?</td>
<td>Referral status:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- non-admissions</td>
<td>- Dashboard for descriptive stats.</td>
</tr>
<tr>
<td></td>
<td>- declined services</td>
<td>- (why?) report on Focus Group discussion regarding why youths do not access mental health services.</td>
</tr>
<tr>
<td></td>
<td>- moved</td>
<td></td>
</tr>
<tr>
<td>How many clients in the SBMH program are referred to adult mental health services?</td>
<td>File Disposition Form, Reason for Closure</td>
<td>Dashboard for descriptive stats.</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Outcome Evaluation Question</th>
<th>Measures</th>
<th>Plan for Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has SBMH served to improve behavioural and emotional functioning for the clients?</td>
<td><strong>CAFAS:</strong> Decreased severity levels (0, 10, 20 or 30) of 5 CAFAS scales (behavior towards others, moods/emotions, self-harmful behav., substance use, thinking) from T1 to T14.</td>
<td>Analysis will depend on the N. Possibly Mann Whitney-U, Chi-square or T-tests.</td>
</tr>
<tr>
<td>Has SBMH services served to increase clients’ problem-solving skills</td>
<td><strong>Children’s Hope Scale:</strong> Increased scores on the Post CHS</td>
<td>Same analysis above.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Important to indicate in the report that results will be out of a population of only those who completed treatment. Assumption that clients who withdraw from services never complete the Post Hope scale.</td>
</tr>
<tr>
<td>Do SBMH services help to improve the students’ overall functioning at school?</td>
<td><strong>CAFAS:</strong> decreased severity level of the School Domain scale</td>
<td>T-Test</td>
</tr>
</tbody>
</table>

May 30/13. CL
Appendix K: Clinician Interview Consent Form
School-Based Mental Health Services

I __________________________ (please print name) agree to participate in the clinician interview on __________________________, to discuss my experiences with the School-Based Mental Health Program only as it relates to the Doing Program Evaluation. I understand that I will be asked questions about my experiences within the School-Based Mental Health program, as offered by the Child and Family Centre. I will also be asked about my perspectives on the processes and outcomes of the program. I understand that participation in this interview will pose no consequences or repercussions to my employment or membership in the Doing Program Evaluation.

I understand that this interview is strictly voluntary and I may withdraw participation at any time. I am aware that I can choose not to answer any question. I understand that any identifying information will not be disclosed and that the information I share will be confidential. This information will be collected for the purpose of understanding my views/perceptions regarding School-Based Mental Health Services, which will help the Child and Family Centre evaluate the effectiveness of its program and improve services offered to youths at this time. I understand that all personal information will be kept in a locked file cabinet and upon completion of this project, all data (recordings, notes, and transcripts) will be destroyed.

I understand that my participation in this CLINICIAN INTERVIEW is voluntary and I may withdraw at any time.

Signature: __________________________________________

Date: __________________________________________
Appendix L: Youth Focus Group Consent Form

YOUTH FOCUS GROUP

School-Based Mental Health Services

I, __________________________________________ (Please print name) agree to participate to the YOUTH FOCUS GROUP, on ________________, to discuss School-Based Mental Health services. This Focus Group is offered by the Child and Family Centre in partnership with St-Charles College.

I understand that I will be asked to complete an anonymous survey regarding mental health issues, services and activities. I understand that my name will not be disclosed and that the information I share will be confidential. This information will be collected for the purpose of understanding my views/perceptions regarding School-Based Mental Health Services, which will help the Child and Family Centre evaluate the effectiveness of its program and improve services offered to youths at this time. I understand that upon completion of this project, all data (recordings, notes, and transcripts) will be destroyed.

I understand that my participation in this FOCUS GROUP is voluntary and I may withdraw at any time.

Signature: __________________________________________

Witness: ___________________________________________

Date: _______________________________
Appendix M: Statement of Personal Health Information Practices

CLIENT NAME:_________________________     D.O.B.:______________________

This information may have previously been discussed with you at the Children’s Community Network Intake meeting.

The Child and Family Centre (CFC) is committed to respecting, safeguarding and protecting your personal health information (PHI) and complying with the Personal Health Information Protection Act, (PHIPA) 2004, which requires that PHI be kept private and secure.

CFC is a mental health agency providing services to children/youth and their families. CFC provides a spectrum of programs including counselling, mental health treatment, developmental, clinical and community support services, Outreach, Day treatment and resource programs in English and French, as well as in other languages with the support of interpreters, and within the native cultural context.

What is Personal Health Information (PHI)?
PHI is information pertaining to your health. It may include demographic information, facts and information about you or your child's health history, including mental, social and service history, family/home environment, the provision of health care including the identification of a person as a provider of health care provider and your health card number.

We will not collect more information than is necessary to meet our purpose.

We will not collect information if other information will serve the purpose.

How do we collect PHI?
CFC collects information about you or your child/adolescent,
• directly from you, your child or from someone acting for you
• Indirectly, i.e. from other services or from your school, where you have given CFC permission or where the law allows.

Why do we collect PHI?
CFC only collects PHI for the following reasons:
• to provide the requested mental health assessment, programming and treatment services
• to prevent harm or respond to emergency situations
• to communicate with other health care providers, agencies and schools involved in providing services.

Non-identifying information related to client service is used for:
• strategic management
• planning, administration, decision making
• allocation of resources, for reporting to the Ministry of Children and Youth Services (MCYS)
• to undergo an Accreditation process
• to comply with legal and regulatory requirements and
• to fulfill other purposes permitted or required by law.
• to measure the effectiveness of its services, CFC is committed to conduct evaluations of agency programs. Your non-identifying information (anonymous and confidential) may also be collected for this purpose.

To whom does CFC disclose your PHI?
CFC shall disclose PHI to:
• other CFC staff and consultants employed by CFC for consultation and supervision;
• to professionals in your ‘Circle of Care, unless you tell us not to.

The Circle of Care includes authorized service providers you are involved with and who have a need to know your PHI to provide services and treatment to your child/youth. The Circle of Care may include the Service Coordinators at CCN, family physicians, psychiatrists, paediatricians and other health specialists.

The Circle of Care does not include Children Aid Societies, Education, Employee Assistance Programs (EAPs) or the Youth Justice System. For individuals or agencies outside the Circle of Care, CFC must get your written permission to release any PHI.

CFC will not give out this information unless permitted or required by law to do so.

CFC may be required to give out PHI in specific circumstances:
• when information is obtained about a child that may be in need of protection
• where you or your child are at risk of self-harm or at risk of harming others
• where the Centre is served with a subpoena
• where the Ministry of Children and Youth Services is investigating or auditing our records.

What if you change your mind? (Withdrawal of Consent)
You can withdraw or withhold your consent about your PHI at any time, or from any service provider;

You can request that specific sensitive information be blocked although your name, date of birth, address and service providers you are involved with will be accessible in the Client Information Management System (CIMS).

How does CFC store and manage your PHI?
All paper records containing PHI are maintained in secure and locked files.

CFC shares an electronic charting system with other services providers who have access to your record because they are part of your Circle of Care. Unless you tell us not to allow this, the partners who are providing you with services will have access to your PHI.

Records will be retained until the client turns 28 years old, at which time they will be shredded/destroyed.

Can I see my record? If there are mistakes, how are corrections made?
You have the right to request access to and correction of your PHI. To do so, contact your assigned worker or the Privacy Officer. The following individuals can access the
record:

- the custodial parent of a client under 16, unless the child is 12+ and has arranged the services on his/her own
- a client who is 12 years or over, who has arranged the services on his/her own,
- a client 16 or over.

There may be circumstances where you may not be able to access your information, or where CFC will not be able to make the requested corrections. Reasons will be given if these circumstances exist.

**How is my PHI kept safe?**

All electronic records require passwords to access. CFC will take all reasonable steps to ensure the PHI is protected against theft, loss and unauthorized use or disclosure.

Everyone who performs services for CFC, will protect your privacy and use your PHI only for the purposes you have consented to.

In the unfortunate event that PHI is stolen, lost or accessed without authorisation, we will inform you at the first reasonable opportunity.

**Concerns and complaints about Privacy**

If you have any questions or concerns regarding the privacy and/or information practices at CFC, please contact our Privacy Officer, Linda Dugas. We will answer all questions and will promptly investigate any concerns raised regarding this policy or a potential privacy breach. If an issue is found to have merit, we will take all appropriate measures, including taking disciplinary action or amending our information practices.

Linda Dugas, Director of Clinical Programs
Child and Family Centre
319 Lasalle Blvd, Unit 4
Sudbury, ON P3A 1W7
705-566-5866 ext. 2533
ldugas@childandfamilycentre.on.ca

Although we will make every effort to resolve all privacy concerns, if you are not able to resolve a privacy issue directly with our agency, you may contact:

Office of the Information and Privacy Commissioner of Ontario
2 Bloor St. East, Suite 1400
Toronto ON M4W 1A8
1-800-387-0073

Having reviewed the CFC Statement of Personal Health Information Practices and understood them, I hereby authorize CFC to collect, use and disclose my PHI.

______________________________  ________________________
Client Signature                                                  Date

______________________________  ________________________
Parent/Guardian/Substitute Decision Maker Signature    Date

________________________________________
Linda Dugas
Director of Clinical Programs
Child and Family Centre
319 Lasalle Blvd, Unit 4
Sudbury, ON P3A 1W7
705-566-5866 ext. 2533
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Having reviewed the CFC Statement of Personal Health Information Practices and understood them, I hereby authorize CFC to collect, use and disclose my PHI.

______________________________  ________________________
Client Signature                                                  Date

______________________________  ________________________
Parent/Guardian/Substitute Decision Maker Signature    Date
Appendix N: Descriptive Statistics for School-Based Mental Health Program 2012-2013

<table>
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<tr>
<th></th>
<th>N</th>
<th>Min</th>
<th>Max</th>
<th>Mean</th>
<th>Std. Error</th>
<th>Std. Deviation</th>
<th>Variance</th>
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<td>Pre- Children's Hope Scale Total Score</td>
<td>19</td>
<td>11</td>
<td>32</td>
<td>22.00</td>
<td>1.33</td>
<td>5.80</td>
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<td>Post- Children's Hope Scale Total Score</td>
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<td>18</td>
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<td>CAFAS T14_SCHOOL</td>
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<td>CAFAS T14_HOME</td>
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<td>173.33</td>
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