An Evaluation of Good Shepherd Youth Services Community Mental Health Program:
Providing Clinical Care to Street Involved Youth with Mental Health Difficulties

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Good Shepherd Youth Services, Community Mental Health Program
Providing Clinical Care to Street Involved Youth with Mental Health Difficulties
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The following evaluation is an extension of the 2012-2013 Planning Evaluation Grant examining the Community Mental Health Program. This evaluation takes a closer look at the youth being referred to the Program, the experiences of those who participate and if the program components are positively impacting the clients global functioning, emotional symptoms and behavioral symptoms.

The Purpose

- To identify the demographic characteristics and primary issues of concern of the youth referred to the Community Mental Health Program.
- To describe the involved program staff and youth’s experiences (i.e. level of satisfaction, contribution to treatment, convenience of location/appointment times, suggested improvements to service delivery and usefulness of skills training) of the Community Mental Health program.
- To evaluate the global functioning of the youth who participate in the Community Mental Health Program.
- To determine if participation in the Community Mental Health Program decreases emotional and behavioral symptoms.

The Program

The Community Mental Health Program began seven years ago and is funded by the Ontario Ministry of Child and Youth Services. The program focuses on referral, triage, assessment and treatment, providing clinical interventions to street involved youth ages 16 – 21 in Hamilton, Ontario. In 2013 the program, which has 1.6 Masters prepared clinicians, served over 200 unique individuals. Upon referral a Child and Adolescent Needs and Strengths Assessment is completed along with a triage interview to determine the appropriate type of service provision. Crisis counseling and advocacy may be offered to youth after triage. A mental health assessment is completed before determining treatment that may include consultation with adolescent psychiatrists. Youth may participate in skill development group programming and/or individual therapy. The Mental Health Team also facilitates an education program called Skills for Life. The primary goal of the Mental Health Program is to increase the global functioning of street involved youth with mental health problems.
The Plan

Youth identified with mental health difficulties referred to the Community Mental Health Program between February 1st 2014 and July 1st 2014 were eligible for participation in the evaluation. For this pre-post comparison evaluation our sample size goal was 25 participants. Upon referral, the youth were invited to participate in the evaluation and given an information letter and consent form. Attached to the Referral Form was the pre CANS-SC completed by a certified staff member. Youth were asked to complete 3 online standardized assessments: CDI 2: Self-Report, MASC 2-Self-Report and Connors 3 – Self-Report. These were administered at the time of entry to the program and at the end of data collection. Upon completion of both the pre and post evaluation activities youth were offered a $5.00 gift card as an incentive for completion. At the end of data completion youth were asked to complete a Youth Satisfaction Questionnaire, and the assigned case managers were also asked to complete a Staff Satisfaction Questionnaire and a post CANS-SC.

The Product

Clinicians now know much more about the youth being referred to the Program. The overall impression of the Program aligns with current standards for best practice which emphasize youth friendly services. The Program’s priority of improving the global functioning for those that participate has proven to be consistent for 2 years. Generally more than half of the youth who participate in the Program experience a decrease in depressive and anxious symptoms. An area that requires improvement is the Program’s ability to treat youth with behavioral profiles. Tremendous learning has taken place over the last 2 years that has positively informed many aspects of the Mental Health Program’s service provision. Undoubtedly, the evaluations have improved the effectiveness and efficiency of service for the youth referred to the Mental Health Program and have assisted the clinicians in their desire to provide care to this unique population. Our experience with this evaluation has truly allowed the Mental Health Program and its clinicians to be an influence at the agency, cultivating an enthusiasm for learning and setting the standard of capacity development.

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Introduction and Literature Review

In 2013, Good Shepherd Youth Services Community Mental Health Program received a Doing Evaluation Grant from the Ontario Centre of Excellence for Child and Youth Mental Health. The purpose of the evaluation was to examine whether the program was meeting the needs of the youth served. The following evaluation is an extension from the 2012 Planning Evaluation Grant that took place in partnership with the Centre of Excellence for Child and Youth Mental Health. The Doing Evaluation Grant takes a more extensive look at the youth being referred to the Community Mental Health Program, defining street involvement, determining the presenting mental health problems and the program’s ability to address the youth’s needs. Additionally, we broadened our evaluation capacity and this is reflected within our evaluation framework, particularly the data collection tools used to determine if the program activities impact global functioning.

The Community Mental Health Program began seven years ago and is funded by the Ontario Ministry of Child and Youth Services. Initially the program was single staffed by a liaison nurse, whose primary role was to advocate and liaise with health care providers, frontline staff, and youth. In 2008, the program expanded to its current form, a transdisciplinary model that focuses on referral, triage, assessment and treatment; providing clinical interventions to street involved youth in Hamilton, Ontario. The target population is street involved youth ages 16 – 21 with mental health problems and mental illnesses. In 2013 the program, which has 1.6 Masters prepared clinicians, provided services to over 200 unique individuals.

Upon referral, a Child and Adolescent Needs and Strengths Service Coordination (CANS-SC) Assessment is completed with a triage interview to determine treatment options. Crisis counseling

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1 The Mental Health Program’s Planning Evaluation Grant Final Report can be viewed on the Centre’s website, Grants and Awards Index: http://www.excellenceforchildandyouth.ca/resource-hub/grants-and-awards-index
and advocacy may be offered to youth after triage. Advocacy refers to clinicians offering supportive lobbying to other agencies, programs and schools, with the goal of facilitating positive change in the mental health of the youth. A full mental health assessment is completed before determining treatment that may include Cognitive Behavioral Therapy, Dialectical Behavioral Therapy, and consultation with adolescent psychiatrists. Youth may participate in skill development group programming and/or individual therapy.

The Mental Health Team facilitates a comprehensive education program called *Skills for Life* which is comprised of 18 skills emphasizing functioning, emotion regulation and shaping behavior. Skills for Life is informed by the clinicians’ knowledge of global functioning, clinical experience with street involved youth and principles of Dialectical Behavior Therapy. McCay and Aiello (2013) conducted a study using Dialectical Behavior Therapy with street involved youth and their findings suggest that these interventions increase the youth’s capacity to endure challenging situations, manage emotional instability, and because of the emphasis on practical strengths, improve quality of life. The Skills for Life program is a didactic and transferrable curriculum designed for frontline staff members and is the foundation of the group programming for the youth. See Appendix A for a Skills for Life Curriculum Summary.

A comprehensive literature review was conducted which showed there is a broad range of implications when using the term “street involved”. For the purposes of this evaluation we found it necessary to describe what is meant by the term street involvement and its relevance to the youth engaged in the Community Mental Health Program. Edidin et al. (2011) define street involved youth as runaways (youth who have spent more than one night away from home without parental permission), throwaways (youth who have been forced to leave home by their parents), street youth (youth who live in high risk nontraditional locations such as under bridges and in abandoned
buildings) and system youth (youth who have previously been involved in government systems such as foster care or juvenile justice). Edidin stated that:

“A homeless person is anyone who lacks a fixed, regular, and adequate nighttime residence; and whose primary nighttime residence is a supervised shelter designed to provide temporary living accommodation, including emergency shelters, transitional housing, or a place not designed for regular nighttime human habitation (e.g., such as under a bridge or in a car)” (p. 355).

The youth served by the Community Mental Health program in the last five years are best encapsulated in Edidin et al’s (2011) definition of street youth. The youth were in one, more, or all of these categories when they initially became involved in the Program. The reality of being a young person who is street involved in Hamilton often includes use of mood altering substances; academic, attendance and/or behavioral issues in school; living in extreme poverty; having parents with limited parenting skills; high risk of criminal involvement; limited access to and knowledge of the need for primary health care; lack of availability of food, particularly appropriate nutrition, and lack of a secure place to sleep. These characteristics are seen in the youth who are participating in the Community Mental Health Program.

In clinical work with street involved youth, service providers must be aware of the compounding features of street involvement and adolescence. “Street life presents a series of contradictions for youth. While it offers a supportive escape from a lonely, obstructive, and often violent family life, the street also exposes youth to another kind of risky, stigmatizing and lonely community existence” (Karabanow et al., 2007, p. 29). In the Planning Evaluation Grant, primary issues of concern and demographic characteristics were collected to learn more about the youth referred to the program. The evaluation revealed that the primary issues of concern were ADHD, anxiety, depression, emotional symptoms, self-harm/suicidal ideation, trauma, family stress/youth’s
parents having limited parenting skills, and high risk behaviors. The demographics collected showed the average age of the youth who participated in the evaluation was 18.8 years, 71% of the participants were female and 28% male. The ethnic representation was Afro-Caribbean and Caucasian. The primary issues of concern and demographic characteristics were also collected in this evaluation but the internally developed data collection tools used to answer these process questions were revised.

There is very little research literature on mental health interventions with street involved youth. Most information focuses on access to mental health services and models of service delivery rather than what interventions contribute to improved outcomes for these youth. The literature emphasizes how to work with street involved youth, calling attention to strength based and youth friendly services, acknowledging street involved youth as being a hard to reach population. It is well documented that it is a struggle to engage street involved youth in mental health services. The precarious lifestyle often makes them hard to reach but a compounding contributing factor is the view of being unwell on the streets. Bhui et al. (2006) found that “homeless young peoples’ views of mental health is more negative with homeless participants perceiving mental health services as being for “crazy people” often leading to a denial of their own mental health problems” (p.152). Further, O’Reilly et al. (2009) suggests, “young homeless peoples’ perception of mental health can have real consequences in regard to how they view and engage in mental health services” (p. 1738).

In the Planning Evaluation Grant we found it useful to explore the experiences of those who participated in the Community Mental Health Program. Through the administration of satisfaction questionnaires, most youth and staff endorsed that they strongly agreed and agreed with overall satisfaction with mental health services, choice in services and treatment planning, and in a pleasant environment with convenient appointment times. The experiences of the Community Mental Health Program align with the literature on mental health interventions that address the importance of
scheduling flexibility, sensitivity to culture and services delivered respectfully. The qualitative data collected helped inform service provision and was also collected within the Doing Evaluation Grant, although the data collection tools were modified and a Skills for Life inquiry section was added.

A part of the Community Mental Health Program’s approach to care prioritizes optimal global functioning for the youth involved. In fact, one of the primary goals of the Program is to increase the global functioning of street involved youth who are coping with mental illness and mental health problems. Global functioning refers to the adequacy of a youth’s sleep and eating patterns, their physical health and participation in the activities of daily living, limited criminal involvement, substance use, and high-risk behaviors. For street involved youth participating in treatment, the combination of inadequate global functioning and mental illness is so severe that there is impact in multiple domains of their life. For instance, the Diagnostic and Statistical Manual, (Diagnostic and Statistical Manual of Mental Disorders (DSM-5), has a global assessment of functioning scale (GAF) that is used by clinicians to assess a person’s overall level of psychological functioning (American Psychological Association, 2012). The GAF makes reference to difficulties including school functioning, criminal behavior, peer relations, ability to care for oneself and others, failure to maintain personal hygiene, and minor sleep disruption.

Kazdin (1993) writes of how “mental health encompasses the absence of dysfunction in psychological, emotional, behavioral and social spheres. Dysfunction refers to impairment in everyday life” (p. 128). Symptoms of psychiatric disorders, including anxiety, depression and psychosis, are examples of dysfunction and can hinder daily behaviors and functions, for example interpersonal relationships and school performance. Substance misuse or suicidal ideation threaten wellbeing, resulting in further negative impact on functioning. Kazdin discusses how adolescent behaviors and conditions to which they are exposed, for example poverty and homelessness, impede their functioning and may lead to further physical and psychological impact (1993). Street involved
youth’s basic needs are often neglected and since there is a relationship between secure basic needs and adequate global functioning, service providers must devise interventions that address this relationship (Kidd, 2013). In working with street involved youth, positive mental health interventions must emphasize the development of skills. Kazdin reiterates this by explaining it is important to understand that skill based interventions enable strength building, resilience and coping to improve functioning (1993).

After reviewing the literature we determined that the first 20 items on the Child and Adolescent Needs and Strengths Assessment (CANS-SC), a tool already integrated within the Good Shepherd Program referral process, accurately captured various elements of youth’s global functioning. We used the CANS-SC in the Planning Evaluation Grant to measure global functioning and kept it as the primary measure for the Doing Evaluation Grant. John Lyons and the Praed Foundation permitted the Program to create a scoring grid exclusively for the purposes of this evaluation that allowed us to analyze our comparative data concisely.

Throughout the development of the Planning Evaluation Grant it became clear the program did not have the necessary data collection tools to answer questions pertaining to emotional and behavioral symptoms. The primary issues of concern revealed during the Planning Evaluation Grant showed a majority of the youth who entered the Program were experiencing difficulties with emotion, behavior and high-risk behaviors. The Program introduced two new standardized measures assessing mood difficulties during the pilot data collection: the Children’s Depression Inventory 2nd edition (CDI 2) and the Multidimensional Anxiety Scale for Children 2nd edition (MASC 2). A new measure assessing behavior was introduced during this grant cycle: Connors 3rd edition (Connors 3). The data collection tools will be discussed further in the methodology section. See the Program Logic Model in Appendix B.

Evaluation Questions
Process Evaluation Questions

1. What are the primary issues of concern that are referred to the Community Mental Health Program?

2. What are the demographic characteristics of the youth served?

3. What are the youth and staff experiences of the Community Mental Health Program?
   a. Experience refers to the a) youth’s and b) case manager’s overall level of satisfaction, the availability and flexibility of the clinicians, invitation to contribute to treatment plans, convenience of location and appointment times, and suggested improvements to service delivery. The questionnaires also ask for feedback on the Skills for Life interventions and their effectiveness.

Outcome Evaluation Questions

1. Does the global functioning improve for youth who participate in the Community Mental Health Program?

2. Does youth participation in the Community Mental Health Program decrease emotional symptoms?

3. Does youth participation in the Community Mental Health Program decrease behavioral symptoms?

Methodology

Participant Characteristics

Youth between the ages of 16 – 21 with identified mental health difficulties referred to the Community Mental Health Program between February 1st 2014 and July 1st 2014 were eligible for
participation within the evaluation. For this pre-post comparison evaluation our sample size goal was 25 participants. Only those referred from Notre Dame House, an emergency shelter for homeless youth; Brennan House, a co-ed transitional housing program; and Notre Dame Community Resource Centre, a drop-in centre for street involved youth, were invited to participate in the evaluation. Youth accessing the Program from other sites served by the Mental Health Program had a dependent child, or their primary point of access was within other community agencies. Throughout the course of the data collection, 14 youth participated in the evaluation. Of those participants 5 youth were referred from Notre Dame House, 5 from Brennan House, and 4 youth from the Notre Dame Community Resource Centre. Of the participants, various primary issues of concern and demographic characteristics were represented which will be developed further in the results section.

Data Collection Tools

The following data collection tools were utilized in this evaluation:

1. **Community Mental Health Program Referral Form**

   An internally developed document used across the various programs served by the Community Mental Health Program. The Referral Form is designed to capture identifying information and concerns regarding the youth’s thoughts, feelings and behaviors. The Referral Form allowed us to identify primary issues of concern and was completed during pre data collection (Appendix C).

2. **Community Mental Health Program Triage Form**

   An internally developed document used at the triage interview, typically the first scheduled appointment with a youth, designed to elaborate on the information collected at referral, prioritize the youth’s needs, and determine the type of participation in the Program. The Triage Form allowed us to determine the immediacy of the presenting issues and identify demographic characteristics, and was completed during pre data collection (Appendix D).
3. **Youth Satisfaction Questionnaire**

An internally developed document adapted from the Youth Satisfaction Survey (YSS; Brunk, 1999) encompassed client experiences of the program as stated in our process evaluation question #3. This questionnaire was administered during the post data collection phase of the evaluation (Appendix E).

4. **Staff Satisfaction Questionnaire**

An internally developed document adapted from the Youth Satisfaction Survey (YSS; Brunk, 1999) encompassed staff experiences of the program as stated in our process evaluation question #3. This questionnaire was administered to referring staff members during the post data collection phase of the evaluation (Appendix F).

5. **Child and Adolescent Needs and Strengths Assessment – Service Coordination (CANS-SC; Praed Foundation, 2014)**

The CANS-SC is used to facilitate a linkage between assessment processes and the design of individualized treatment plans. Each item is scored using a four level scale with specific definitions. The definitions are characterized to promote the development of supportive action. The CANS-SC was completed by a staff member upon referral and once again at the completion of data collection. The CANS-SC is a 45-item assessment, for this evaluation the first 20 items were identified for comparison, as these items are the most relevant reflection of the developed definition of global functioning. With permission from John Lyons, the creator of CANS, a total score of the 20 items was tallied by adding up each rating by the total possible number (Appendix G).

6. **Children’s Depression Inventory 2nd Edition (CDI 2; Kovacs, 2011)**

The CDI 2 is a multi rater assessment of depressive symptoms for children and youth ages 7 – 17 years of age. We used the CDI 2: Self Report (CDI 2:SR) electronic form made available
through purchasing the online software and accessing the MHS Assessment Center. The inventory has 28 items, each item having a group of three sentences. Participants were asked to pick one sentence for each item that best described them over the past two weeks. The CDI 2:SR has six subscales: Negative Mood/Physical Symptoms, Negative Self Esteem, Ineffectiveness, Interpersonal Problems, Emotional Problems, and Functional Problems in addition to a total score. The CDI 2 is an assessment used to assist in identifying children and adolescents with depressive symptoms, and aids in the early identification of youth vulnerable to these emotional difficulties and monitors the impact of intervention. The tool reflects affective, cognitive, motivational and functional coverage of symptoms facilitating diagnostic decisions and to guide treatment planning. For the purposes of evaluation we asked the participants to complete the CDI 2:SR at the beginning of data collection and upon completion for pre and post comparison.

7. **Multidimensional Anxiety Scale for Children 2nd Edition (MASC 2; March, 2013)**

The MASC 2 is a multi rater assessment of anxiety dimensions for children and youth aged 8 – 19 years. We used the MASC 2-Self-Report (MASC 2-SR) electronic form made available through purchasing the online software and accessing the MHS Assessment Center. The assessment has 50 items answered using a four-point scale of frequency, ranging from *Never* to *Often*. The MASC 2-SR has a total score, Anxiety Probability Score, 2 scales: Social Anxiety and Physical Symptoms and 8 subscales: Separation Anxiety/Phobias, Generalized Anxiety Disorder (GAD) Index, Harm Avoidance, Humiliation/Rejection and Performance Fears (inclusive under the Social Anxiety scale), Panic and Tense/Restlessness (inclusive under the Physical Symptoms scale). The evolution of the MASC 2 acknowledges that early identification and treatment of youth with anxiety is reasonable to expect. There is extensive literature explaining that many anxiety disorders can begin in childhood and the MASC 2 was
designed to reliably identify displayed symptoms in a clinical context. The assessment acknowledges the developmental and gender differences of anxiety, the differences in daily routines and environments within a wide spectrum of symptoms. For the purposes of this evaluation we asked the participants to complete the MASC 2-SR at the beginning of data collection and upon completion for pre and post comparison.

8. **Connors 3rd Edition (Connors 3; Connors 2013)**

The Connors 3 – Self-Report (Connors 3 – SR) is a multi rater assessment of behavioral difficulties for children and youth aged 8 – 18 years. We used the electronic form made available through purchasing the online software and accessing the MHS Assessment Center. The assessment has 97 questions using a four-point scale of frequency, ranging from *Not true at all* to *Very much true*. Participants are asked to consider the past month and respond with their opinion of relevancy to each statement. The Connors 3 focuses on the DSM-IV-TR symptom counts for ADHD Inattentive, ADHD Hyperactive-Impulsive, Conduct Disorder, Oppositional Defiant Disorder and an ADHD Index Probability Score. The Connors 3 is a widely used child behavior rating scale focusing on the diagnostics of attention, hyperactivity, and organization of time and possessions. The assessment items target areas of concern pertaining to behavioral difficulties within the home, learning and social environments, and employment. For the purposes of this evaluation we asked the participants to complete the Connors 3 – SR at the beginning of data collection and upon completion for pre and post comparison.

Note: the CDI 2, MASC 2 and Connors 3 were selected by the mental health clinicians as the primary data collection tools to examine emotional and behavioral symptoms as the findings on consistency and factorial structure showed good psychometric properties, with notably respected reliability and positive validity. Through the introduction of these standardized measures, particularly
using the online software, clinicians could readily identify the emotional and behavioral concerns of
the youth who accessed the Community Mental Health Program and track any changes in these areas
after participating in treatment, addressing the final outcome questions.

Participant Consent

The youth who were invited to participate in the evaluation were given a letter of
information outlining intent and parameters of participation; upon agreement the youth signed a
consent form. All the youth participating in the evaluation were over 16 years of age so no guardian
signature was required. The Letter of Information and Consent Form are attached in Appendix H.

Pre-Data Collection

Upon referral, youth had a triage appointment with a mental health clinician. At the
beginning of the triage interview the youth were invited to participate in the evaluation and given an
information letter and consent form by a mental health clinician. The 1st and 2nd process evaluation
questions addressing primary issues of concern and demographic characteristics were collected via
document review of the Referral Form and Triage Form. The primary issues of concern were
classified within four categories: behavioral symptoms, emotional symptoms, psychosis, and risk
behaviors\(^2\). The results from the Planning Evaluation Grant informed the selection of categories.

All concerns presented were sorted into the appropriate categories. The primary clinician
completed the categorization at triage. Attached to the Referral Form was a CANS-SC completed by a
certified staff member, most often the assigned case manager. Within a month of signed consent,
youth were asked to complete the online CDI 2:SR, MASC 2-SR and Connors 3 – SR on program
computers. Upon completion the online software generated a report providing a summary of scores

\(^2\) For the purposes of this evaluation risk behaviors is defined as it relates to the developed definition
of global functioning and informed by the 4 items within this same category in the CANS-SC.
and brief interpretation. Youth were offered a $5.00 gift card as an incentive for completion. Gift cards were available for Giant Tiger, McDonald’s Restaurants, Shoppers Drug Mart and Tim Horton’s.

The youth then participated in treatment with a mental health clinician. Appointments were scheduled between the youth and clinician. Typically appointments occurred on a weekly or biweekly basis throughout the data collection. Each session was up to 1 hour long. Client files containing confidential information and evaluation documentation was stored in a locked filing cabinet at the Mental Health Program’s main office in a locked room.

Post-Data Collection

At the end of the 5-month data collection, the week of June 23rd 2014, youth were given appointments to conduct the post data activities (this may or may not have been the final appointment as some of the participants continued as clients of the Program once the data collection was completed). Once again, youth completed the online CDI 2:SR, MASC 2-SR and Connors 3 – SR. Clinicians also connected with the youth’s assigned case manager and asked for the completion of a Staff Satisfaction Questionnaire and a post CANS-SC. A mental health worker also administered a Youth Satisfaction Questionnaire to the youth whom participated in the evaluation. Upon completion of the post data collection activities youth were offered a $5.00 gift card as an incentive for participating in data collection. Gift cards were available for Giant Tiger, McDonald’s Restaurants, Shoppers Drug Mart and Tim Horton’s. Refer to Appendix I for a summary of evaluation questions, indicators and data collection tools in the Evaluation Framework.

Data Analysis

The first process evaluation question identified the primary issues of concern. Once this information was collected from the Referral Form, it was categorized by a clinician and manually entered into the evaluation database. Aggregated results were tabulated into a horizontal bar graph using Microsoft Excel and are presented in the results section of this report.
The second process evaluation question identified the demographic characteristics of the youth referred to the Program. This data was collected using the Triage Form, manually entered into the evaluation database and compared to the statistics collected during the Planning Evaluation. Demographic characteristics are presented in the results section of this report.

The third process evaluation question asked for the youth and staff’s experiences of the Program. Questions addressing elements of satisfaction were tallied and computed in a Microsoft Word table using percentages to represent the sum of each numeric value. Responses to open ended questions were grouped in themes and summarized.

The first outcome evaluation question asked if the global functioning improves for those who participate in the Program. Pre and post data gathered from the CANS-SC was entered into the evaluation database and a bar graph, created in Microsoft Excel, compared the pre and post total scores. Pre and post data collection also included tracking the number of items within each level of the scoring scale and these differences were compared using Microsoft Excel pre and post pie graphs.

The second outcome evaluation question asked if youth participation in the Program decreases emotional symptoms. Data was collected using the CDI 2 and MASC 2 and pre and post data was entered into the evaluation database. Total T-scores were tabulated using Microsoft Excel to create comparative vertical bar graphs, highlighting the Normative Sample Average Score to observe any changes between the periods of measurement. A recommendation from the Planning Grant Final Report was to further explore the subscales of the data collection tools. For the CDI 2 subscales, Emotional Problems and Functional Problems were compared and the pre and post T-scores were illustrated using Microsoft Excel bar graphs. For the MASC 2, the pre and post Anxiety Probability Score was compared and illustrated using a Microsoft Excel bar graph.
The third outcome evaluation question asked if the Program decreases behavioral symptoms among youth participants. Data was collected using the Connors 3, and pre and post data was computed into the evaluation database. ADHD Index Probability Scores were tabulated using Microsoft Excel into a vertical bar graph, highlighting the Normative Sample Average Score, to observe any changes between the periods of measurement. Pre and post scores of the Symptom Scales were also compared using Microsoft Excel bar graphs.

Limitations of the Methodology

Of the 14 youth who participated in the evaluation only 8 fully completed the pre and post data evaluation activities. The remaining 6 participants did not engage in all the evaluation activities due to losing contact or failing to arrive to scheduled appointments. The sample size of 25 was not achieved due to clients refusing participation at the time of participant consent and losing contact with referred youth prior to triage. As illustrated in the literature review, street involved youth live in precarious situations, which makes retaining clients throughout treatment difficult. The incentives introduced during this evaluation improved recruitment to the evaluation.

A second limitation was the allocated maximum age of the standardized measures ending at seventeen for the CDI 2, nineteen for the MASC 2 and eighteen for the Connors 3. Some of the participants exceeded the maximum age for one or more of the measures, so result interpretation had to be taken with caution.

Throughout the evaluation there were a number of external variables that could not be isolated that very likely impacted the results, particularly the youth from the Community Resource Centre, namely the end of the school year and youth participating in multiple social service agencies/supports. Additionally, the precariousness of the living situations of youth involved in the program made it very difficult for some to participate in both pre and post data collection activities.
Many factors beyond the control of the Program but endemic to the living situations of street involved youth have a profound effect on the mental health and global functioning of these youth.

Results and Interpretation

Primary Issues of Concern and Demographic Characteristics

Review of the Program Referral Form allowed the clinicians to classify the primary issues of concern within the four pre-determined categories. Of the 14 participants, 13 were identified with emotional symptoms, 11 participating in risk behaviors, 9 were identified with behavioral symptoms and 1 identified with psychosis (Graph 1). These results are congruent with the 2012-2013 Planning Evaluation Grant results in which emotional symptoms and risk behaviors were similarly predominant.

Graph 1: Primary Issues of Concern

The Program Triage Form provided demographic characteristics including age, gender, community of origin and ethnicity. The average age of program evaluation participants was 18.1 years old, with 8 male participants and 6 female participants. The community of origin most represented was Hamilton, Ontario and the primary ethnicity of representation was Caucasian. These results are similar to those collected in the Planning Evaluation Grant, but the only significant
differences in this sample are the male presiding gender ratio (2013 EPG: 5F/2M) and community of origin more commonly Hamilton versus various regions/provinces (2013 EPG: Alberta, Brantford, British Columbia, Haldimand/Norfolk, Manitoba).

Experiences of the Community Mental Health Program

5 Youth Satisfaction Questionnaires and 8 Staff Satisfaction Questionnaires were completed. As reinforced by the literature review, the Program puts a strong focus on street involved youth’s access to mental health services and models of service delivery that emphasize youth friendly services and youth’s perceptions of the service.

83% of youth respondents either strongly agreed or agreed to overall satisfaction with services, involvement in treatment plans, convenience of location/appointment times and reasonable availability of clinicians. 70% of staff either strongly agreed or agreed to involvement in treatment plans, 100% to convenience of location/appointment times and 90% to reasonable availability of clinicians. 100% of staff strongly agreed to overall satisfaction of the mental health services. Refer to Appendix J for a summary of quantitative results.

The questionnaire also invited youth and staff to comment on the most helpful aspects of service and potential areas of improvement. The consensus of these comments, consistent with the reviewed literature, showed satisfaction with access to trusted professionals, specialized service, and ease of connecting/referring. The one repeated area of improvement requested was more clinicians.

On questions specific to the Skills for Life aspect of the Program, youth most readily identified 3 Things, Distractions, Pros and Cons, Self-Soothing, and Sleep Hygiene as new skills that helped in the ability to make decisions easily, and assisted in gaining perspective. 75% of staff stated that they taught the Skills for Life curriculum to the youth and identified that half of the skills assisted them in their work with youth participants.

Global Functioning
Of the 14 participants, 13 pre and 7 post CANS-SC were completed. CANS-SC pre and post total scores indicate that overall global functioning remained unchanged or improved (Graph 2). The scoring anchors of the CANS-SC are defined as 3 = severe problem/immediate action required, 2 = moderate need/action required, 1 = history/watchful & prevention, 0 = no evidence of a problem/no action required, so a decrease on the four level scale (e.g. 3 to 1) indicates an improvement in global functioning.

Graph 2: CANS-SC Pre and Post Total Scores

These results are the same as those observed in the Planning Evaluation Grant. Further analysis allowed for the isolation of the CANS-SC 4 level scoring scale, specifically to examine any changes. See Graph 3 and 4.
Items rated “2” decreased 18% which indicates a significant decrease in severity of supportive action required, from moderate need to no evidence of a problem. These results show a substantial contribution to the improvement of global functioning (i.e. changes in their eating and sleeping patterns, increased participation in activities of daily living, etc.) and reducing the impact of mental health problems of the youth who participated in the Mental Health Program. As seen in Graph 3 and 4 there was no change to the items rated “3” perhaps indicating severe problem/immediate action items require longer treatment time to create change.

Emotional Symptoms

The CDI 2:SR and MASC 2-SR were administered at pre and post data collection. Both measures have total scores that were used to examine emotional symptoms. For both measures T-scores of 70 or higher indicate very elevated depressive/anxious symptomology. 13 of the 14 participants completed both pre assessments, while 8 completed the post CDI 2 and 7 completed the post MASC 2.
Analysis of the pre CDI 2:SR showed 80% of the participants had a Very Elevated (70+) total score which indicates that these youth may be experiencing an elevated number of depressive symptoms (Kovacs, 2011), while the remaining 20% scored in the Average (40 – 54) and High Average (55 – 59) classifications. Analysis of the post CDI 2:SR showed 2 participants maintained their pre scores: Participant 1 in the Very Elevated classification and Participant 14 in the Average classification. Participant 6 total post score increased by 3, shifting from the (57) Average to (60) High Average classification. The CDI 2 Technical Manual draws particular attention to these slight changes in T-scores. The score cutoffs that define the categories are mainstream guidelines rather than absolutes – scores that fall in the proximity of two categories require careful clinical consideration (2011). The remaining 5 participants T-scores decreased by 3 intervals, either maintaining their pre classification or decreasing 14 intervals from Very Elevated to High Average.
These interval changes, whether slight or large, are evidence that the raw score’s numeric values (item responses that were endorsed) have changed. An example from the Self Report would be “I am sad all the time” to “I am sad once in a while” and these raw score changes are why we see the decrease in T-scores and classifications. In other words, of the participants who completed the pre and post CDI 2:SR, 63% of the participants showed a decrease in depressive symptoms (Graph 5). The score classifications are outlined in the CDI 2 Technical Manual and are automatically applied, but each youth expresses symptoms differently and the importance of the test results was interpreted through clinical attention to client need.

Analysis of the subscales Emotional Problems (negative mood, physical symptoms, negative self-esteem) and Functional Problems (ineffectiveness and interpersonal problems) indicate an overall decrease illustrated in Graph 6 and 7 in Appendix K.

Analysis of the pre MASC 2-SR showed 70% of the participants had a Very Elevated (70+) total score, indicating that these youth were experiencing high anxiety symptoms (March, 2013), while the remaining 30% scored in the Average (40 – 54) to Elevated (65 – 69) classification. Analysis of the post MASC 2-SR showed Participant 5 and 14 post scores increased slightly but stayed within their pre score classifications (Very Elevated and Average, respectively). Participant 13 increased slightly shifting from (59) High Average to (64) Slightly Elevated – another score change on the transition of classifications and requiring further clinical examination. The MASC 2 Technical Manual (2013) highlights special interpretation of the High Average classification, as it is often comprised of a combination of clinically significant cases and non-clinical cases. The remaining 4 participant T-scores decreased by either 2 intervals, maintaining their pre classifications, to 14 intervals a change of Very Elevated to Elevated. These interval changes are evidence of lower raw scores indicating lower symptom prevalence. Of the participants who completed the pre and post MASC 2-SR, 57% of the participants showed a decrease in anxiety symptoms. See Graph 8.
The Anxiety Probability Score (2013) estimates the likelihood that a youth is experiencing one or more anxiety disorder (based on elevations of generalized anxiety, phobias, social anxiety and separation anxiety). Analysis of this score indicated (see Graph 9 in Appendix L) 5 of the 8 participants who completed both measures had at least a 1-interval decrease evidence of a decrease in the level of difficulties associated with anxiety. The MASC 2 does not formally diagnose but rather the results are to be interpreted as indications (2013). The Anxiety Probability Scores indicating likelihood of one or more diagnoses required an accompanied clinical assessment by a clinician to determine impression and appropriate treatment.

Behavioral Symptoms

The Connors 3 – SR was administered at pre and post data collection. The Connors 3 ADHD Index was the score representative of a total score used for comparison within this evaluation. The Index Score is a classification of probability and is read in percentage. All 14 participants completed
the pre Connors 3 – SR and 7 completed the post assessment. These results had the greatest range of variety. For example, Participant 4’s pre Index Score was 26% (low), so a diagnosis of ADHD was unlikely (Connors, 2013). By comparison, Participant 3 was 99% (very high), so a diagnosis of ADHD was very likely. Youth who were in the very high probability range (80% or higher) either maintained or increased their Connors scores, but youth in low range (20 – 40% probability) decreased their Connors scores (Graph 10).

Graph 10: Connors 3 – SR Total Score Summary

We also conducted further analysis of the Connors 3 DSM-IV-TR Symptom Scales: ADHD Predominantly Inattentive Type, ADHD Predominantly Hyperactive-Impulsive Type, Conduct Disorder and Oppositional Defiant Disorder. T-scores of 65 or higher (93%+) indicate elevation. An elevated or very elevated Symptom Scale score demonstrates significant features of the disorder are present and that the symptoms are occurring in excess to that of their peers with the same age and gender.
(2013). See Graph 11 and 12 in Appendix M. Similar to the Index Scores, when isolating the Symptom Scales for further analysis, the results varied greatly.

**Stakeholder Involvement and Knowledge Exchange**

Collaboration is embedded in the culture of the program and is a part of creating positive change in the lives of the youth served. During the Planning Evaluation Grant, internal and external stakeholders were identified and this list was revised throughout this grant cycle. Youth Services program staff including youth support workers, housing workers, and administrative support were kept informed through quarterly presentations, emails and circulating information of evaluation activities and milestones. Case managers at Notre Dame House, Notre Dame Community Resource Centre and Brennan House became involved throughout the evaluation and completed pre and post data collection measures. The Youth Services Management Team, many of whom are on the evaluation core team, supported the evaluation efforts. A number of external stakeholders included community partners at the Street Youth Planning Collaborative, consulting adolescent Psychiatrists, and organization leadership and professional associations. The primary methods used to inform these parties were emails, conversations of support, and meetings at collaborative tables.

Knowledge exchange activities have included presentations at staff meetings and a quarterly newsletter about program developments and initiatives that is electronically circulated within Youth Services and to our community partners. Future knowledge exchange activities include a presentation at the Street Youth Planning Collaborative November Forum, presentation at the 2014 Children’s Mental Health Ontario Conference in November and a conference for street serving agencies that the Mental Health Program plans to host in Hamilton Spring 2015.

The Community Mental Health Program is highly invested in ongoing knowledge exchange as it allows for professional continuing education and creates opportunities to overcome challenges and
maintains our commitment to a strong evaluative capacity. Learning and sharing from the expertise and experiences in our community maximizes our reach and strengthens practice.

Conclusion and Action Plan

At the completion of the Planning Evaluation Grant there were reflections on the evaluation’s positive impact on various program components and the clinicians increased evaluation capacity. Throughout the Doing Evaluation Grant the Program gained a more resourceful library with a thorough understanding of the current literature on this unique population. Our understanding of youth recruitment and engagement was strengthened. Online standardized measures were introduced, reinforcing assessment and impressions to determine evidence informed treatment choices. The Program also introduced Skills for Life in client and clinician satisfaction questionnaires, and received formal youth feedback for the first time.

The clinicians have increased confidence in their knowledge of the youth being referred to the Program, and that the overall impression of the Program and the services provided align with current standards for best practice. The Program’s priority of improving the global functioning for those that participate has proven to be consistent for two years. Normally, more than half of the youth who participate in the Program experience a decrease in depressive and anxious symptoms. An area that requires improvement is the Program’s ability to treat youth with problematic behavioral profiles. The results show that behavioral symptoms generally increased in difficulty.

Our partnership with the Centre has been an extremely rewarding experience for the Mental Health Program, the core team involved in the evaluation, and Youth Services at large. Significant learning has taken place over the last 2 years that has positively informed many aspects of the Mental Health Program’s service provision. Undoubtedly, the evaluations have improved the effectiveness and efficiency of service for the youth referred to the Mental Health Program and has assisted the clinicians in their passion to provide care to this unique population.
Next Steps In Ensuring Sustainability

The Program’s evaluation capacity has grown immensely over the past year and evaluation has become a practice improvement tool. Funding has been secured for continued use of the pre and post standardized assessments in two residential treatment programs that the Mental Health Program serves. The Program has introduced a revised database collected monthly with analysis occurring annually, maintaining data on the demographic information for the youth participating in the Program. The Program is drafting new online satisfaction questionnaires using Google Docs that will be administered to youth at the end of treatment, maintaining our best efforts to provide youth friendly services. The Skills for Life curriculum has also been revised (informed by the feedback from program staff and youth), copyrighted and re-launched in a new and improved manual promoting its future use and holding potential for its own evaluation.

Our experience with this evaluation has truly allowed the Mental Health Program and its clinicians to be leaders at Youth Services, cultivating a culture of learning and setting the standard of capacity development. This evaluation has excited stakeholders and ourselves, has left us feeling innovative and on the forefront of best practices for street involved youth with mental illnesses.
References

http://www.behavioralhealthce.com


Bloomington, MN: Pearson.


[https://canstraining.com/](https://canstraining.com/)
Appendices
Appendix A

Skills for Life Curriculum

*What is Skills for Life?*
Skills for Life is a program that was created by the Mental Health Program at Good Shepherd Youth Services between 2010 and 2012. It evolved from:

1) Youth Services desire for a DBT milieu and DBT skills to be accessible to and used by street involved youth;
2) The Program’s increased understanding of global functioning and this unique population’s basic needs differing from that of their peers;
3) The clinical experience of the clinician’s who participated in the development of the curriculum.

The individual skills are grouped below:

**Framework:**
1. Adolescent Model
2. Maslow’s Hierarchy of Needs
3. 3 C’s
4. Trauma Informed Care

**Functioning:**
5. Teen Routine
6. Sleep Hygiene
7. PLEASE

*What to do when you are experiencing intense thoughts/emotions:*

8. Validation
9. TIPS
10. 3 Things
11. Riding the Wave
12. Distractions
13. Self Soothing

**Shaping Behaviour:**
14. BCA’s and Repair
15. Pros and Cons
16. Building Positivity
17. Radical Acceptance
18. DEARMAN
## Appendix B  Program Logic Model - Good Shepherd Youth Services Community Mental Health Program

### Need in the Community:
There is a growing number of street-involved youth struggling with mental illness and mental health problems in the Hamilton community.

### Program Goal(s):
To increase the global functioning of street-involved youth ages 16 – 21 with mental illness and mental health problems.

### Rationale(s):
The research shows that the use of evidence informed practice leads to improved global functioning of youth with mental illness and mental health problems.

### Program Components

#### Activities
- Referral form completed by front line workers
- Collect relevant documentation (consent for prior assessments, staff observations)
- Prioritize needs based on functioning, risk behaviors and family functioning using the Child and Adolescent Needs and Strengths Service Sector Assessment
- Triage Interview
- Exchange of information from Mental Health Clinicians to front line workers about management of youth’s specific mental health problems

#### Short-Term Outcomes
- ↑ in basic functioning (eating, sleeping, physical health, school or work attendance)
- ↑ awareness of mental illness/mental health problems

#### Assessment
- Conduct assessment interview
- Complete Personal Health Information Protection Act consent form (if applicable)
- Complete clinical impression
- Complete referral to family physician (if referral to psychiatry needed)
- Youth referred to psychiatry attend psychiatric assessment interview
- ↑ knowledge of needs and strengths related to mental health problems
- ↑ knowledge of mental health treatment options
- ↓ in drug and alcohol use

#### Treatment
- Individual Therapy (Cognitive Behavioral Therapy, Dialectical Behavior Therapy, Motivational Interviewing, Short Term Crisis Support, Advocacy, Liaison)
- Group Programming
- Appointment to consulting Adolescent Psychiatrist
- Refer to Barrett Crisis Centre
- Conduct Staff Coaching
- Refer to Emergency Room at hospital for assessment
- Skills from Skills for Life Curriculum
- ↓ in high risk behaviors (dangerousness, runaway, crime/delinquency, sexual aggression)
- ↑ global functioning
- ↑ ability to regulate emotions
- ↑ ability to organize time and possessions
- ↑ ability to regulate behavior
- ability to utilize Skills for Life with limited supports

#### Medium-Term Outcomes
- ↑ ability to regulate behavior with limited supports
- ↑ ability to regulate emotions with limited supports
- ↑ ability to organize time and possessions with limited supports

#### Long-Term Outcomes
- ↑ ability to regulate emotions independently
- ↑ ability to organize time and possessions independently
- ↓ anxiety symptoms
- ↓ depression symptoms
- ↑ ability to regulate behavior independently
- ↑ ability to utilize Skills for Life independently

### Assumptions:
- Youth are committed to participate within mental health program activities
- Front line workers are committed to the mental health program
**Appendix C**

**Good Shepherd Youth Services Community Mental Health Program – Referral Form**

<table>
<thead>
<tr>
<th>Name of Youth: ___________________________</th>
<th>Age: ______</th>
<th>Date of Birth: ________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender: _________________________________</td>
<td>HC #: __________________________</td>
<td>Youth’s Phone #: ______</td>
</tr>
<tr>
<td>Email: ____________________________</td>
<td>Facebook: __________________________</td>
<td></td>
</tr>
<tr>
<td>Current Address: ____________________________</td>
<td>Attending school? If so, name of school: ____________________________</td>
<td></td>
</tr>
<tr>
<td>Community of Origin: ___________________________</td>
<td>Cultural Background: ____________________________</td>
<td></td>
</tr>
</tbody>
</table>

**High Risk Behaviors (i.e. dangerousness, runaway, sexual aggression)?**  Yes / No

**Does the youth have academic failure (been suspended/missed credits)?**  Yes / No

**FACS/CAS/CCAS Involvement?**  Yes / No

**Youth Justice Involved?**  Yes / No

**Does parent have mental illness?**  Yes / No

**Do you have concerns that the youth is going to hurt themselves/someone else in the next week?**  Yes / No

<table>
<thead>
<tr>
<th>Issue of Concern</th>
<th>In the Last Month?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thoughts of suicide</td>
<td>yes / no</td>
</tr>
<tr>
<td>Previous suicide attempts</td>
<td>yes / no</td>
</tr>
<tr>
<td>Self harming behaviour</td>
<td>yes / no</td>
</tr>
<tr>
<td>Thoughts of harming behaviour</td>
<td>yes / no</td>
</tr>
<tr>
<td>Angry/aggressive outbursts</td>
<td>yes / no</td>
</tr>
<tr>
<td>Been inpatient for mental health</td>
<td>yes / no</td>
</tr>
<tr>
<td>Been to Barrett/EPAU/CHYME</td>
<td>yes / no</td>
</tr>
<tr>
<td>Substance use</td>
<td>yes / no</td>
</tr>
</tbody>
</table>

**Current Medications:** ____________________________________________________________

<table>
<thead>
<tr>
<th>Prescribed by: ___________________________</th>
<th>Pharmacy: ____________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>How many pills are left: ___________</td>
<td>Number of refills: ___________</td>
</tr>
</tbody>
</table>

**Has the youth seen a mental health clinician/psychiatrist/pediatrician/been hospitalized for mental health reasons?**  Yes / No

<table>
<thead>
<tr>
<th>If so, complete PHIPA/fax and attach confirmed fax copy</th>
</tr>
</thead>
</table>

**Referral Source:** ____________________________

<table>
<thead>
<tr>
<th>Date: ___________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Name of worker: ____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Case Manager: ____________________________</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Organization: ____________________________</th>
<th>Phone Number: ____________________________</th>
</tr>
</thead>
</table>

**Please rate on a scale from 1 (low) – 5 (high) the concerns for this youth:** ____________

**Note:**

| ____________________________________________________________________________ |
|______________________________________________________________________________|
| ____________________________________________________________________________ |

- Completed CANS is attached to this referral
- A copy of the youth’s health card is attached
Appendix D

Good Shepherd Youth Services Community Mental Health Program – Triage Form

Name of Youth: ___________________________ Date of Birth: ___________________________ Health Card Number: ___________________________
Clinician: ___________________________ Date: ___________________________
GAF: ___________________________
Why are you here today? ___________________________

What areas of your life have been impacted by main issue? ___________________________

1. Current treatment
Medication: No / Yes
Medication: ___________________________ Dose: ___________________________ When started: ___________________________
Medication: ___________________________ Dose: ___________________________ When started: ___________________________
Is this medication being taken as prescribed? No/Yes ___________________________
Therapy: No / Yes – Clinician: ___________________________ Phone: ___________________________

2. Mental health history
Has a mental health diagnosis been given? No/Yes ___________________________
Worked with a mental health clinician in the past, but not now? No/Yes ___________________________
Visits to ER for psychiatric reasons? When ___________________________
Previous psychiatric hospitalization? Where: ___________________________
Any recent police involvement? ___________________________

3. Mood
What has your mood been like recently? ___________________________
Does your mood change a lot? What makes it change? Typical for you? No/Yes ___________________________
Ever been really sad for a couple of weeks or more in a row? No/Yes ___________________________
Ever been really grumpy for a couple weeks or more in a row? No/Yes ___________________________
Ever felt really happy, on top of the world, like you were unstoppable? No/Yes ___________________________

4. Daily Routine
How have you been sleeping lately? ___________________________
How have you been eating lately? ___________________________
How is your concentration level lately? ___________________________

5. Substance Use
Alcohol use? Lifetime: No / Yes – When did you last use/how much ___________________________
Marijuana use? Lifetime: No / Yes – When did you last use/how much ___________________________

6. Suicidal Thinking
Do you think about dying ____________ if yes ___________________________
Ever think about doing something to kill yourself? Lifetime: No / Yes – Past month No / Yes ___________________________
Have you ever thought about how you would kill yourself? ___________________________

7. Psychosis
Ever been a time you could hear things other people could not hear? See thing? No/Yes ___________________________
Do people ever find it hard to understand you, like your ideas don’t make sense? No/Yes ___________________________
Appendix E  

**Youth Satisfaction Questionnaire**

Please assist Good Shepherd Youth Services Community Mental Health Program improve services by answering some questions about the services you received while participating in the Mental Health Program. Your answers will remain confidential. Please indicate if you **Strongly Disagree, Disagree, are Undecided, Agree** or **Strongly Agree** with each of the statements below. Please put an X in the box that best describes your answer.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, I am satisfied with the mental health services I received</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>I helped to choose the mental health services I received</td>
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<tr>
<td>I helped determine my treatment goals</td>
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<td></td>
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<td></td>
</tr>
<tr>
<td>The people helping me stuck with me no matter what</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The location of services was convenient</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Services were available at times that were convenient for me</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I got as much help as I needed</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff treated me with respect</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff were sensitive to my cultural/ethnic background</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The environment I received services in was pleasant</td>
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</tbody>
</table>

1. What has been the most helpful thing about the mental health services you received?

   ____________________________________________________________

2. What would improve the Community Mental Health Program services?

   ____________________________________________________________

3. While participating in the Community Mental Health Program did you learn any *Skills for Life* while working with the clinician’s or youth support workers (please circle below)?

   YES  NO

4. If so, please circle the skills you learned below:
   - Teen Routine
   - Sleep Hygiene
   - 3 Things
   - BCA
   - Riding the Wave
   - Self Soothing
   - Distractions
   - Radical Acceptance
   - DEARMAN
   - Pros & Cons
   - Building Positivity/Mastery
   - PLEASE
   - TIP

5. From the *Skills for Life* which skill(s) did you find most useful? Why?

   ____________________________________________________________

6. From the *Skills for Life* which skill(s) did you not find useful? Why?

   ____________________________________________________________

Thank you for your feedback

Adapted from the Youth Satisfaction Survey (YSS), Brunk, M., Koch, J.R., & McCall, B.
Appendix F

Staff Satisfaction Questionnaire

Please assist Good Shepherd Youth Services Community Mental Health Program in our ongoing efforts to improve services by answering some questions. Your answers are confidential. Please indicate if you Strongly Disagree, Disagree, are Undecided, Agree or Strongly Agree with each of the statements below. Please put an X in the box that best describes your answer.

<table>
<thead>
<tr>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was involved in selecting the mental health services for the youth I referred</td>
<td></td>
<td></td>
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<tr>
<td>I was involved in determining treatment goals for the youth I referred</td>
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<tr>
<td>I received as much staff coaching from the clinician’s as desired</td>
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<tr>
<td>Clinicians were respectful of my contributions to the clinical care of the youth I referred</td>
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<tr>
<td>The location of services was convenient for staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental health services were available at times that were convenient for staff</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>The clinicians were helpful in planning goals for this youth</td>
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<tr>
<td>Clinicians were sensitive to the youth’s cultural background/ethnicity</td>
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<tr>
<td>The environment the clinical services were offered was pleasant</td>
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</tr>
<tr>
<td>For the youth I referred to the Community Mental Health Program overall, I am satisfied with the mental health services</td>
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<td></td>
</tr>
</tbody>
</table>

1. What has been the most helpful thing about the mental health services (pertaining to referring youth to the program)?

________________________________________________________________________
________________________________________________________________________

2. What would improve the Community Mental Health Program services?

________________________________________________________________________
________________________________________________________________________

3. Did you participate in teaching a youth skills from the Skills for Life Program?
   YES     NO

4. If so, which skills assisted you most within your role at Good Shepherd Youth Services? Please List.

________________________________________________________________________
________________________________________________________________________

Thank you for your feedback

Adapted from the Youth Satisfaction Survey (YSS), Brunk, M., Koch, J.R., & McCall, B.
**Appendix G**

**CHILD AND ADOLESCENT NEEDS AND STRENGTHS (CANS)** ©

**SERVICE COORDINATION (CANS-SC)**

<table>
<thead>
<tr>
<th>CHILD AND ADOLESCENT NEEDS AND STRENGTHS</th>
<th>SERVICE COORDINATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please √ appropriate use:</td>
<td></td>
</tr>
<tr>
<td>[ ] Baseline</td>
<td></td>
</tr>
<tr>
<td>[ ] 6-month follow-up</td>
<td></td>
</tr>
<tr>
<td>[ ] 12-month assessment</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Child’s/Youth’s Name</th>
<th>m</th>
<th>m</th>
<th>d</th>
<th>D</th>
<th>y</th>
<th>Y</th>
<th>[ ] M</th>
<th>[ ] F</th>
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</thead>
</table>

<table>
<thead>
<tr>
<th>Referral Acceptance Date</th>
<th>/</th>
<th>/</th>
<th>/</th>
<th>DOB</th>
<th>Gender</th>
<th>Pref. Language</th>
</tr>
</thead>
</table>

**SCORING ANCHORS**

<table>
<thead>
<tr>
<th>0 = No evidence of problem - No need for action</th>
<th>1 = History – Watchful waiting &amp; prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>2 = Moderate need – action required</td>
<td>3 = Severe problem/need – Immediate/intensive action required</td>
</tr>
</tbody>
</table>

**FUNCTIONING**

<table>
<thead>
<tr>
<th>1. Medical/Physical</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>U</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Eating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Sleeping</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>4. Elimination</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>5. Communication</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Development/Intellectual</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Motor</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Cultural Stress</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Emotional Symptoms</td>
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<tr>
<td>11. Behavioral Symptoms</td>
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</tr>
<tr>
<td>12. Adjustment to Trauma/Traumatic Life Experiences</td>
<td></td>
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<tr>
<td>13. School</td>
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<tr>
<td>14. Sexual Development</td>
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<tr>
<td>15. Activities of Daily Living</td>
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**RISK BEHAVIOURS**

<table>
<thead>
<tr>
<th>16. Dangerousness</th>
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<tbody>
<tr>
<td>17. Runaway</td>
<td></td>
<td></td>
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<tr>
<td>18. Sexual Aggression</td>
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<td>19. Crime/Delinquency</td>
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<tr>
<td>20. Family Stress</td>
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**INTENSITY AND ORGANIZATION OF SERVICES**

<table>
<thead>
<tr>
<th>21. Treatment</th>
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<tbody>
<tr>
<td>22. Funding/Eligibility</td>
<td></td>
<td></td>
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<tr>
<td>23. Service Permanence</td>
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<tr>
<td>24. Access to Service</td>
<td></td>
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</tr>
<tr>
<td>25. Coordination of Care/Communication</td>
<td></td>
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**SPECIFY CAREGIVER RELATIONSHIP TO CHILD FOR ITEMS 25-36:**

**FAMILY/CAREGIVER NEEDS & STRENGTHS**

<table>
<thead>
<tr>
<th>26. Family Functioning</th>
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<tbody>
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<td>27. Developmental/Physical/Behavioral Health</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>28. Family Response to Illness</td>
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<tr>
<td>29. Involvement as Caregiver</td>
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<tr>
<td>30. Ability to Provide Treatment</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>31. Language</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>32. Supervision</td>
<td></td>
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<tr>
<td>33. Involvement</td>
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<tr>
<td>34. Knowledge</td>
<td></td>
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<tr>
<td>35. Empathy for Child</td>
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<td>36. Residential Stability</td>
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<td>37. Transportation</td>
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<td>38. Financial Resources</td>
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<tr>
<td>39. Social Resources</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40. Impact on Employment</td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>41. Safety</td>
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</table>

**STRENGTHS**

<table>
<thead>
<tr>
<th>42. Recreation</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>U</th>
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</thead>
<tbody>
<tr>
<td>43. Advocacy</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>44. Talents/Interests</td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>45. Community Involvement</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Information Letter

Description of the evaluation and your participation:
Good Shepherd Youth Services is conducting an evaluation of the Community Mental Health Program. The purpose of the evaluation is to assess the effectiveness of the program to determine if it is the meeting the needs of street involved and homeless youth ages 16 – 21 with mental health difficulties.

As a youth participating in the Community Mental Health Program, we would like to invite you to participate in the evaluation study. Your participation will involve the completion of questionnaires at the beginning of the program, at the end of the study approximately January 2014 and June 2014 (alternatively at the end of your treatment). If you choose to participate, a mental health clinician/worker will call, text or email (whatever your preference) and set up a time that is convenient for you to complete the questionnaires. The questionnaires will most likely be completed during scheduled therapy time.

We will use the information from the evaluation to determine whether the Community Mental Health Program is helpful in addressing the mental health needs of street-involved and homeless youth.

Confidentiality:
All the information that you provide will be kept confidential. The information collected will be kept in a locked file, and when the evaluation is completed the information will be archived. Your name and any personal identifying information will not be used in any report.

Voluntary Participation:
Your participation in this evaluation is voluntary. You may choose not to participate or you may withdraw from the evaluation at any time. You will not be penalized in any way if you decide not to participate in this evaluation or choose to withdraw at a later date. The information you provide will help us understand some of the ways the program can be improved.

Contact Information:
If you have any questions or concerns about this evaluation or if any problems arise please contact Chloe Frisina at Notre Dame House via phone: 905-308-8090 or text 905-517-2481.

Consent:
I have read the above information regarding my participation in the evaluation of the Community Mental Health Program and have been given the opportunity to ask questions. I give my consent to participate in this evaluation.

Youth Name: ________________________________
Youth Signature: ___________________________
Date: ________________________________
Contact Information:
    Phone: ________________________________
    Email: ________________________________

Please keep the information portion of this consent form
**Appendix I**  
**PROCESS EVALUATION FRAMEWORK**

<table>
<thead>
<tr>
<th>Evaluation Questions</th>
<th>Link to activities or target population in logic model</th>
<th>Indicator(s)</th>
<th>Data Collection Method(s)</th>
<th>Data Collection Tool(s)</th>
<th>Respondent(s)</th>
<th>Person(s) Responsible for Data Collection</th>
<th>Timing of Data Collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>What are the primary issues of concern that are referred to the community mental health program?</td>
<td>Referral &amp; Triage</td>
<td>Referral form</td>
<td>Document review</td>
<td>Mental Health Referral Binder (internally developed)</td>
<td>Clinician</td>
<td>Mental Health Worker</td>
<td>February 2014 Pre data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Previous Assessments from other mental health agencies</td>
<td>To be categorized within categories: emotional symptoms, behavioral symptoms, psychosis, risk behaviors</td>
<td>Client files</td>
<td>Program staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Document review</td>
<td>Triage interview form (internally developed)</td>
<td>Clinician</td>
<td>Program staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Age, gender, community of origin</td>
<td></td>
<td>Program Staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What are the demographic characteristics of the youth served?</td>
<td>Triage interview</td>
<td>Document review</td>
<td>Triage interview form (internally developed)</td>
<td>Clinician</td>
<td>Program staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rating of satisfaction</td>
<td></td>
<td>Program Staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Skills for Life</td>
<td></td>
<td>Case Manager</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What are the youth’s and staff’s experiences of the community mental health program?</td>
<td>Program delivery</td>
<td>Questionnaire</td>
<td>Staff Satisfaction Questionnaire</td>
<td>Program Staff</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Skills for Life</td>
<td></td>
<td>Youth Satisfaction questionnaire</td>
<td>Youth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>*Adapted from the Youth Satisfaction Survey (YSS)</td>
<td></td>
<td></td>
<td></td>
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</table>

*Adapted from the Youth Satisfaction Survey (YSS)*
### OUTCOME EVALUATION FRAMEWORK

<table>
<thead>
<tr>
<th>Evaluation Questions (What do we want to know about this program?)</th>
<th>Link to outcomes in logic model (What outcome from the logic model does the evaluation question relate to?)</th>
<th>Indicator(s) (What is one possible measurable approximation of the outcome?)</th>
<th>Data Collection Method(s) (What data collection method will be used to measure the indicator? E.g., Survey, focus group, interview, document review, etc.)</th>
<th>Data Collection Tool(s) (What specific tool will be used? Specify the name and whether it is a standardized tool or internally-developed)</th>
<th>Respondent(s) (Who will provide the information needed? For example, parent, child, clinician, teacher, program staff, etc.)</th>
<th>Person(s) Responsible for Data Collection (Who is responsible for ensuring the data are collected?)</th>
<th>Timing of Data Collection (When will the data be collected?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the global functioning improve for the youth who participate in the mental health program?</td>
<td>↑ global functioning</td>
<td>↑ sleep, ↑ eating, ↑ physical health, ↑ activities of daily living, limited criminal involvement</td>
<td>Questionnaire</td>
<td>CANS-SC</td>
<td>Youth</td>
<td>Case Manager</td>
<td>February/July 2014 Pre/post data</td>
</tr>
<tr>
<td>Does youth participation in the Community Mental Health Program decrease emotional symptoms?</td>
<td>↓ anxiety symptoms, ↓ depression symptoms</td>
<td>↑ ability to regulate emotions</td>
<td>Assessments</td>
<td>CDI 2, MASC 2</td>
<td>Youth</td>
<td>Mental Health Worker</td>
<td>February/July 2014 Pre/post data</td>
</tr>
<tr>
<td>Does youth participation in the Community Mental Health Program decrease behavioral symptoms?</td>
<td>↑ attention, ↓ hyperactivity, ↓ opposition, ↑ ability to organize time and possessions, ↓ difficulties with conduct, ↑ ability to regulate their behavior</td>
<td>Assessment</td>
<td>CONNORS 3</td>
<td>Youth</td>
<td>Mental Health Worker</td>
<td>February/July 2014 Pre/post data</td>
<td></td>
</tr>
</tbody>
</table>

42
## Appendix J

### Table 1: Youth Satisfaction Questionnaire Quantitative Results

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall I am satisfied with the mental health services I received</td>
<td>50%</td>
<td>33%</td>
<td>0%</td>
<td>17%</td>
<td>0%</td>
</tr>
<tr>
<td>I helped to choose the mental health services I received</td>
<td>33%</td>
<td>33%</td>
<td>17%</td>
<td>17%</td>
<td>0%</td>
</tr>
<tr>
<td>I helped determine my treatment goals</td>
<td>17%</td>
<td>66%</td>
<td>0%</td>
<td>17%</td>
<td>0%</td>
</tr>
<tr>
<td>The people helping me stuck with me no matter what</td>
<td>17%</td>
<td>50%</td>
<td>17%</td>
<td>17%</td>
<td>0%</td>
</tr>
<tr>
<td>The location of services was convenient</td>
<td>33%</td>
<td>50%</td>
<td>17%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Services were available at times that were convenient for me</td>
<td>50%</td>
<td>33%</td>
<td>17%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>I got as much help as I needed</td>
<td>17%</td>
<td>67%</td>
<td>0%</td>
<td>17%</td>
<td>0%</td>
</tr>
<tr>
<td>Staff treated me with respect</td>
<td>50%</td>
<td>50%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Staff were sensitive to me cultural/ethnic background</td>
<td>40%</td>
<td>60%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>The environment I received services in was pleasant</td>
<td>17%</td>
<td>83%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

### Table 2: Staff Satisfaction Questionnaire Quantitative Results

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I was involved in selecting the mental health services for the youth I referred</td>
<td>50%</td>
<td>30%</td>
<td>10%</td>
<td>0%</td>
<td>10%</td>
</tr>
<tr>
<td>I was involved in determining treatment goals for the youth I refer</td>
<td>10%</td>
<td>60%</td>
<td>10%</td>
<td>20%</td>
<td>0%</td>
</tr>
<tr>
<td>I received as much staff coaching from the clinicians as desired</td>
<td>70%</td>
<td>30%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Clinicians were respectful of my contributions to clinical care of the youth I referred</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>The location of service was convenient for staff</td>
<td>60%</td>
<td>40%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Mental health services were available at times that were convenient for staff</td>
<td>80%</td>
<td>10%</td>
<td>10%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>The clinicians were helpful in planning goals for this youth</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Clinicians were sensitive to the youth’s cultural background/ethnicity</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>The environment the clinical services were offered was pleasant</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>For the youth I referred to the Community Mental Health Program overall, I am satisfied with the mental health services</td>
<td>100%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Appendix K

Graph 6: CDI 2:SR Subscale Emotional Problems Summary

Data reflects the completion of both pre and post CDI 2. Participants 2, 4, 8, 10, 11, 12 did not complete both measures therefore no data was entered.

Graph 7: CDI 2:SR Subscale Functional Problems Summary

Data reflects the completion of both pre and post CDI 2. Participants 2, 4, 8, 10, 11, 12 did not complete both measures therefore no data was entered.
Appendix L

Graph 9: MASC 2-SR Anxiety Probability Score Pre and Post Summary

MASC 2 Anxiety Probability Scores

![Graph showing MASC 2 Anxiety Probability Scores]

Data reflects the completion of both pre and post MASC 2. Participants 2, 4, 8, 10, 11, 12 did not complete both measures therefore no data was entered. Participant 13 pre and post score were 0 and Participant 14 pre score was 0 (not seen clearly in Graph 9).
Appendix M

Graph 11: Pre and Post T-scores for ADHD Symptom Scales\(^6\)

![Graph 11: ADHD Predominantly Inattentive Presentation & ADHD Predominantly Hyperactive-Impulsive Presentation]

Graph 12: Pre and Post T-scores for Conduct and Opposition Symptom Scales\(^7\)

![Graph 12: Conduct Disorder & Oppositional Defiance Disorder]

---

\(^6\) Data reflects the completion of both pre and post MASC 2. Participants 2, 4, 8, 10, 11, 12 did not complete both measures.

\(^7\) Data reflects the completion of both pre and post MASC 2. Participants 2, 4, 8, 10, 11, 12 did not complete both measures.