School-Based Mental Health: 
Program Evaluation, Planning Phase

Evaluation Grant #: EPG 1449

October 31, 2012

Dr Bertrand Guindon, CPsych, Executive Director

Child and Family Centre 
Sudbury, ON
TABLE OF CONTENTS:

Executive Summary ................................................................................................. 3

Introduction and Literature Review ..................................................................... 5
  Program Overview ............................................................................................... 5
  Program Activities .............................................................................................. 5
  Literature Review ............................................................................................... 6
  Evaluation Goals ................................................................................................. 9
  Process and Outcome Questions ...................................................................... 9

Methodology ......................................................................................................... 10
  Sample ............................................................................................................... 11
  Timing of Data Collection ................................................................................. 11
  Client and Stakeholder Feedback ................................................................... 11
  Client Characteristics ....................................................................................... 12
  Measures ........................................................................................................... 12
  Data Analysis ..................................................................................................... 13
  Ethical Considerations ....................................................................................... 13

Results .................................................................................................................. 14
  Timing for data collection, sample size and sample descriptive statistics ............. 14
  Client feedback questionnaire responses ......................................................... 16
  Discussion .......................................................................................................... 18

Stakeholder Involvement and Knowledge Exchange ........................................... 20

Conclusion and Recommendations ..................................................................... 22

References .......................................................................................................... 24

Appendix A: Program Logic Model .................................................................... 32
Appendix B: Outcome Evaluation Questions Matrix ........................................... 33
Appendix C: Process Evaluation Questions Matrix ............................................. 34
Appendix D: School-Based Mental Health Referral Form .................................... 35
Appendix E: Client Feedback Questionnaire ....................................................... 38
Appendix F: School Feedback Questionnaire ..................................................... 40
Appendix G: Dashboard (Data Collection System) ............................................... 42
Appendix H: Consent Form .................................................................................. 43
Appendix I: SBMH Program Evaluation Process Chart ...................................... 44
Appendix J: Accounting Summary of Expenditures ............................................ 44
Child and Family Centre: School-Based Mental Health Program Evaluation
Linda Dugas, Director of Clinical Services
Chantal Lafleur, Program Manager

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 client and stakeholder satisfaction, 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, and problem solving skills among adolescents.

The Program

The School-Based Mental Health program serves male and female adolescents between the ages of 12 to 18 years old who are referred by representatives of four school boards out of concern for the youth’s mental health. 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 Program Evaluation of the School-Based Mental Health program will inform clinical practice and will allow shifting in order to better meet client needs.
The Plan

The Program Logic Model was created with the Core Team and process and outcome evaluations questions were developed. Measurement tools were then selected to answer to these questions. The Referral Form was chosen to collect demographic data, target population, number of eligible and excluded referrals, and the most prevalent presenting problems. Two surveys were also designed to measure the client’s and School’s satisfaction with services. In order to measure outcome, we utilize the Children’s Hope Scale (Snyder et al., 1997) which relating to problem-solving skills, and the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 2000), relating to the client’s behavioural, emotional and school functioning. Finally, we measure the average number of sessions and outcomes 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 piloted the implementation of the Program Evaluation from May to September 2012. The anticipated sample size for this pilot was N = 15.

The Product

The timing of data collection (over the summer months) for the pilot study created challenges in our ability to obtain an adequate sample size (N = 8) and our ability to effectively answer the Process and Outcome evaluation questions. Alternatively, our focus for this pilot study shifted more towards the testing and evaluation of the program, evaluation process, and the effectiveness of the selected measurement tools.

The Child and Family Centre is building on acquired knowledge from the School-Based Mental Health Program Evaluation process, including resources provided by the Ontario Centre of Excellence and tools to develop an evaluation model for future program evaluations. The Agency will also extend this knowledge transfer to community partners and future program evaluation stakeholders. As the Child and Family Center shares this knowledge, Agency staff, community partners and stakeholders will develop greater confidence, awareness, and enthusiasm towards future program evaluation initiatives.

Amount awarded: $ 25 000
Final report received: October 31, 2012
Region: Sudbury, ON, Northeast Region
Introduction and Literature Review

Program Overview

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 the Child and Family Centre (CFC) and its four local School Boards (English/French, Separate, Public). The Agency recognizes many stakeholders, such as the four School Boards of the Greater Sudbury Area, the Ministry of Children and Youth Services (MCYS), the Agency Clinicians, Management, the Agency’s participating staff (i.e. Psychology, Secretarial staff), the Laurentian University Student, and most importantly the youths and families served by the School-Based Mental Health (SBMH) program.

The Child and Family Center has dedicated two Clinicians to high schools in the four School Boards. The School Boards contribute in kind, offering office space and equipment to allow clinical work to be provided in a confidential setting. The overall goal of the program is to facilitate access and provide time limited intervention to adolescents who are struggling with mental health problems in their school milieu (see Appendix A for the Program Logic Model).

Clients are youths, male and female, between the ages of 12 to 18 years who are referred by representatives of four School Boards out of concern for the youth’s mental health. Mental health problems are identified though the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA; Gowers, et al., 1999) screening tool. Most often, presenting concerns included depression, anxiety, substance use, and family and peer conflicts.

Program Activities

The first step in the School-Based Mental Health Program occurs when the Child and Family Centre (CFC) Program Manager receives the referral package from the school referral agent (typically a guidance counselor, teacher or social worker). The referral package includes the referral form (see Appendix D) and the HoNOSCA (Gowers, et al., 1999) screening tool.
Using the referral package, eligibility is determined. The Clinician then proceeds to a full orientation of services and Program Evaluation with the referred student. Students wishing to pursue services are then assigned to a Clinician who completes a comprehensive time limited assessment, including the Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 2000) and the Children’s Hope Scale (Snyder et al., 1997).

The Clinician develops a time-limited (maximum of 12 sessions) treatment plan. Depending on the needs and strengths identified, the Clinician will utilize treatment approaches such as cognitive-behavioural therapy, solution focused therapy and/or motivational interviewing. An extensive literature review was conducted which supports the use of the approaches as discussed in the following section. As you will note, these approaches are known to be most effective at treating the prevalent presenting issues with the program’s target population, such as anxiety, depression, anger control, family conflict, behavior difficulties.

Upon treatment completion, the student is asked to complete a post-Children’s Hope Scale (Snyder et al., 1997) and a Client Satisfaction Questionnaire (see Appendix E). The Clinician then completes a closing summary and post-Child and Adolescent Functional Assessment Scale (CAFAS; Hodges, 2000) and the referral agent completes a School Feedback Questionnaire (see Appendix F). For data entry and data collection purposes, an internal process has been developed to indicate all steps for data to be forwarded to the clerical staff and data collector.

Since the onset of the School-Based Mental Health program, an estimated 110 youths have been referred to these services. Of these 110 referrals, 70 clients have received mental health intervention.

**Literature review:**

Schools are an ideal forum for providing mental health services to youth because the majority of adolescents spend over thirty hours in the classroom during a typical week (Wei & Kutcher, 2011). Therefore, most adolescents can be reached easily through the school they
attend (Anglin, 2003). Schools play a significant role in the provision of mental health services (Burns et al., 1995; Rones & Hoagwood, 2000). In fact, the education system is the most common portal through which youth first receive mental health services (Farmer, Burns, Philip, Angold, & Costello, 2003). Burns et al. (1995) found that over three quarters of children who received mental health services received them through the education system. Furthermore, many children were receiving services solely through this sector.

Schools are a strategic venue to provide mental health services for many reasons, including complementary goals of the education system and those of mental health practitioners (Owens & Murphy, 2004; Wei & Kutcher, 2011). Although educational focus has traditionally been on physical health (Wei & Kutcher, 2011), mental health issues are of great concern as well. Untreated mental health issues may create barriers to learning and are associated with a higher risk of drop out, absenteeism, lower academic achievement, overall functioning, and shortened life expectancy (Owens & Murphy, 2004; Wei & Kutcher, 2011; Weist, Goldstein, Morris, & Bryant, 2003). Schools offer a unique position for intervention because treatment can be focused, cost effective, and convenient for the youth (Wei & Kutcher, 2011). Students in need can be identified early, connected to health care providers in a timely fashion (Wei & Kutcher, 2011; Weist, Goldstein, et al., 2003), and multiple perspectives including students, teachers, clinicians, and parents can be taken into account (Owens & Murphy, 2004). School based mental health services can help reduce stigma associated with mental health by being a visible presence, and mental health services may improve emotional functioning, behavioral functioning, coping skills, depression, attendance, and disciplinary referrals (Weist, Goldstein, et al., 2003).

The effectiveness of school based mental health has been demonstrated in a number of studies (Weist, Paskewitz, Warner, & Flaherty, 1996). In fact, in an investigation of mental health service effectiveness, Armbruster and Lichtman (1999) found treatment was just as
effective whether delivered in a school or clinic setting. School based mental health services have been found effective for students with depression or at high risk of developing depression (Clarke et al., 2002; Kahn, Kehle, Jenson, & Clarke, 1990; Sheeber, Lewinsohn, & Seely, 1995; Shirk, Kaplinski, & Gudmunsen, 2009; Weist, Paskewitz, et al., 1996), anxiety (Masia-Warner et al., 2005; Wheeler, 2001) and substance abuse (McCambridge, Day, Thomas, & Strang, 2011; Wheeler, 2001). Studies have also suggested that both students and those who refer them find school based mental health services helpful for a variety of issues (McKenzie, Murray, Prior, & Stark, 2011).

Although not specifically tested in the educational context, the adolescent treatment literature provides support for various treatment options. This study will focus on three: cognitive behavioural therapy, solution focused therapy, and motivational interviewing. Cognitive behavioural interventions are aimed at transforming maladaptive thought processes through a number of exercises (Maag & Swearer, 2005). Cognitive behavioural therapy has been found effective with adolescent depression (Chu & Harrison, 2001; Michael & Crowley, 2002; Shirk et al., 2009; Spielmans, Pasek, & McFall, 2007) and anxiety, (Cartwright-Hatton, Roberts, Chitsabesan, Fothergill, & Harrington, 2004; Chu & Harrison, 2001; Ishikawa, Okajima, & Sakano, 2007; Prins & Ollendick, 2003). Solution focused therapy emphasizes client competencies, strengths, goals and successes while utilizing language to assist the client in positive change (Maree & Fernandes, 2003). Solution focused therapy has been found efficacious with adolescent depression, anxiety, and substance abuse (Cepukiene & Pakrodnis, 2011; Wheeler, 2001), and is associated with increased self-esteem and coping, reduction in problem behaviour, improved social skills, and help reaching goals (Cepukiene & Pakrodnis, 2011; Gostautas, Cepukiene, Palrosnis, & Fleming, 2005; Hopson, & Kim, 2004). Motivational interviewing is a client-centered, collaborative approach in which autonomy of the client is respected by eliciting arguments for change from the client themselves (Naar-King, 2011). This approach has been studied mainly with a focus on substance abuse (Naar-King, 2011) and has
been found effective when working with adolescent substance use (Bailey, Baker, 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).

In sum, providing mental health services in the educational context offers the opportunity for early identification and intervention in a cost-effective, convenient manner with a variety of effective treatment options. It provides a unique setting for the delivery of services, an optimum place to reach youth who might otherwise not have access to mental health services, and can involve a number of different perspectives. The parallel between the overall goals of educational staff and mental health service providers make this an ideal partnership.

**Evaluation Goals**

The purpose of the School-Based Mental Health program evaluation is to determine the effectiveness of this program with respect to the delivery of its services based on evidence informed practices and client outcomes.

**Process and Outcome Questions**

Outcome and Process Evaluation Matrixes are included in Appendices B and C. The process-related questions (see Table 1) reflect 1) client satisfaction; 2) school referral agent satisfaction; 3) treatment duration; 4) inclusion and exclusion rates, as well as participation rates; 5) general demographic characteristics of population served; 6) mental health problems prevalence rates; 7) and transfer rates to adult mental health services.

<table>
<thead>
<tr>
<th>Table 1</th>
<th>Process Evaluation Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are clients satisfied with SBMH services?</td>
<td>2. Are the referral agents of the serviced schools satisfied with SBMH services?</td>
</tr>
<tr>
<td>5. How many eligible youths were referred to SBMH and pursued services?</td>
<td>6. How many clients were not eligible for SBMH services and why?</td>
</tr>
</tbody>
</table>
Outcome-related questions (see Table 2) examine whether treatment improved youth participant’s 1) emotional and behavioral functioning; 2) scores on problem-solving ability and self-perception measures; and 3) youth’s overall functioning at school.

Table 2

<table>
<thead>
<tr>
<th>Outcome Evaluation Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has SBMH served to improve behavioral and emotional functioning for the youth?</td>
</tr>
<tr>
<td>2. Has SBMH services served to increase youth's problem-solving skills?</td>
</tr>
<tr>
<td>3. Do SBMH services help to improve the youth’s overall functioning at school?</td>
</tr>
</tbody>
</table>

Methodology

Prior to formulating the methodology for this program evaluation, the Core Children’s Mental Health Team and the Centre of Excellence were able to arrive at ten Program Evaluation questions that sought to understand the processes and outcomes related to the School Based Mental Health program (SBMH). These ten questions served as an important program evaluation framework upon which a methodology could be constructed. Variables related to the eight Process-related and three Outcome-related questions were identified and included within referral and survey questionnaires. Other data were collected to gain some additional insight regarding the general characteristics of the population accessing School-Based Mental Health program services, as well as data representing the “voice” of the program’s process (VOP) and still other data representing the “voice” of the clients (VOC), including stakeholders (ex: clinicians and school referral agents). The data analysis approach for this project is a mixed-methods approach, which includes the use of descriptive and inferential statistics, as well as qualitative (ex: client survey and open ended questions) and quantitative approaches (ex: Child and Adolescent Functional Assessment Scale and Children’s Hope Scale) in hopes of gaining a more comprehensive picture understanding about the process; general characteristics of the participant’s profiles within the educational, medical, social and behavioural domains; perceptions and feedback from various stakeholders; and outcomes associated with the School-Based Mental Health program.
Sample

The sample for this pilot included students between grade 7 and grade 12 and ranged in ages from 12 - 18 years. The pilot sample included English and Francophone speaking populations from three different types of ethnic backgrounds: Anglophone, Francophone and Aboriginal populations. Sample size proved a limitation for this particular pilot study due to the approaching end of the school year. The number of referrals seems to be larger when school is in session.

Timing of Data Collection

The sampling period occurred between May 1st, 2012 to August 31st, 2012.

The School Based Mental Health Referral Form (see Appendix D), the CIMS database, the Client Feedback Questionnaire (see Appendix E) and the School Feedback Questionnaire (see Appendix F) are the major sources for Process related variables, while the Child and Adolescent Functional Assessment Scale (Hodges, 2000), and Children’s Hope Scale (Snyder et al., 1997) are the major sources for Outcome related variables. Descriptions of the measures are included under the Measures subsection below.

Client and Stakeholder Feedback

The “voice” of the program’s process and the “voice” of the client Process variables examined the treatment duration, waitlist numbers and waitlist times, number of sessions, file disposition type, number of client cancellations (number of times students cancelled sessions), and number of client no-shows (number of times clients did not alert the clinician of the session cancellation). “Voice of the client” variables reflected feedback from the youth participants, school referral agents, and School-Based Mental Health program Clinicians. The Client Feedback Questionnaire (see Appendix E), an electronic form also available in French, is composed of 10 questions that examine client overall satisfaction regarding the services received, as well as client engagement, availability of the Clinician, respect of clients values, and questions reflecting the youth’s perceptions about their current ability to cope, get along
with friends and family, and whether they feel they are doing better at school and/or work. Each question is on a 5-point Likert scale ranging from Strongly Disagree to Strongly Agree. Feedback from the school referral agent was collected via the School Feedback Questionnaire (see Appendix F), an electronic form also available in French. Question 3 and question 5 on the School Feedback Questionnaire ask the school referral agents whether the School-Based Mental Health program was helpful for the student and overall satisfaction with the program, respectively.

**Client Characteristics**

The School-Based Mental Health program provides service to children and youth between the ages of 12 – 18 years of age. The School Based Mental Health Referral Form (see Appendix D), an electronic form also available in French, provided the major source of data reflecting the general profiles of School-Based Mental Health program referrals within the educational, medical, behavioral, and social domains.

**Measures**

**The Children’s Hope Scale.** A six-item measure that measures the child’s belief that one can find pathways to desired goals and become motivated 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).

**Data Analysis**

The methodology outlined above presents many data analytical possibilities due to the many sources of data available; however, the small sample size for this particular pilot study limited the data analysis to descriptive statistics. It is anticipated that with more substantial sample sizes, many other inferential statistics can be conducted such as repeated measures t-tests, Mann-Whitney test, analysis of variance (ANOVA) and multivariate analysis of variance (MANOVA), multiple regression, logistic regression, and profile analysis.

Another important piece to the data analysis approach was the creation of a real-time Dashboard system (see Appendix G) that provides up-to-date information regarding the number of participants referred to the program, average ages, male/female ratios, average educational, medical, behavioral and characteristics by gender, program completion rates, file disposition rates, average number of sessions, average wait times, number of participants on the waitlist, etc. The purpose of the Dashboard was to provide the manager of the School-Based Mental Health program the ability to monitor and report process and outcomes data efficiently and effectively with tables and graphs that automatically update with every new entry within the database. This data can then be easily accessed and included in monthly, quarterly or annual reports.

Despite the small sample size, the School-Based Mental Health program was able to gain some insight regarding the general characteristics of the pilot participants via the Dashboard results (descriptive statistics), which are discussed within the section below.

**Ethical Consideration**

The Child and Family Center informed clients regarding the evaluation of this program, its methods and procedures as well as its risks and benefits. Their written consent to participate was then sought via a Consent Form (see Appendix H), which was also available in French.
Clients were informed that their participation in the evaluation was voluntary, they could withdraw at any time, and their participation would not affect the services they received in any way.

**Results**

Although the methodology was designed to collect information surrounding process, outcomes, general characteristics of the population being served, and client and stakeholder feedback, the timing of the data collection period seemed to contribute to the small sample size obtained for this pilot sample (N = 8); the data collection period began May 1\(^{st}\) 2012 and ended August 31\(^{st}\), 2012, representing only 20% of the remaining school year to collect data for the purposes of this pilot evaluation, posing limitations on the samples size and hence the types of analyses that could be conducted with the data set collected. The small sample size for this study also affected the generalizability of the results obtained during this pilot. For these reasons, the emphasis for this pilot was to set up and test the various Program Evaluation components so that these were operational in time to support the 2012-2013 School-Based Mental Health program delivery period. Therefore, the results obtained during this pilot study should be interpreted with caution.

**Timing for Data Collection, Sample size, and Sample Descriptive Statistics**

Data were collected between May 1\(^{st}\) 2012 and August 31\(^{st}\) 2012. The sample consisted of eight referrals, six client feedback survey responses, and one school feedback survey response. As mentioned earlier, the timing of the data collection period coincided with the end of the school year, perhaps limiting the number of referrals made to the program.

Regarding the referral sample (N = 8), 62% were placed on the waitlist or sent to School-Based Mental Health program Clinicians so that they could meet with the client and complete an orientation to services, 25% of participants were assigned to Clinicians, while 13% were excluded from the pilot study. Of the referred youth, 50% were female, 50% were male; the mean age for both groups had was 15.75 years (SD = 1.16). All subjects were identified as
English Speaking (100%) and belonging to the English culture (100%). The medical profile survey questions identified 13% of the sample as being on medication, and 25% of students were identified as having a developmental or intellectual disability.

Regarding the referred youth’s general academic characteristics, 63% of the referred youth were in Grade 9, 25% in Grade 11, and 13% in grade 12. Sixty-three percent (63%) of the students referred were in the Academic stream, 13% were in the Locally Developed stream, while 25% were in the Applied stream. Referral questions inquired about the students’ current academic grade however 75% of the data were missing for the question, suggesting perhaps that referral agents do not have information regarding students’ academic performance at the time of referral. As a result, 13% were identified as being within the 60-69% (n = 1) range, and 13% (n = 1) in the 70-79% range. Other referral questions reflecting referred students’ experience revealed that 25% of students had an IEP, 25% failed or repeated a course, 13% required resource support, and 65% were considered academically “at risk”. Regarding absenteeism, 50% of the sample missed more than 10 days per month, while 26% missed two or fewer days per month. Twenty-five percent (25%) of the students referred to the School-Based Mental Health program had a history of truancy issues, 38% of the students had been suspended within the last 12 months, while no students were reported to be have been expelled.

Questions reflecting the referred youth’s social development were also collected (see Table 3). Over 1 out of 3 referred youth were identified as preferring to be alone (38%), while 1 out of 4 students were reported to be teased by other students.

Regarding referred youth’s general behavioral characteristics (see Table 4), 1 out of 4 students were identified as engaging in risk taking behavior, having impulsivity issues, and were deemed a danger to themselves or others. Over 1 out of 3 students were described as being excessively worried or anxious, while 1 out of 4 students were identified as being sexually
active. One student within this sample was identified to have either threatened to commit or had attempted to commit suicide (13%).

Table 3
**Social Developmental Variables**

<table>
<thead>
<tr>
<th>Variable</th>
<th>Percentage of Referred Students</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prefers to be alone</td>
<td>38%</td>
</tr>
<tr>
<td>Difficulty making friends</td>
<td>13%</td>
</tr>
<tr>
<td>Not sought out for friendship by peers</td>
<td>13%</td>
</tr>
<tr>
<td>Overly trusting of others</td>
<td>0%</td>
</tr>
<tr>
<td>Has difficulty with turn-taking</td>
<td>0%</td>
</tr>
<tr>
<td>Engages in attention seeking behaviour</td>
<td>13%</td>
</tr>
<tr>
<td>Excessively shy or timid</td>
<td>0%</td>
</tr>
<tr>
<td>Teased by other students</td>
<td>25%</td>
</tr>
<tr>
<td>Difficulty seeing another person’s point of view</td>
<td>13%</td>
</tr>
<tr>
<td>Doesn’t appreciate humor</td>
<td>0%</td>
</tr>
<tr>
<td>Has difficulty with physical boundaries</td>
<td>13%</td>
</tr>
<tr>
<td>More interested in objects than people</td>
<td>0%</td>
</tr>
<tr>
<td>Bullies other students</td>
<td>0%</td>
</tr>
<tr>
<td>Doesn’t empathize with others</td>
<td>0%</td>
</tr>
<tr>
<td>Tends to gravitate towards negative peers</td>
<td>13%</td>
</tr>
<tr>
<td>Withdraws from social settings</td>
<td>13%</td>
</tr>
<tr>
<td>Approaches and discloses information to people immediately</td>
<td>13%</td>
</tr>
</tbody>
</table>

Table 4
**General Behavioural Characteristics of Referred Youth**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Percentage of Referred Youth</th>
<th>Characteristic</th>
<th>Percentage of Referred Youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stubborn</td>
<td>0%</td>
<td>Purposely harms or injures self</td>
<td>13%</td>
</tr>
<tr>
<td>Strikes out at others</td>
<td>13%</td>
<td>Cries frequently</td>
<td>13%</td>
</tr>
<tr>
<td>Stealing</td>
<td>13%</td>
<td>Not affected by negative consequences</td>
<td>13%</td>
</tr>
<tr>
<td>Risk taking behaviour</td>
<td>25%</td>
<td>Alcohol use</td>
<td>13%</td>
</tr>
<tr>
<td>Impulsivity control issues</td>
<td>25%</td>
<td>Doesn’t complete work or tasks</td>
<td>13%</td>
</tr>
<tr>
<td>Dangerous to self or others</td>
<td>25%</td>
<td>Frequent angry outbursts</td>
<td>0%</td>
</tr>
<tr>
<td>Seems depressed</td>
<td>13%</td>
<td>Lying</td>
<td>0%</td>
</tr>
<tr>
<td>Overly preoccupied with details</td>
<td>13%</td>
<td>Low frustration threshold</td>
<td>0%</td>
</tr>
<tr>
<td>Drug use</td>
<td>13%</td>
<td>Needs a lot of supervision</td>
<td>13%</td>
</tr>
<tr>
<td>Motivation issues</td>
<td>25%</td>
<td>Skips school</td>
<td>38%</td>
</tr>
<tr>
<td>Irritable, angry, or resentful</td>
<td>13%</td>
<td>Unusual fears, habits, mannerisms</td>
<td>0%</td>
</tr>
<tr>
<td>Throws or destroys things</td>
<td>0%</td>
<td>Excessively worried or anxious</td>
<td>38%</td>
</tr>
<tr>
<td>Argumentative with adults</td>
<td>13%</td>
<td>Overly attached to certain objects</td>
<td>0%</td>
</tr>
<tr>
<td>Runs away</td>
<td>0%</td>
<td>Sexually active</td>
<td>25%</td>
</tr>
<tr>
<td>Poor sense of danger</td>
<td>13%</td>
<td>Doesn’t like to engage in new activities</td>
<td>13%</td>
</tr>
</tbody>
</table>

**Client Feedback Questionnaire Responses:**

In total, six surveys were collected; 4 out of the 6 surveys identified themselves as female, no males were identified within this sample, and two survey respondents did not identify their gender. Survey questions responses did not contain any missing data.

Regarding client satisfaction (Q1; see Table 5), 83% of respondents reported that they agreed that the program did meet their satisfaction, 17% of respondents strongly agreed. Fifty
percent of respondents were undecided about whether they had helped choose their treatment or service goals (Q2), compared to 33% agreeing that they had, while 17% strongly agreed that they had. Half of the client satisfaction sample strongly agreed that they felt that they had someone to talk to when they were in trouble (Q3), compared to 33% who answered “Agree”; 17% of this sample disagreed, indicating that they did not feel that they had someone to talk to in this situation. Over 4 out of 5 respondents agreed or strongly agreed that they participated in their own treatment (Q4), while 100% of the respondents agreed or strongly agreed that the clinician respected their cultural, spiritual and religious beliefs (Q5). Over 4 out of 5 children agreed or strongly agreed that they are better able to cope (Q6), compared to 17% of the respondents who answered “undecided”. Over 4 out of 5 respondents agreed that they got along better with friends (Q7), compared to 17% who responded “undecided”. Two out of 3 respondents agreed or strongly agreed that they got along better with family (Q8), compared to 17% of respondents who disagreed with this statement. Over 4 out of 5 respondents agreed or strongly agreed that they got along with people (Q9), compared to 17% who answered “undecided”. Two out of 3 youth agreed or strongly agreed that they were doing better at school as a result of the service (Q10), compared to 17% who answered “undecided” and 17% who disagreed with this statement.

<table>
<thead>
<tr>
<th>Client Feedback Question</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q.1 Overall, I am satisfied with the services I received</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>83%</td>
<td>17%</td>
<td>0%</td>
</tr>
<tr>
<td>Q.2 I helped to choose my services and my treatment goals.</td>
<td>0%</td>
<td>0%</td>
<td>50%</td>
<td>33%</td>
<td>17%</td>
<td>0%</td>
</tr>
<tr>
<td>Q.3 I felt I had someone to talk to when I was troubled.</td>
<td>0%</td>
<td>17%</td>
<td>0%</td>
<td>33%</td>
<td>50%</td>
<td>0%</td>
</tr>
<tr>
<td>Q.4 I participated in my own treatment.</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>33%</td>
<td>33%</td>
<td>17%</td>
</tr>
<tr>
<td>Q.5 The clinician respected my religious, spiritual, and cultural beliefs.</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
<td>33%</td>
<td>67%</td>
<td>0%</td>
</tr>
<tr>
<td>Q.6 As a result of the services received, I am better able to cope when things go wrong.</td>
<td>0%</td>
<td>0%</td>
<td>17%</td>
<td>17%</td>
<td>67%</td>
<td>0%</td>
</tr>
<tr>
<td>Q.7 As a result of the services received, I get along better with friends.</td>
<td>0%</td>
<td>0%</td>
<td>17%</td>
<td>83%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Q.8 As a result of the services received, I get along better with family.</td>
<td>0%</td>
<td>17%</td>
<td>0%</td>
<td>33%</td>
<td>33%</td>
<td>17%</td>
</tr>
<tr>
<td>Q.9 As a result of the services I received, I get along better with other people.</td>
<td>0%</td>
<td>0%</td>
<td>17%</td>
<td>50%</td>
<td>33%</td>
<td>0%</td>
</tr>
<tr>
<td>Q.10 As a result of the services I received, I am doing better in school and/or work.</td>
<td>0%</td>
<td>17%</td>
<td>17%</td>
<td>50%</td>
<td>17%</td>
<td>0%</td>
</tr>
</tbody>
</table>
Discussion

The timing of data collection seems to have unfortunately contributed to the small sample size obtained for this pilot sample (N = 8), which in turn limited the types of analyses that could be conducted and the generalizability of the results obtained. However, data from the School-Based Mental Health Referral Form provide a glimpse into the general social and behavioural characteristics of youths being referred to this program. Indeed, the findings “paints the picture” of youths who have recently transitioned into secondary (63% of students are in Grade 9), who are being teased by others (25%), who prefer to be alone, withdraw from social settings and have difficulty making friends and who are excessively worried or anxious (38%). Interestingly, these youths also appear to often skip school (38%), perhaps indicating a correlation between the youths internalizing symptoms and school-avoidant behaviour. The collection of this data has already proven useful in the understanding of the population we seek to serve. In fact, the School-Based Mental Health program Clinicians and Program Manager, in collaboration with School Stakeholders are in the process of reviewing the ways they reach out to clients with attendance issues.

Based on findings from the few collected Client Satisfaction Questionnaires, 100% of the clients strongly agreed (17%) and agreed (83%) to this statement: “Overall, I am satisfied with the services I received”. Areas in which clients indicated a less favorable feedback were with respect to their determination of services and their treatment goals (50% were undecided) and in their participation in their own treatment (17% disagreed). Also, only 50% of clients indicated that they felt they had someone to talk to when troubled. The general comment to this statement was that they wished to have more frequent/regular appointments with their clinician. This finding may be due to the fact that Clinicians were involved in several training sessions as part of the first year of implementation of School-Based Mental Health program services, which has impacted their direct service time to clients. As we move into our second year of implementation, careful consideration will need to be made to service delivery and staff training.
needs. Also, consideration will need to be made for the client’s involvement in the development of treatment plans, as well as the client’s understanding of their involvement in Program Evaluation. Do clients fully understand the importance of their feedback and input? In sum, due to the small sample size (N = 6) it is difficult to interpret such results, however these may be areas which require improvement and thus will be closely monitored throughout this program evaluation.

As previously discussed, the timing of the data collection created challenges in our ability to obtain an adequate sample size and our ability to answer this Program Evaluation’s Process and Outcome questions (see Appendices B and C). In fact, only 20% of the school year remained from May to the end of June. This time of the year is often chaotic for school personnel, as their work demands increase (i.e. exams, report cards) and can be chaotic for the students as well (i.e. anxiety regarding exams, fatigue). Alternatively, our focus for this pilot study shifted more towards the testing and evaluation of the program process and the effectiveness of selected measures.

Firstly, this pilot study allowed the Evaluation Team time to consolidate an internal process for program evaluation at the Child and Family Centre (see Appendix I). The Process Flow Chart indicates the role of the clinical, secretarial, management, and data collection staff at each phase of data collection (referral, assignment, assessment/treatment and closure). This process was followed during the pilot study and was modified several times to ensure its feasibility and effective functioning. In sum, the pilot study permitted the Child and Family Centre staff to practice following the process for this Program Evaluation. The Child and Family Centre staff indicated they now feel more confident in accomplishing their respective roles and tasks, as evidenced by their engagement and their administration of measurement tools.

Secondly, this pilot study focused on the effectiveness of the selected measurement tools, forms, and surveys utilized for the program evaluation. Although this pilot study has not yielded results from the Children’s Hope Scale (Snyder et al., 1997) or the CAFAS (Hodges,
results are available for the School-Based Referral Form (see Appendix D), and limited results are available for the Client Feedback Questionnaire, \( N = 1 \) (see Appendix E) and the School Feedback Questionnaire (see Appendix F). As these forms were being completed by stakeholders, user-related and data-related challenges were identified (i.e. difficulty opening the form, adding additional fields). The pilot permitted the evaluation team to put the forms “to the test” and make necessary revisions.

Thirdly, the pilot study also provided an opportunity for the Evaluation Team to test and revise the functioning of the Dashboard (Data Collection System). As data was collected and inputted into the dashboard, revisions were made to add variables that had been overlooked. The Data Collector also developed a data import procedure to enhance the efficiency of data entry.

**Stakeholder involvement and knowledge exchange**

The Evaluation Team consists of staff from the Child and Family Centre (Managers, Clinicians, Research Lead, Secretaries and Data Collector) and school representatives from each of the four local School Boards (Sudbury Catholic School Board, Rainbow District School Board, Conseil Catholique du Nouvel Ontario, and Conseil Publique du Grand Nord de l’Ontario). The Executive Director, as well as agency Board Members supported the Agency in this endeavor.

The members and stakeholders of the Evaluation Team participated in a first meeting with a Consultant from the Ontario Centre of Excellence for Child and Youth Mental Health and developed the Program Logic Model in October 2011. Two leads for this project were identified, Linda Dugas and Chantal Lafleur who were responsible to regularly communicate any changes/progress with the Evaluation (i.e. Revisions made to the PLM, Measurement tools/templates, etc.). The Evaluation Team reconvened on two other occasions to (1) establish Outcome and Evaluation Questions and to (2) review and discuss the selection of measures.
Collaborative operational review meetings were held regularly (approximately every 2 months) with the School Board representatives.

Although clients were not included in the Evaluation Team, their feedback was solicited through the Agency client satisfaction survey. The Agency recognizes the importance to further engage the youth clients in program evaluation initiatives as they can offer important insights into what needs to be evaluated. For this reason, we plan to begin to engage clients in the Doing Phase of this program evaluation, by having an open forum with youths to discuss School-Based Mental Health Services. We will seek youth participation to this forum by utilizing the creation of the SBMH pamphlet as the catalyst and invite youths to become active members of the Evaluation Team.

The Agency values knowledge transfer and subsequently has devoted time and resources for this exchange with its solution focused brief therapy program evaluation, which is to be completed following the learning principles acquired through the Planning Evaluation process undertaken for the School-Based Mental Health program.

Child and Family Centre plans to present its preliminary results (pilot results) of the Program Evaluation during the next Annual General Meeting with Child and Family Centre staff and Community Partners (i.e. MCYS, Children’s Community Network, the Children’s Aid Society).

The Agency will share the final Planning Evaluation Report with stakeholders. We recognize that it is important to relay important findings relating to the services offered and to the program evaluation to School-Based Mental Health program stakeholders on a regular basis. The Implementation Lead sends monthly reports to the school board liaisons which include referral information and status of the files. Quarterly reports will also be sent including information relating to referrals, characteristics of youths referred and outcome results.

Laurentian University, with the help of the participating student, will be given a copy of the Program Evaluation findings to be shared amongst her peers. Finally, School Board
representatives are committed to knowledge exchange for their respective school boards and school personnel.

**Conclusion and Recommendations**

Although there were some limitations in the pilot study speaking to the Process and Outcome evaluation questions, some important insights have been gained. The first challenge we experienced was the timing of data collection. Since only approximately 20% of the school year remained for data collection, a small number of students participated. This small sample size created limitations for data analysis and generalizability. However, greater participation in the next phase of Program Evaluation is anticipated and greater sample sizes will allow many other inferential statistics to be conducted. Despite the small sample size, some insight was gained regarding the general characteristics of the pilot participants via descriptive statistics.

Furthermore, during this phase of Program Evaluation, the Dashboard data collection system was designed for use with the School-Based Mental Health program. Dashboard allows staff efficient and effective real-time access to data. Furthermore, a data input procedure was put into place and tested. Internal process development allowed evaluation of all aspects of the program which led to user-related and data-related challenges being identified and improved. The collection of this data has already proven useful in understanding the population we seek to serve. In fact, the School-Based Mental Health program Clinicians and Program Manager, in collaboration with the School Stakeholders, are reviewing ways in which clients with attendance issues can be reached more effectively. Furthermore, Child and Family Centre staff have indicated that practicing the internal School-Based Mental Health program processes has resulted in the ability to carry out their respective roles and tasks with more confidence.

Other areas which require consideration were identified as well, including the client’s involvement in the development of treatment plans and the client’s understanding of their involvement in Program Evaluation. To help address these issues, we plan to begin to engage
clients in the Doing Phase of the Program Evaluation, by having an open forum with youths to discuss School-Based Mental Health Services. We will seek youth participation in this forum by utilizing the creation of a School-Based Mental Health program pamphlet to invite youths to become active members of the Evaluation Team.

In regard to the Program Evaluation process itself, we have learned the importance of and setting realistic and attainable goals. With this in mind, communication is essential between team members, the Centre of Excellence Consultant, and stakeholders. Client and stakeholder involvement in the Program Evaluation process is also crucial. Finally, we have learned that the timing of the program must be carefully considered before implementation.

Despite the limitations of the pilot, including small sample size and limited time for data collection, the evaluation process has provided the School-Based Mental Health program the ability to fine tune internal processes, data collection procedures, and measurement tools. The focus on putting the program process and measures “to the test” has enabled us to be in the best position in September to commence the implementation of this Program Evaluation for the 2012-2013 school year.
References

References marked with an asterisk indicate studies included in the literature review.


## PROGRAM LOGIC MODEL: SCHOOL-BASED MENTAL HEALTH, CHILD AND FAMILY CENTRE

**Program Goal:** Facilitate access and provide time-limited intervention to youths who are struggling with mental health problems in their school.

<table>
<thead>
<tr>
<th>INPUTS (Resources e.g. $, staff, equipment)</th>
<th>ACTIVITIES (Services e.g. Counseling, outreach, support groups)</th>
<th>OUTCOMES (Impact or effectiveness of the program on the client)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff:</td>
<td>1. Orientation to school staff/partners; engaging stakeholders; on-going communication</td>
<td><strong>SHORT-TERM</strong> Improve Behavioural functioning: ↑ positive and healthy coping skills ↓ substance use ↓ inappropriate sexualized behaviour ↓ in conduct and oppositional behaviours</td>
</tr>
<tr>
<td>• 2 clinicians</td>
<td>2. Referral process (Referral form and screening tool)</td>
<td>↓ self-esteem, self-confidence</td>
</tr>
<tr>
<td>• I.T. / Data collector</td>
<td>3. Client orientation with Clinician (Consents, PHIPA and agency package)</td>
<td>↑ anger management</td>
</tr>
<tr>
<td>• Secretarial staff</td>
<td>4. Assignment to Clinician</td>
<td>↑ self-regulation</td>
</tr>
<tr>
<td>• Program Manager</td>
<td>5. CCN complete intake review</td>
<td></td>
</tr>
<tr>
<td>• Clinical consultation</td>
<td>6. Clinician and School Board liaison communication</td>
<td><strong>LONG TERM OUTCOMES:</strong> ↓ adolescents overall well-being (emotional, behavioural, social) ↓ adolescents’ mental health problems ↓ adolescents receiving and accessing mental health services</td>
</tr>
<tr>
<td>Partners:</td>
<td>7. Assessment/intervention with client (time-limited, internal and external referrals)</td>
<td></td>
</tr>
<tr>
<td>• School Board reps. (liaisons)</td>
<td>8. Closing and transition plan</td>
<td></td>
</tr>
<tr>
<td>• Parents</td>
<td>9. Data Collection</td>
<td></td>
</tr>
<tr>
<td>• CCN</td>
<td><strong>TARGET POPULATION</strong> N.B: On-going documentation is embedded in every level of process.</td>
<td></td>
</tr>
<tr>
<td>Financial Resources:</td>
<td><strong>OUTPUTS</strong></td>
<td></td>
</tr>
<tr>
<td>• In-kind contribution from School Boards</td>
<td>• Referral Form and screening tool</td>
<td></td>
</tr>
<tr>
<td>• CFC Agency contribution</td>
<td>• 12 sessions in 5 month time-frame</td>
<td></td>
</tr>
<tr>
<td>Equipment:</td>
<td>• Operational Review every 2 months</td>
<td></td>
</tr>
<tr>
<td>• Computer, printer, locking filing cabinet</td>
<td>• Orientation yearly to school staff</td>
<td></td>
</tr>
<tr>
<td><strong>LONG TERM OUTCOMES:</strong></td>
<td><strong>TARGET POPULATION</strong> N.B: On-going documentation is embedded in every level of process.</td>
<td></td>
</tr>
<tr>
<td>• Service up to 150 clients yearly</td>
<td><strong>OUTPUTS</strong></td>
<td></td>
</tr>
<tr>
<td>• Age: 12-18 years</td>
<td>• Referral Form and screening tool</td>
<td></td>
</tr>
<tr>
<td>• Students with mental health problems</td>
<td>• 12 sessions in 5 month time-frame</td>
<td></td>
</tr>
<tr>
<td><strong>LEGEND:</strong> CCN = Children’s Community Network</td>
<td>PHIPA = Personal Health Information Protection Act</td>
<td><strong>LONG TERM OUTCOMES:</strong> ↓ adolescents overall well-being (emotional, behavioural, social) ↓ adolescents’ mental health problems ↓ adolescents receiving and accessing mental health services</td>
</tr>
</tbody>
</table>
## 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 (specify month/year)</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 of 5 CAFAS scales (behavior towards others, moods/emotions, self-harmful behav., substance use, thinking)</td>
<td>-Pre/post CAFAS</td>
<td>-Clinicians complete CAFAS at assessment and at closure</td>
<td>Penny Emes, I.T.</td>
<td>May 2012</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>-Pre/Post Children’s Hope Scale</td>
<td>-Clinicians administer CHS at assessment and at closing</td>
<td>Penny Emes, I.T.</td>
<td>May 2012</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>-Pre/Post CAFAS, School Domain</td>
<td>Clinicians completes Pre/Post CAFAS</td>
<td>Penny Emes, I.T.</td>
<td>May 2012</td>
</tr>
</tbody>
</table>
## APPENDIX C

### 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 clients satisfied with SBMH services?</td>
<td>Termination of services/closure</td>
<td>Client’s self-reported score of satisfaction</td>
<td>CFC Client Satisfaction Survey</td>
<td>Clinician gives to client during closure session</td>
<td>Penny Emes, I.T.</td>
<td>May 2012</td>
</tr>
<tr>
<td>Are the referral agents of the serviced schools satisfied with SBMH services?</td>
<td>Termination of service</td>
<td>Referral agent’s reported score of satisfaction</td>
<td>SBMH School Feedback Questionnaire</td>
<td>At termination, Clinician gives the questionnaire to the referral agent. They fax it to CFC.</td>
<td>Penny Emes, I.T.</td>
<td>May 2012</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</td>
<td>-Clinician indicate success of treatment in CAFAS closing and the number of sessions on Closing Form</td>
<td>Penny Emes, I.T.</td>
<td>May 2012</td>
</tr>
<tr>
<td>Did the program reach the target population?</td>
<td>Youths 12-18</td>
<td>-# of assigned clients</td>
<td>Referral Form</td>
<td>Client demographics on Referral Form</td>
<td>Penny Emes, I.T.</td>
<td>May 2012</td>
</tr>
<tr>
<td>How many eligible youths were referred to SBMH and pursued services? How many clients were not eligible for SBMH services and why?</td>
<td>Youths referred with mental health problems</td>
<td># of clients who (1) were referred and (2) who completed treatment</td>
<td>-Running list of Clients referred (WL) -CAFAS closing episode</td>
<td>Program Manager keeps record of running list Clinician complete closing CAFAS</td>
<td>Penny Emes, I. T.</td>
<td>May 2012</td>
</tr>
<tr>
<td>How many youths in the SBMH program are referred to Adult Mental Health Services?</td>
<td>Number of youths who are “aging out” of service.</td>
<td>Reason for File closure</td>
<td>Closing Form</td>
<td>Clinician to complete closing form</td>
<td>Penny Emes, I.T.</td>
<td>May 2012</td>
</tr>
<tr>
<td>What are the most prevalent presenting problems treated?</td>
<td>Mental Health problem (ex. Anxiety, depression)</td>
<td>-Referral agent’s concerns on referral form -Prevalence of CAFAS scales</td>
<td>-Characteristics of client in Referral Form -CAFAS results</td>
<td>Dashboard (qualitative data)</td>
<td>Penny Emes, I. T.</td>
<td>May 2012</td>
</tr>
</tbody>
</table>
# School Based Mental Health Referral Form

## General Information:

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

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

## Medical History:

<table>
<thead>
<tr>
<th>M1. Is the student on medication?: Select</th>
<th>M1a. If on medication, what type of medication?:</th>
</tr>
</thead>
<tbody>
<tr>
<td>M2. Has the student been diagnosed with a mental health disorder?: Select</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?: Select</td>
<td>M3a. If yes, what kind?:</td>
</tr>
<tr>
<td>M4. Does the student have a Developmental or Intellectual disability?: Select</td>
<td>M4a. If yes, what is the disability?:</td>
</tr>
</tbody>
</table>

## Educational Profile: Please check all that apply

<table>
<thead>
<tr>
<th>E1. Number of courses completed:</th>
<th>Suspensions and Truancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>E2. What is the student’s academic program: Select</td>
<td>E12. Student has been suspended within the last 12 months;</td>
</tr>
<tr>
<td>E3. Overall, what is student’s average mark this year Select</td>
<td>E13. If box is checked, please indicate how many Incidences?</td>
</tr>
<tr>
<td>E4. Student has IEP</td>
<td>E14. And how many days missed?</td>
</tr>
<tr>
<td>E5. Student has failed or repeated a course</td>
<td></td>
</tr>
<tr>
<td>E6. Student has failed a grade</td>
<td></td>
</tr>
<tr>
<td>E7. Student has been held back a grade</td>
<td></td>
</tr>
<tr>
<td>E8. Student requires Resource Support</td>
<td></td>
</tr>
<tr>
<td>E8a. If Yes, then what type of support?</td>
<td></td>
</tr>
<tr>
<td>E9. Student’s academic success is at risk</td>
<td></td>
</tr>
<tr>
<td>Absenteeism:</td>
<td></td>
</tr>
<tr>
<td>E10. Within the last 12 months, on average, how often does the student miss school? Select</td>
<td></td>
</tr>
<tr>
<td>E11. Student has left school without permission</td>
<td></td>
</tr>
<tr>
<td>E15. Student has been Expelled</td>
<td></td>
</tr>
<tr>
<td>E16. Student has a history of truancy issues</td>
<td></td>
</tr>
</tbody>
</table>
**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 behaviour
- 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 sources primary concern re: student? :

Has the student ever threatened to commit, or has attempted to commit suicide? Select PRSUI

**Support Services, special education programs or specialized assessments**
Please check if the student ever received some of the following services:

- SS1. Services from a Social Worker or/and Attendance Counselor –Date (yyyy/mm/dd)  SS1a
- SS2. Psychological Assessment: date of last evaluation (yyyy/mm/dd)  SS2b
SS3. Does student have access to an EAP? Select

SS4. Is the student receiving services elsewhere (other community agencies involved)? Select

SS4a. If yes, then please specify:

AI1. ADDITIONAL INFORMATION: (include 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.

☐ Received approval from school Principal

**Referral Process:**
Board Liaison e-mails the Referral Form and completed HoNOSCA screening tool to the Child and Family Centre Program Manager:

Mrs. Chantel Lafleur, E-MAIL: clafleur@childandfamilycentre.on.ca
School Based Mental Health Program
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>Strongly Disagree</th>
<th>Disagree</th>
<th>Undecided</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Overall, I am satisfied with the services I received.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>2. 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>3. 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>5. The clinician treated me with respect</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>6. 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>7. 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></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</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 family.</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 get along better with other people.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10.</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>
</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:
School Based Mental Health Program
School Feedback Questionnaire

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

I am a: Select Explain: _______________________

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.

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 student?

Select

3.a If ‘Yes’ please describe how the program was helpful to the student; If ‘No’, please include a brief description about why the program was not helpful for the student.
4. Since participating to the program, has it become easier for the student 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?

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>

5. Overall, were you satisfied with the program? Select

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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
</table>

6. ADDITIONAL COMMENTS:

Please return this questionnaire 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

THANK YOU!
School Based Mental Health Program Evaluation Consent Form

What is the purpose of the program evaluation?
Child and Family Centre is committed to an evaluation of the School Based Mental Health Program, in order to determine the program’s efficiency and to determine if we are reaching our program goal to facilitate access and provide time-limited intervention to youths who are struggling with mental health problems in their school.

Methods and procedures:
During the course of treatment with your clinician, you will be asked to complete a few questionnaires. Scores from these questionnaires will be utilized as data for the purpose of this evaluation. Other important information, such as your demographic information (i.e. gender), number of treatment sessions, etc. will also be collected in our database. The amount of time required for your participation will be minimal.

You can be assured that your name will not be disclosed and that the information you share with us will be confidential. No names or identifying information will be used for the purpose of the program evaluation.

Benefits and Risks:
There are no known risks to your participation, and while you will not benefit directly from participating, it is our hope that your participation may help us understand some of the ways the program can be improved for others.

If you have any questions or concerns about this evaluation or if any problems arise, please contact Chantal Lafleur at 705-525-1008.

Please note that your participation in this evaluation is voluntary and you may withdraw at any time. Your participation will not affect the services you receive in any way.

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

Signature of client: _____________________________

Signature of Clinician: __________________________

Date: ____________________
**APPENDIX I**

**REFERRAL**
- Referral form received by Program Manager (PM). PM determines admission. If excluded, PM enters data into the exclusion database.
- PM sends referral by email to Data collector, indicating admission in the message (W/A/E/C).
- Data Collector enters data from Referral form and informs PM when completed (reply email says DONE).
- If Clinician has capacity, PM forwards Referral Form and HoNOSCA to Clinician for orientation to services.

**ASSIGNMENT**
- Clinician completes orientation with referred student. Completed orientation package (including Service Agreement, PHIPA and CIMS Client Information Form) given to SBMH Secretary and informs PM that file will be assigned.
- Secretary creates CIMS file for student and informs the Data Collector of the CIMS # and client name.
- PM sends Referral form and HoNOSCA to secretary to be uploaded as E-file in CIMS.

**ASSESSMENT/TREATMENT**
- Clinician completes the Pre-Children’s Hope Scale at orientation (part of the orientation package) and gives the completed form to the Secretary.
- The Secretary will scan and upload the Pre-Children’s Hope Scale in the CIMS assessment section. She informs the clinician and Data collector that it is uploaded.
- Clinician completes the Pre-CAFAS (T1) with the client, within 4 sessions, and uploads such in CIMS.
- Data collector inputs Pre-Children’s Hope Scale to dashboard.

**CLOSURE**
- Clinician completes the Post-Children’s Hope Scale and gives to secretary to upload in the CIMS assessment section.
- Clinician completes the Post-CAFAS (T14) with the client.
- Clinician requests that client complete the Client satisfaction Survey.
- Clinician to inform PM and School of file closure and request that referral agent complete the School Feedback Survey.
- Clinician complete the File Disposition Form (electronically) and emails to SBMH Secretary for file closure.
- Secretary (by email) informs the Data Collector when CHS uploaded and emails the File Disposition Form.
- Upon receipt of the file disposition form, the Data Collector will input all CAFAS data (T1 and T14) and closure information.
- PM receives (English) Client Satisfaction Survey and gives to Data Collector for input.
- PM receives (English) School Feedback Survey and gives to Data Collector for input.
- For French SSQ and SFS, The PM will input data into the Dashboard.