



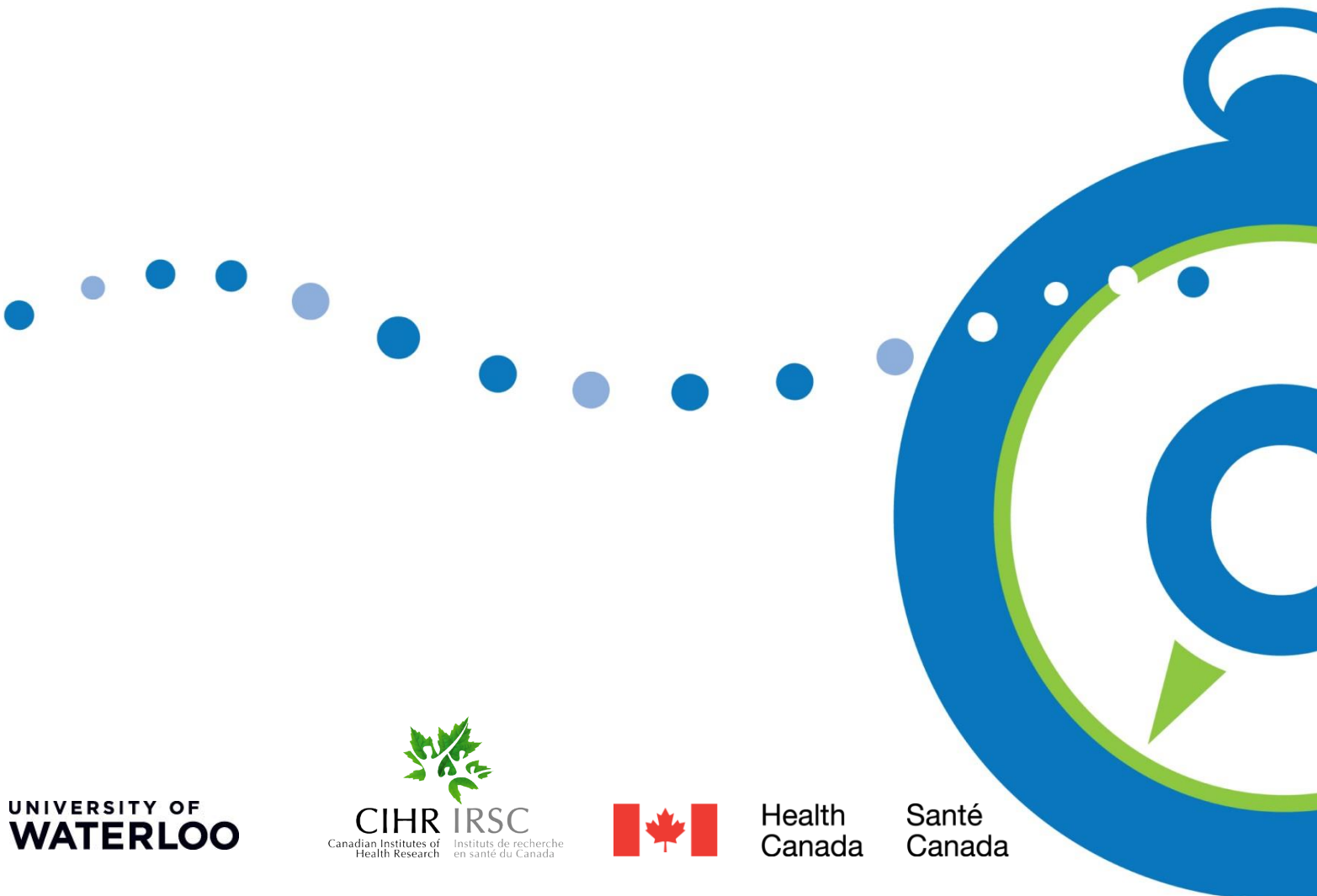
Cohort study evaluating how changes in school programs, policies, and resources impact youth health behaviours

Development of a mental health module for the compass system: Improving youth mental health trajectories

Part 1: Tool Development and Design

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Karen A. Patte PhD¹, Chad Bredin BA², Joanna Henderson PhD CPsych^{3,4}, Tara Elton-Marshall⁵, Guy Faulkner PhD⁶, Catherine Sabiston PhD⁴, Mark Ferro PhD², Kate Battista MMath², & Scott T. Leatherdale PhD²

1 – Brock University, St. Catharines, Ontario

2 – University of Waterloo, Waterloo, Ontario

3 – Centre for Addiction and Mental Health (CAMH), Toronto, Ontario

4 – University of Toronto, Toronto, Ontario

5 – CAMH, London, Ontario

6 – University of British Columbia, Vancouver, British Columbia

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Contact:

COMPASS Research Team
University of Waterloo
200 University Ave West, BMH 1038
Waterloo, ON Canada N2L 3G1
compass@uwaterloo.ca

Acknowledgements.....	3
Introduction	5
Background	5
The COMPASS System Overview	6
The COMPASS Mental Health Module (MH-M).....	7
MH-M DRAFT DEVELOPMENT AND DESIGN	8
Mental Health Student Questionnaire (MHq)	8
Mental Health School-level Program and Policy Scan Tool (MHpp).....	12
Mental Health School-specific Knowledge Exchange Tool (MHkte).....	14
References	16
Appendix A: MHq	20
Appendix B: MHpp	22
Appendix C: MHkte	26

Introduction

COMPASS is a 9-year longitudinal study (starting in 2012-13) designed to follow a prospective cohort of grade 9 to 12 students attending a convenience sample of Canadian secondary schools over several years to understand how changes in school environment characteristics (policies, programs, built environment) and provincial, territorial, and national policies are associated with changes in youth health behaviours [1]. COMPASS originated to provide school stakeholders with the evidence to guide and evaluate school-based interventions related to obesity, healthy eating, tobacco use, alcohol and marijuana use, physical activity, sedentary behaviour, school connectedness, bullying, and academic achievement. COMPASS has been designed to facilitate multiple large-scale school-based data collections and uses in-class whole-school sampling data collection methods consistent with previous research [2-5]. COMPASS also facilitates knowledge transfer and exchange by annually providing each participating school with a school-specific feedback report that highlights the school-specific prevalence for each outcome, comparisons to provincial/territorial and national norms or guidelines, and provides evidence-based suggestions for school-based interventions (programs and/or policies) designed to address the outcomes covered in the feedback report. (refer to: www.compass.uwaterloo.ca).

Background

The prevention and early identification of mental illness, and promotion of mental health, are leading national and provincial strategic priorities.¹⁻⁵ Youth represent a key target population for such efforts^{5, 6} because the onset of ~70% of all mental illnesses occurs before age 18.² One in five young Canadians will experience a mental illness,² placing them at heightened risk of various physical illnesses, early mortality, suicide, and substance use. Among Ontario youth, there are rising internalizing symptoms (with 34% reporting moderate-to-severe psychological distress)⁷ and mental health-related emergency department visits and hospitalizations (with most cases having no prior contact with care).⁸ These trends clearly demonstrate the need for improved prevention and early identification strategies to avoid the escalating severity and chronicity of problems.

Experts point to the need to meet youth where they are, with schools recognized as the ideal context to equitably address mental health.^{1,3,4,9-12} Schools offer unparalleled access to youth, as the location where almost all young Canadians (regardless of socioeconomic status) spend ~25 hours each week. However, despite increased attention to mental health, more than 1 in 4 Ontario students report not knowing who to approach for help.^{7,13} Also, in a survey of 177 school districts and 643 schools across Canada, over 80% reported unmet student mental health needs in their school/board.⁹

Assisting schools in supporting student mental health is a priority,^{3,4,9} yet limited evidence exists on how to effectively and safely intervene. Pressures to address youth mental health have led to the expansion of programs being developed and implemented; however, the Mental Health

Commission of Canada (MHCC)⁹ identified that less than half of mental health-related programs in schools had been evaluated. Similarly, less than half of the public health initiatives addressing child and youth mental health in Ontario are considered evidence-based.⁶

Therefore, most programs are potentially benign (representing an opportunity lost) or even harmful.¹⁴ Additionally, little research has explored how different school contexts impact delivery and effectiveness, resulting in continued difficulty developing sustainable and scalable mental health programs.¹⁵⁻¹⁸ Furthermore, longitudinal data is necessary to establish temporality and test the impact of interventions at the individual level, yet current youth population studies use repeat cross-sectional designs. Researchers call for pragmatic large-scale effectiveness trials and cohort designs within the school system to better understand what interventions work, for whom, and in what setting.^{12,15,18}

The COMPASS System Overview

In spring 2016, our team received CIHR bridge funding (PJT-149092) to develop and test a robust tool to determine the “real-world” effectiveness of school-based mental health interventions – the COMPASS mental health module (MH-M). The MH-M is designed to be incorporated to a well-established chronic disease prevention system referred to as COMPASS.¹⁹ The CIHR-funded COMPASS system (OOP-110788; MOP-114875; PJT-148562) uses a rigorous longitudinal quasi-experimental research design to evaluate how changes in programs, policies, or built environment resources²⁰ are related to changes in youth risk and health behaviours and outcomes over time.¹⁹ The quasi-experimental design represents a robust method for assessing causality when a randomized design is not feasible or ethical.²¹ COMPASS also facilitates knowledge translation and exchange (KTE) by annually providing participating schools with customized KTE tools to connect them to relevant prevention resources.

The COMPASS Student Questionnaire (Cq)²² collects student-level data and the COMPASS School Programs and Policies Questionnaire (SPP) provides school-level program and policy data.

The Cq is designed for multiple large-scale school-based data collections and collects individual-student data on obesity, screen time, sleep, physical activity, diet, substance use (alcohol, cannabis, tobacco, e-cigarettes), bullying, school connectedness, and demographics.²² The Cq includes questions to create a unique student code for linkage purposes. Cq items have demonstrated reliability and validity.^{19,22}

The SPP is an online survey completed by the school administrator(s) most knowledgeable about the school program and policy environment. Items assess programs, policies, practices, and resources that relate to the domains measured in the Cq. COMPASS also includes measures of the built environment within and surrounding schools using: (a) the COMPASS School Environment Application (Co-SEA; a downloadable scan application on mobile devices that uses previously-validated audit measures and photographs to record data pertaining to school

resources); and (b) the COMPASS Built Environment Database (C-BED; collated from Desktop Mapping Technologies Inc. [DMTI] at 500m/1km buffers).²⁰

To help foster relevant prevention action, participating schools are provided a customized School Health Profile (SHP).⁴⁷ For each Cq content domain, the SHP provides school administrators with: (a) data on their students' health behaviours; (b) national/provincial norms to allow for comparisons to gauge how well their students are doing; (c) evidence-based suggestions for interventions, programs, policies, or curriculum supplements; and, (d) local public health unit contact information.

To enhance the utility of the SHP, each school is assigned a COMPASS Knowledge Broker (KB) who works with them to foster and advance context appropriate interventions. In each school, a KB: (a) facilitates ongoing interaction between the research team, schools, and community partners; (b) assists administrators in determining appropriate priorities for immediate and future action based on student needs and available resources; (c) collects process measures from schools pertaining to intervention actions taken annually; and, (d) works with schools and external partners to identify resources (e.g., funding, equipment, personnel) to support particular actions within a school.

To date, COMPASS is currently effectively guiding and continually improving school-based prevention research and practice in the domains of substance use and obesity prevention. Schools participating in the COMPASS study (OOP-110788; MOP-114875; PJT-148562) consistently list mental health as their leading prevention priority. In year 3 (2014/2015) of the study, 62% of schools ranked mental health as their number one prevention concern, with 90% ranking it within the top three priorities in relation to existing domains. The MH-M expands the functionality of the COMPASS system by developing tools necessary to address youth mental health, filling this research-to-practice gap identified by COMPASS schools and national and provincial stakeholders.¹⁻⁵

The COMPASS Mental Health Module (MH-M)

The MH-M serves to build capacity and provide infrastructure to continually evaluate and improve school-based programs, policies, and resources for the advancement of youth mental health. Building on the existing COMPASS infrastructure provided a cost-effective and proficient means of achieving this goal by taking advantage of already established partnerships and a design with demonstrated efficacy.

The MH-M was designed for seamless incorporation into the COMPASS system. In line with the COMPASS design, the MH-M has three components:

1. Student mental health questionnaire (MHq)
2. School-level mental health program and policy scan tool (MHpp)
3. School-specific mental health knowledge exchange tool (MHkte)

Development and testing of the MH-M took place over a 1-year period, using a design and protocol similar to that used for the development of the original COMPASS tools, and including both quantitative (pilot testing) and qualitative (focus groups) methods. To reflect both science- and practice-based concerns, initial conceptualization of the MH-M tools was informed by past and ongoing school-based youth and mental health research, national and provincial strategic priorities, school programming, and consultations with researchers, clinicians, school stakeholders, and public health partners. The draft MH-M was pilot tested in a sample of purposefully selected schools participating in the COMPASS study. Focus groups with students were conducted in one of these schools to ensure appropriateness, comprehension, and comprehensiveness of the MHq. Following necessary revisions, the tools will be automated and incorporated into the existing ongoing COMPASS system infrastructure, available for future implementation.

The current technical report outlines the development of the draft COMPASS Mental Health Module. A follow-up technical report provides the pilot test and focus group results, tool revisions, and presents the finalized tools.

MH-M DRAFT DEVELOPMENT AND DESIGN

To reflect both science- and practice-based concerns, initial conceptualization of the tools was informed by past and ongoing youth research, national and provincial strategic priorities, school programming, and consultations with researchers, clinicians, public health professionals, and school stakeholders. Beginning in November 2016, our team members with expertise in survey development (Leatherdale, Faulkner, Bredin) and youth mental health (Henderson, Elton-Marshall, Faulkner, Sabiston, Patte, Carney), convened a working group to develop initial drafts of the MH-M. School board mental health leads and public health representatives (Carney, Mann) were invited to ensure the tools address stakeholder needs, and produce relevant and useable information. COMPASS staff members (Bredin, Battista, Reel) were included to inform on the COMPASS system implementation requirements.

Designed for seamless incorporation into the COMPASS system, the MH-M consists of a mental health student questionnaire (MHq) to include as an insert for the COMPASS student questionnaire (Cq), a school-level mental health program and policy scan tool (MHpp) to include in the COMPASS School Policies and Practices questionnaire (SPP), and a school-specific mental health knowledge exchange tool (MHkte) to include in the COMPASS School Health Profile (SHP). More detail is provided below for the individual components of the module.

Mental Health Student Questionnaire (MHq)

The MHq (see Appendix A) is designed to collect longitudinal individual-student data pertaining to mental health, and to be incorporated into the COMPASS Student Questionnaire (Cq).

The MHq was developed with the following considerations:

1. Items assess positive mental health and well-being, protective/risk factors, and correlates (e.g., self-rated mental health, psychosocial functioning, social support, family relationships, home environment, life purpose and engagement, optimism, self-concept, etc.), as well as symptoms indicating risk of mental health problems or disorders, to fit with national and provincial strategic priorities of both universal mental health promotion (e.g., aligning with the PHAC Positive Mental Health Indicator Framework²⁵), and the prevention and early identification of mental illness. The choice of specific scales (i.e., depression, generalized anxiety) to be included was based on the most prevalent disorders at this age and ones that can be reliably assessed with limited self-report items. Notably, bullying and substance use are already addressed in COMPASS.
2. Items were largely derived from well-established and short scales that have been validated among adolescent nonclinical populations, and/or used in large and long-running national and provincial surveys (e.g., Canadian Community Health Survey [CCHS], Health Behavior in School-Aged Children Survey [HBSC], National Longitudinal Survey of Child and Youth [NLSCY], Ontario Child Health Survey [OCHS], Ontario Student Drug Use and Health Survey [OSDUHS], School Mental Health Survey [SMHS], etc.), to provide synergy with other youth-focused surveillance systems, ensure validity, and enable comparisons with representative samples.
3. For KTE and to promote school engagement, school stakeholders helped inform the MH-M design to ensure items are valuable from a school and school-board level perspective, and the project will produce relevant and useable knowledge.
4. Items aim to facilitate evaluation of school-based programs and curriculum. For example, included items reflect the educational focus on developing socio-emotional skills (e.g., emotional awareness and regulation strategies), as informed by school stakeholders involved in the design, and provincial and national strategies and curricula.
5. The tool was designed for the realities of large-scale school-based research, for which the majority of the existing mental health-related scales are inappropriate. More specifically, to minimize the burden on schools and students, and to ensure survey completion in one class period when completed with the Cq (~30-40 minutes), the MHq was designed for brevity (i.e., one page, double-sided), while maximizing validity, reliability, and comprehensiveness of key constructs.
6. Items needed to be appropriate for use with the passive-consent active-information procedures used in the COMPASS study protocol, ruling out areas such as trauma/abuse, suicidality, self-harm, and violent/aggressive behavioural problems.

7. Resulting data were required to have the ability to link to the COMPASS system's longitudinal behavioural data from a variety of other domains (e.g., substance use [alcohol, cannabis, tobacco use], weight [status, perception, and loss/gain/maintenance intentions], physical activity, diet, sedentary behaviour [e.g., screen time], sleep, bullying [victimization, perpetration], school connectedness, and academic outcomes [achievement, aspirations, preparedness, engagement, truancy]) to understand how different behavioural and health changes are related to mental health outcomes over time.

Applying the above considerations, the specific items chosen for the draft MHq were:

1. **Self-rated mental health:** Self-rated mental health provides a higher-level global measure useful for KTE purposes. The item has been used in the CCHS and OSDUHS, which allows for comparison to a representative sample, and is one of five PHAC Positive Mental Health Indicators.²⁵
2. **Family and friends:** Items were included to assess social support from family and friends, relationships, and home environment, given their critical role in adolescents' current and future mental health and wellbeing. Items are used in the HBSC, and derived from the *Multidimensional Scale of Perceived Social Support (MSPSS)*²⁶, which demonstrates acceptable validity and reliability.
3. **Positive mental health/psychosocial wellbeing:** The *Flourishing Scale*²⁷ was developed based on more recent theories of psychological and social wellbeing than comparable scales, and to provide a brief summary measure of respondent's self-perceived social-psychological functioning, tapping into areas such as life purpose, meaning, and satisfaction, engagement and interest in one's activities, optimism, self-esteem and perceived competence, and relationships. The scale provides a single psychological wellbeing score, and is shown to have strong psychometric properties across various age groups;^{28,29} whereas the primary alternative considered demonstrated poor validity when used in youth population surveys.³⁰ The 8 items are scored 1 to 5 for responses of "strongly agree" to "strongly disagree" and summed.
4. **Self-concept:** Consistent with the NLSCY, self-concept was assessed using five of the items from the *Self Description Questionnaire (SDQ) II*³¹, which is intended for adolescents. Marsh's SDQs are among the most widely used scales of self concept.³²
5. **Perceived deterrents to help seeking in schools:** To provide schools with specific and practical feedback, an item was included to assess student perceived barriers to accessing help for potential mental health concerns in the school context. Schools have been identified as critical settings for early identification of mental health problems and

disorders, given the amount of time that youth across all population groups spend there. Similar items have been used in related youth surveys (e.g., SMHS, OSDUHS, HBSC).

6. **Generalized Anxiety:** The *Generalized Anxiety Disorder 7 (GAD-7)*³³ scale is one of the most widely used brief scales to assess symptoms of generalized anxiety, and demonstrates strong psychometric properties among general population samples of adolescents. It is designed primarily as a screening and severity measure for generalized anxiety disorder, but is said to have moderate sensitivity for panic disorder, social anxiety disorder, and post-traumatic stress disorder. Items are scored 0 to 3 for responses of “not at all” to “nearly every day” and summed. When screening for anxiety disorders, a recommended cut point for further evaluation is a score of 10 or greater, with scores of 5, 10, and 15 said to indicate mild, moderate, and severe levels of anxiety symptoms.
7. **Socio-emotional skills (emotional awareness, acceptance, and clarity; self-regulation strategies, goal directed behaviour; impulse control):** Based on input from the school stakeholders, and aligning with new strategic frameworks or recommendations for school-based mental health programs (e.g., Ontario Ministry of Education, 2016; People for Education; School Mental Health ASSIST), items from the *Difficulties in Emotional Regulation Scale (DERS)*³⁴ were added to reflect socio-emotional skills. The DERS has been widely validated in diverse adolescent populations.³⁵⁻³⁷ Considering space and time restraints, one item on each subscale was included (based on factor loadings across past studies using general population samples of adolescents).³⁵⁻³⁷ The 6 subscales include: lack of emotional clarity, lack of emotional awareness, difficulties engaging in goal-directed behaviour, limited access to emotional regulation strategies, impulsive control difficulties, and nonacceptance of emotional responses. These items allow for evaluation of whether school-based mental health programs are effectively improving students’ emotional regulation skills, which are shown to be predictive of later wellbeing and/or dysfunction.
8. **Depression:** The *Centre for Epidemiological Studies Depression Scale Revised (CESD-R-10)*^{38,39} is designed to assess risk for, or symptoms of, unipolar depression. The CESD is one of the most well known self-report scales for measuring depression risk, and valid and reliable for use among general population samples of adolescents.³⁸ The CES-D-10 is a shortened version and demonstrates factor validity and internal consistency in adolescent community samples.⁴⁰ The items are scored from 0 to 3 for “none or less than one day” to “five to seven days”, with items (e) and (f) reverse scored. Scores of 10 or above indicate significant depressive symptoms. Note that an alternative 10-item version – the *CESD Scale-Revised 10-Item Version for Adolescents (CESDR-10)*⁴¹ - was not used because the item “better off dead” would likely not be permissible using passive-permission procedures. While the version chosen (the CES-D-10³⁹) does not include an

irritability item – an important symptom in youth depression – irritability is assessed on the MHq as part of the GAD-7.

9. **The Kids Help Phone logo:** The COMPASS leadership team felt strongly that if we were going to ask students to reflect on questions pertaining to their mental health, that we would ethically want to also provide any students who may be in need of some support with a mechanism for reaching out for help. As such, we reached out to a well recognized, robust, and free resource available to youth nationally known as The Kids Help Phone and asked permission to include their logo and contact information within the MHq. School data collectors also bring Kids Help Phone wallet cards to the schools, providing free easy-to-access resources to youth participating in COMPASS who may be experiencing mental health problems. This led to continuing discussions on furthering a partnership with Kids Help Phone on the current project moving forward.

Mental Health School-level Program and Policy Scan Tool (MHpp)

The MHpp (see Appendix B) was designed to collect the longitudinal school-level program, policy, and resource data pertaining to mental health, allowing for the ongoing evaluation of how many changes impact student-level data. The MHpp is intended to be incorporated into the existing COMPASS School Policies and Practices questionnaire (SPP). The MHpp and SPP are completed by the school administrator(s) most knowledgeable about the program and policy environment within the school. Schools administrators are emailed a link to complete the MHpp and SPP online (see figure 1). The questionnaires are also available in paper form if school contacts prefer.

The MHpp working group convened November 2016 in Waterloo (ON) to develop a draft version of the MHpp. The MHpp was designed with the following considerations:

1. Items are consistent with the SPP items assessing school programs, policies, priorities, and staff development related to other areas of student health and wellbeing.
2. Items align with recommendations for school environments supportive of student mental health.^{3,8} For example, items assess staff training, availability of universal mental health promotion programs, targeted prevention and early intervention programs for at-risk students, in-school mental health services and specialist staff, coordination with off-site services, and referral procedures.
3. Items are designed to measure the absence/presence of and any changes to programs, policies, or resources related to mental health within each school in order to allow for evaluation of their effectiveness.
4. Items assess the school-level priorities and practice-based needs.

5. As with the MHq, items were designed to provide synergy with school surveys that have been validated and used in similar settings and populations (e.g., SMHS, People for Education), allowing comparison to representative samples.
6. Items reflect current programming and strategic priorities within schools relevant to mental health.
7. The tool is intended to be brief and simple to complete, in order to minimize burden on schools and to ensure proper completion and future continued engagement in the COMPASS study.

COMPASS School Policies and Practices Questionnaire 2016-17 - Mental Health Pilot

Mental Health Questions

51. Please rank the following areas of primary concern related to your students' mental health:
(Rank items from 1 to 8 where 1 = highest priority, 8 = lowest priority)

Select Option	Select Rank	Final Ranking (click to remove)
Attentional problems	1	1.
Disruptive behavioural issues	2	2.
Depressed mood	3	3.
Anxiety symptoms	4	4.
Disordered eating	5	5.
Self-harm and/or suicidality	6	6.
Trauma	7	7.
Substance use	8	8.

52. Are there any other mental health-related issues that are important to your school that are not listed in Question 51 above?
Yes (please list):
No

[Previous](#) [Next](#)

27/31

Figure 1. Screen shot from the MHpp online tool

Mental Health School-specific Knowledge Exchange Tool (MHkte)

Previous experience in school-based prevention programming has demonstrated that schools value simple context-appropriate knowledge exchange tools (e.g., customized feedback reports) that provide them with school-specific understanding of the characteristics of their student population, the quality of the school environment they are providing to their students, and suggestions of relevant programs, policies, or changes to the built environment they can introduce to improve student outcomes.^{42,43}

To help foster and enable schools to create healthier school environments aligned with their own capacity and priorities, the MH-M provides a customized school-specific Mental Health Knowledge Translation and Exchange Tool (MHkte) to all participating schools. The MHkte was designed to allow schools to quickly and easily see “at a glance” the mental health profile of their student population to inform where and how they should target future prevention activities and resources. The MHkte also includes a list of evidence-based or evidence-informed recommendations for action aimed at changing the school environments to improve and maintain the mental health of the student population.

The MHkte (see Appendix C) was designed to be consistent with the COMPASS SHP and with the following considerations:

1. To provide schools an overview of their student mental health, items from the MHq were chosen that portray students’ overall positive mental health, functioning, and supports, and that indicate the proportion of students at-risk of mental health problems or disorders.
2. Only school-level averages are reported to ensure anonymity.
3. To enhance readability, items were chosen that require minimal explanation or prior knowledge of the scales/concepts.
4. To promote utility and engagement of schools, items provide data on issues that can realistically be addressed by feasible changes in the school environment;
5. The MHkte also includes evidence-based and/or evidence-informed recommendations for action (programs, policies, and/or changes to resources within a school) aimed at changing the school environment to improve or maintain the mental health of the student population. This content was derived from reviewing existing literature and informed by public health and school board mental health professionals.
6. The contact information for the local Public Health Unit staff member(s) responsible for supporting schools with mental health programming will be provided to assist schools in connecting to resources.

7. Working with an illustrator, images were intended to be non-stigmatizing and to reflect diversity within the student population;
8. Recognizing school time restraints, the abundance of information schools receive, and their many competing priorities, the MHkte was limited to one page with minimal content to allow schools administrator to quickly identify priorities and appropriate responses.

As mentioned, the MHkte is enhanced by COMPASS Knowledge Brokers, who assist school administrators in identifying priorities and appropriate actions based on their school context and resources, and in connecting to resources to implement changes. With the COMPASS system longitudinal and quasi-experimental design, any changes to the school programs, policies, or resources can then be evaluated in the following wave(s) of the study, allowing for the continual improvement of schools' ability to support the mental health of their students.

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Appendix A: MHq

Mental Health

66. How would you rate your mental or emotional health?

- Excellent
- Very good
- Good
- Fair
- Poor

67. How much do you agree or disagree with the following statements?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
a) I have a happy home life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b) My parents/guardians expect too much of me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c) I can talk about my problems with my family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d) I can talk about my problems with my friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

68. How much do you agree with the following statements?

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
a) I lead a purposeful and meaningful life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b) My social relationships are supportive and rewarding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c) I am engaged and interested in my daily activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d) I actively contribute to the happiness and well-being of others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e) I am competent and capable in the activities that are important to me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f) I am a good person and live a good life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g) I am optimistic about my future	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h) People respect me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

69. Choose the answer that best describes how you feel.

	True	Mostly true	Sometimes true, sometimes false	Mostly false	False
a) In general, I like the way I am	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b) Overall, I have a lot to be proud of	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c) A lot of things about me are good	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d) When I do something, I do it well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e) I like the way I look	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

70. If you had concerns regarding your mental health, are there any reasons why you wouldn't talk to an adult at school (e.g., a school social worker, child and youth worker, counsellor, psychologist, nurse, teacher, or other staff person)? (Mark all that apply)

- I would have no problem talking to an adult at school about my mental health
- Worried about what others would think of me (e.g., I'd be too embarrassed)
- Lack of trust in these people - word would get out
- Prefer to handle problems myself
- Don't think these people would be able to help
- Wouldn't know who to approach
- There is no one to talk to

Over

Appendix B: MHpp

COMPASS SPP items relevant to mental health

1. **In the past 12 months, have there been any changes to the written policies regarding student health (e.g., healthy eating, substance use, bullying) at your school (including changes to written policies contained in the student handbook or posted on the school website)?**

Yes

No

If yes, please provide us with link to the website location below, or supply a copy of the updated handbook to the COMPASS team.

2. **In the past 12 months, has your school received any grants to support efforts to improve the health of students at your school?**

Yes (please list)

No

If yes, were COMPASS data helpful in selecting or obtaining those grants?

3. **What barriers and/or challenges exist with respect to implementing programs to improve the health of students at your school?**

(Check all that apply)

Inadequate funding and support for school-based health programs and services for students

Lack of information about what programs we should be implementing

Inadequate staff time available to implement programs

Inadequate space available to implement programs

Low priority given to student health versus other initiatives in the school

4. **Please rank these school/health-related issues in terms of importance to your school:**

(Rank items from 1 to 10 where 1 =highest priority, 10 = lowest priority)

Tobacco Use

Alcohol and Other Drug Use

Healthy Eating

Physical Activity

Bullying/Violence

Mental Health

Sexual Health

Sun safety/tanning beds

Obesity/overweight/healthy weight

Sedentary behaviours/screen-time

7. **During the past 12 months, have one or more school staff received training in the following areas:**

e. Mental Health:

In-service training (e.g., by Public/ Regional Health)

Conferences
Workshops on professional development days
Presentations by Community Organizations
Teacher initiated self-training on the Internet
Faculty of Education courses
Other
(please specify)

COMPASS MHq items

51. Please rank the following areas of primary concern related to your students' mental health:

(Rank items from 1 to 8 where 1 =highest priority, 8= lowest priority)

Attentional problems
Disruptive behavioural issues
Depressed mood
Anxiety symptoms
Disordered eating
Self-harm and/or suicidality
Trauma
Substance use

52. Are there any other mental health-related issues that are important to your school that are not listed in Question 51 above?

Yes (please list)

No

53. During the past 12 months, how many staff have received the following training related to mental health?

a. Mental health awareness/literacy (e.g., basic information, key warning signs)

All or most

Some (e.g., 1-5)

None

b. Providing mental health support (e.g., mental health first aid, Supporting Minds, etc.)

All or most

Some (e.g., 1-5)

None

c. Suicide prevention

All or most

Some (e.g., 1-5)

None

d. Other (please specify)

All or most

Some (e.g., 1-5)

None

54. Please list any mental health professionals available at your school (e.g. Social Worker, Child and Youth Worker, Psychologist, etc.):

(Select all availability options that apply)

Personnel #1:

On-call

On-site full-time

Regularly scheduled ____ hours/month:

Personnel #2:

On-call

On-site full-time

Regularly scheduled ____ hours/month:

Personnel #3:

On-call

On-site full-time

Regularly scheduled ____ hours/month:

55. Are any of the following mental health services available on-site at your school?

(Check all that apply)

Assessment for emotional or behavioural problems (including behavioural observation, psychosocial assessment and observation checklists)

Diagnostic assessment (comprehensive psychological evaluation)

Behavioural management consultation with teachers, students, or families

Case management, including monitoring and coordination of services

Referral to specialized programs or services for emotional or behavioural problems or disorders

Crisis intervention (e.g., response to traumatic events, including disasters, serious injury/death of a member of the school community)

Individual counselling/therapy

Group counselling/therapy

Family support services in school setting (e.g., child/family advocacy, counselling)

56. What are your general practices for routine referral to and coordination with community-based mental health organizations or providers?

(Check all that apply)

Staff make passive referrals (e.g., give brochures, lists and contact information of providers or organizations)

Staff make active referrals (e.g., staff complete form with family, make calls or appointments, assist with transportation)

Staff follow-up with student/family (e.g., calls to ensure appointment kept, assess satisfaction with referral, need for follow-up)

Staff follow-up with provider (via phone, e-mail, mail)

Staff host or attend team meetings with community providers

Staff do not make referrals

57. During the past 12 months, what role did your local Public Health Unit (PHU) play when working with your school on improving mental health for students?

(Check all that apply)

No contact with local Public Health Unit

Provided information/resources/programs (e.g., posters, toolkits)

Solved problems jointly

Developed/implemented program activities jointly

58. Other than classes/curriculum, does your school offer any programs to promote mental health? (e.g., stigma reduction, suicide prevention, peer support, stress management strategies, mental health literacy)

(Check all that apply)

Programs run by Public Health Unit

Programs run by external organization

(If any selected). Please provide additional details.

Appendix C: MHkte

Mental Health Outcomes at

Among students at your school:

___% rate their mental or emotional health as good, very good, or excellent

___% report they have a lot to be proud of

___% are optimistic about their future

___% feel competent and capable in activities that are important to them

___% feel engaged and interested in their daily activities

___% report their life is purposeful and meaningful

___% report supportive and rewarding social relationships



___% wouldn't know who to approach at school if they needed help



___% felt nervous, anxious, or on edge several days or more in last 2 weeks



___% felt depressed in the last week



___% have difficulty making sense out of their feelings

WHY THIS IS AN ISSUE

RECOMMENDATIONS

PUBLIC HEALTH CONTACT

University of Waterloo
200 University Ave. W., Waterloo, Ontario, Canada N2L 3G1
Telephone: (519) 888-4567
www.compass.uwaterloo.ca

